



OFFICE OF THE
INFORMATION & PRIVACY
COMMISSIONER
for British Columbia

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INVESTIGATION REPORT F13-05

**PUBLIC BODY DISCLOSURE OF
INFORMATION UNDER SECTION 25 OF
THE *FREEDOM OF INFORMATION AND
PROTECTION OF PRIVACY ACT***

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Information and Privacy Commissioner for BC**

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TABLE OF CONTENTS

	<u>PAGE</u>
COMMISSIONER’S MESSAGE	3
EXECUTIVE SUMMARY	4
1.0 PURPOSE AND SCOPE OF REPORT	6
2.0 ISSUES	8
3.0 SECTION 25 OF FIPPA	8
4.0 CASE STUDIES SUBMITTED BY ELC	12
5.0 ANALYSIS: SURVEY OF PUBLIC BODIES	29
6.0 RECOMMENDATIONS FOR PUBLIC BODIES TO ENSURE COMPLIANCE WITH SECTION 25	31
7.0 PROPOSED AMENDMENT TO SECTION 25(1)(b)	32
8.0 SUMMARY OF FINDINGS AND RECOMMENDATIONS	34
9.0 CONCLUSION	36
10.0 ACKNOWLEDGEMENTS	37

COMMISSIONER'S MESSAGE

Section 25 of the *Freedom of Information and Protection of Privacy Act* (“FIPPA”) contains two grounds upon which public bodies are obligated to provide the public with timely information. One is where there is a significant risk of harm to the environment or to health or safety of the public and the other is where this information is, for any other reason, clearly in the public interest. These provisions override every other provision of FIPPA.

Section 25 has been interpreted as establishing a high legal threshold for disclosure—there must be an urgent and compelling need for compulsory public disclosure.

I believe s. 25 is difficult to apply since, while the grounds for disclosure are stated, the determination of what triggers an urgent and compelling need for disclosure can be open to broad and inconsistent interpretation by the heads of public bodies.

I trust this report will further the understanding of how and when to apply s. 25 to the responsibilities public bodies undertake. I have also included suggestions for amendments to s. 25 to assist in clarifying the basis for disclosure of information that is clearly in the public interest.

Elizabeth Denham
Information and Privacy Commissioner
for British Columbia

EXECUTIVE SUMMARY

Section 25 of the *Freedom of Information and Protection of Privacy Act* (“FIPPA”) requires that public bodies disclose information which would reveal a risk of significant harm to the environment, or to the health or safety of the public, or is otherwise in the public interest. This obligation overrides any other provision of FIPPA, and must be met without delay.

This investigation was initiated in response to a request to my office from the BC Freedom of Information and Privacy Association based on a submission by the University of Victoria’s Environmental Law Clinic. The submission described six case studies where public bodies may have failed to disclose information pursuant to s. 25. I initiated an investigation into five of the six case studies, and surveyed 11 other public bodies regarding the policies and procedures they have in place to comply with their obligations under s. 25. The issues contained in the sixth case study have already been commented on under an Order by an adjudicator in this office.

The first case study related to the 2010 collapse of the Testalinden Dam near the town of Oliver. The Ministry of Forests, Lands and Natural Resource Operations is responsible for the inspection and safety of dams. It had information from inspection reports that the dam was nearing the end of its life and was a hazard to people and property located downstream. I found that when FIPPA came into force in 1993, the Ministry failed to meet its obligation under s. 25 to disclose information about the compromised state of the dam to residents downstream.

The second case study related to an air quality report for the City of Prince George. In 2008, the Ministry of Environment conducted an air quality study in which one test indicated levels of formaldehyde that were significantly higher than normal, and well above safe levels. The Ministry did not fully evaluate this test until seven months later and concluded that the results were incorrect based on other related indicators. I found that the Ministry’s interpretation of the results was reasonable, and therefore there was no urgent and compelling need for disclosure of this information. Accordingly, the Ministry had no obligation to disclose these results under s. 25.

The third case study related to a 2009 BC Centre for Disease Control (“BCCDC”) study which indicated that the incidence of Lyme disease in BC was higher than officially reported. The Environmental Law Clinic argued that this underreporting posed a significant public health risk which should have been disclosed by the BCCDC and the Provincial Health Services Authority (“PHSA”). I found that the information describing an underreporting of the incidence of Lyme disease was not of an urgent and compelling nature and therefore neither the PHSA nor the Provincial Health Officer would have had an obligation to disclose it.

The fourth case study relates to well water tests in the Cowichan Valley Regional District (“CVRD”) which showed elevated nitrate levels. The owners of the wells were informed of the results, but, as neither well supplied drinking water and the water in the aquifer was unaffected, the CVRD did not inform the public. I found that the CVRD did not have an obligation under s. 25 to disclose the test results because there was no urgent and compelling need for public disclosure of the information.

The fifth case study relates to the occurrence of mould in Hamilton Hall, a student residence at Simon Fraser University (“SFU”). One of the rooms at Hamilton Hall was occupied by a graduate student who informed SFU prior to moving in that he had health issues related to mould. I found that SFU was only aware of the presence of mould as a result of engineering reports commissioned after the graduate student had moved out of Hamilton Hall. SFU did not have information that was of an urgent and compelling nature that would have necessitated disclosure to the graduate student or other student residents with relevant health sensitivities. As a result, SFU did not have an obligation to disclose information under s. 25.

With respect to the sixth case study, as my office has already issued Order F10-06¹ on this matter, I did not re-open this case.

The survey of 11 public bodies undertaken for this report indicated that public bodies do not fully understand their obligations under s. 25. I recommend that public bodies should develop policies that provide guidance to employees and officers about their obligations under s. 25 of FIPPA.

A review of the application of s. 25 indicates that s. 25(1)(a), which requires disclosure of information that reveals a risk of significant harm to the environment, or to the health or safety of the public, is effective. However, a review of our records indicates that s. 25(1)(b), which requires disclosure which is otherwise in the public interest, has never been applied by a public body. In my opinion, this is because disclosure must be both in the public interest and urgent. In order to give effect to the intent of s. 25(1)(b), I believe that the public interest disclosure provision should not require urgent circumstances. I recommend that s. 25(1)(b) be amended so that there is a mandatory obligation for public bodies to disclose information of a non-urgent nature where disclosure is clearly in the public interest.

¹ 2010 BCIPC 9 (CanLII).

1.0 PURPOSE AND SCOPE OF REPORT

1.1 Introduction

Public bodies bear significant responsibility for the functioning of our province and for the welfare of citizens. Ministries, local governments, schools, crown corporations, health authorities, municipal police forces, and other public bodies, manage vast quantities of information, some of it critical to the health and safety of citizens.

Where that information reveals a risk of a significant harm to the environment, or to the health or safety of the public, a public body has an obligation to publicly disclose it under s. 25(1)(a) of the *Freedom of Information and Protection of Privacy Act* (“FIPPA”). That duty overrides any exceptions to disclosure that might otherwise apply to that information under FIPPA.

The Freedom of Information and Privacy Association (“FIPA”) wrote to me on June 5, 2012, asking that I investigate whether there has been a widespread failure by public bodies to notify the public of risks of significant harm to people or the environment or of information that is otherwise clearly in the public interest. FIPA’s request was based on a report prepared by the University of Victoria’s Environmental Law Clinic (“ELC”).² In this report, the ELC set out six cases where it alleged that public bodies should have disclosed information to the public under s. 25(1) of FIPPA, but failed to do so. FIPA also asked me to clarify the meaning of s. 25(1), and to provide guidance to public bodies on its interpretation and application.

The ELC did not specifically request that I investigate the six cases it set out. However, I decided that it was necessary to investigate five of these six cases in order to assist me in establishing whether there is a systemic problem with the way public bodies apply s. 25(1). The sixth case was the subject of a previous Order from this office and was not re-opened in this investigation. In that regard I make findings about whether the public bodies in the six ELC cases complied with their statutory obligations.

The results of my investigation of these cases raised a question for me about whether public bodies in BC generally understand their responsibilities under s. 25 of FIPPA. To this end, I surveyed a cross-section of 11 additional public bodies that are likely to deal with s. 25(1) issues as a result of their mandate and the information they have in their possession.

² The full ELC report can be found online at http://www.elc.uvic.ca/press/documents/OIPC-ELC-FOIPA-Submission_June5.2012.pdf.

The outcome of the survey led me to question whether public bodies are taking necessary steps to ensure they are meeting their obligations under s. 25. This report also comments on whether s. 25, as it is presently worded and interpreted in BC, adequately serves the public interest. I conclude this report with a recommendation that government amend FIPPA to more effectively require the disclosure of information that is clearly in the public interest.

1.2 Investigative Process

I have a statutory mandate to monitor the compliance of public bodies with FIPPA to ensure its purposes are achieved. The purposes, as stated in s. 2(1) of FIPPA, are to make public bodies more accountable to the public and to protect personal privacy.

Under s. 42(1)(a) of FIPPA, I have the authority to conduct investigations and audits to ensure compliance with any provision of FIPPA. Consistent with this authority, I investigated public bodies named in five of the six case studies in the ELC report.³ I invited the five public bodies to respond to the allegations set out in the ELC report. The public bodies made submissions to my office, which I considered in making my findings.

Pursuant to s. 42(1)(e), I also have the authority to engage in or to commission research into the achievement of the purposes of FIPPA. Under this authority, I conducted a survey of 11 public bodies in BC about their understanding of s. 25 and what measures they take to ensure compliance with that provision. These 11 public bodies included school districts, health authorities, police departments, and local governments.

I asked these public bodies to provide copies of any policies, procedures, and guidelines they use in determining whether to disclose information under s. 25(1) of FIPPA. The survey participants were not under investigation and, as a result, I have not named them in this report. However, the conclusions I draw from their responses inform my recommendations.

³ The sixth case was the subject of a previous Order by my office and, although not properly the subject of this investigation, I have included a summary of the Order in this report.

2.0 ISSUES

The issues in this investigation are:

1. Whether the public bodies named in five separate case studies submitted by ELC were required under s. 25(1)(a) of FIPPA to disclose information about a risk of significant harm to the environment or to the health or safety of the public or to an affected group of people;
2. Whether those five public bodies were required under s. 25(1)(b) of FIPPA to disclose information, the disclosure of which is, for any other reason, clearly in the public interest;
3. Whether public bodies in BC understand their obligations under s. 25(1) and take appropriate measures to ensure they meet these obligations; and
4. Whether government should amend the public interest disclosure provision in FIPPA to improve its effectiveness.

3.0 SECTION 25 OF FIPPA

The relevant portions of s. 25, as concerns this investigation, read as follows:

- 25(1) Whether or not a request for access is made, the head of a public body must, without delay, disclose to the public, to an affected group of people or to an applicant, information
- (a) about a risk of significant harm to the environment or to the health or safety of the public or a group of people, or
 - (b) the disclosure of which is, for any other reason, clearly in the public interest.
- (2) Subsection (1) applies despite any other provision of this Act.
- (3) Before disclosing information under subsection (1), the head of a public body must, if practicable, notify
- (a) any third party to whom the information relates, and
 - (b) the commissioner.

This office has interpreted s. 25(1) in several Orders. What follows are the most relevant aspects of the s. 25(1) test that I have applied in this investigation.

3.1 The Meaning of “Without Delay”

Previous Orders of this office have interpreted the phrase “without delay” in s. 25(1) as requiring an “element of temporal urgency” such that neither ss. 25(1)(a) or (b) is triggered unless there is an urgent and compelling need for disclosure. The circumstances must be of clear gravity and present significance which compels the need for disclosure without delay.⁴ This sets a very high legal threshold before public bodies are required to disclose information under this section.

For example, a public body would not be required to disclose information about how a hospital responded to a disease outbreak under ss. 25(1)(a) or (b). In this scenario, the health risk has passed and any urgent and compelling need for disclosure that may have existed at the time of the disease outbreak is no longer present.

3.2 Disclosure About a Significant Risk of Harm

Section 25(1)(a) imposes an obligation on public bodies to disclose information about a significant risk of harm. In Order 02-38, former Commissioner David Loukidelis indicated what information would be about a risk identified in s. 25(1)(a). This information includes, but is not 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; and
- information that allows the public to take action necessary to meet the risk or mitigate or avoid harm.⁵

When a public body discloses information pursuant to s. 25(1)(a), it must be able to provide its reasons for doing so to my office upon request.⁶ Reasons should include evidence of the existence of the identified risk, and a description of the nature and extent of anticipated harm.

3.3 Disclosure Required if Clearly in the Public Interest

In considering whether to disclose information pursuant to s. 25(1)(b), a public body must conduct a two-step analysis. First, there must be an urgent or

⁴ Order 02-38, [2002] B.C.I.P.C.D. No. 38, at para. 53.

⁵ *Ibid.*, at para. 56.

⁶ *Ibid.*, at para. 38.

compelling need for disclosure of the information. Second, there must be a sufficiently clear public interest in disclosure of the information in question.⁷

In order for there to be a clear public interest, the information must contribute in a substantive way to the body of information that is already available to enable or facilitate effective use of various means of expressing public opinion and making political choices.⁸ Section 25(1)(b) does not apply to information that will add little or nothing to that which the public already knows.⁹

The potential interest of the public in learning about an issue does not necessarily make disclosure of that information “clearly” in the public interest;¹⁰ rather, it must further the education of or debate among the public on a topical issue.

While information rights are an essential mechanism for holding government to account, s. 25(1)(b) is not intended to be used by the public to scrutinize public bodies.¹¹ In these circumstances, the public may still use its general right to access records under FIPPA.

3.4 Section 25 Overrides All Other FIPPA Sections

Section 25(2) states that s. 25(1) applies despite any other provision of FIPPA. Accordingly, none of the exceptions under FIPPA can be applied to information disclosed pursuant to s. 25(1).¹²

When disclosing information under s. 25, public bodies need only disclose information that “satisfies either the significant harm or clear public interest tests”; they need not disclose entire records.¹³ So, while the exceptions in Part 2 of FIPPA cannot be applied, information in records that is not compelling is not required to be disclosed.

⁷ Order F09-04, [2009] B.C.I.P.C.D. No. 7, at para. 13.

⁸ *Supra* note 3, at para. 66.

⁹ *Supra* note 3, at para. 67.

¹⁰ Order 04-12, [2004] B.C.I.P.C.D. No. 12, at para. 14, and Order 01-20, [2001] B.C.I.P.C.D. No. 21, at para. 31, which reads, “Although the words used in s. 25(1)(b) potentially have a broad meaning, they must be read in conjunction with the requirement for immediate disclosure and by giving full force to the word ‘clearly,’ which modifies the phrase ‘in the public interest.’”

¹¹ Order 00-16, [2000] B.C.I.P.C.D. No. 19, and Order 04-09, [2004] B.C.I.P.C.D. No. 9.

¹² Order 01-20, at para. 34.

¹³ Adjudication Order No. 3 (June 30, 1997), cited in Order 00-16, at p. 13.

3.5 Notification to the Commissioner

When a public body decides that it wishes to disclose information under s. 25, it must notify the Commissioner, if practicable, before disclosing that information. Out of the 49 notifications under s. 25(1)(a) that this office has received since January 2011, 43 of them are from police departments and the Ministry of Justice (which includes the former Ministry of Public Safety and Solicitor General) about dangerous offenders being released into a community. The remaining six notifications came from health and safety authorities and a post-secondary institution.

Our office has not received any notifications that relate to a disclosure that is clearly in the public interest pursuant to s. 25(1)(b).

3.6 Reviewing Public Body Decisions

When a public body decides that s. 25(1) does not apply to particular information and an individual disagrees, that individual may apply to my office to request a review of the public body's decision. This office has issued several Orders under s. 25(1) and, as noted earlier in this report, the legal threshold for this section is very high. In fact, to date, this office has not ordered a public body to disclose information under s. 25(1).

The high threshold for s. 25(1) precludes mandatory disclosure in all but the most urgent and compelling situations. This is one reason why my predecessor called for amendments to s. 25(1) that would authorize the disclosure of non-urgent information in the public interest where the benefits from such disclosure outweigh any potential harm.¹⁴ I will return to this issue in section seven of this report on proposed amendments to s. 25(1)(b).

¹⁴ Submission of the A/Information and Privacy Commissioner to the Special Committee to Review the *Freedom of Information and Protection of Privacy Act*, March 15, 2010, at p. 21. The full submission can be found online at <http://www.oipc.bc.ca/special-reports/1275>.

4.0 CASE STUDIES SUBMITTED BY ELC

4.1 Ministry of Forests, Lands and Natural Resource Operations: The Testalinden Dam Collapse

Background

The Testalinden Dam was a privately-owned earthen dam, constructed in the 1930s on Mount Kobau near the town of Oliver. The dam collected water for irrigation purposes.

The dam had a series of owners, and was the subject of concerns and warnings from water engineers since the 1970s.

The Ministry had professional engineers conduct various inspections and issue investigation reports to the dam owner after each inspection. The following is a summary of the inspection reports from 1977 to 1992 that the Ministry provided my office for review:

- After a 1977 inspection, a professional engineer stated in a report that “The present condition of the dam requires it to be either reconstructed or to be removed.”
- After a 1978 inspection, a professional engineer stated in a report that “The dam in its present condition is a hazard to life and property to some of the settled areas along the Osoyoos-Oliver Highway which lies downstream of the Testalinden Lake dam. We recommend that the dam either be breached or reconstructed. Should you opt not to reconstruct, the dam should be breached prior to April 1st, 1978.”
- After a 1980 inspection, a professional engineer stated in a report that “The dam in its present condition is a hazard, and endangers the settled areas downstream, along the Osoyoos-Oliver highway. We recommend that the dam either be breached or reconstructed prior to May 15, 1981, and that the grate valve be opened immediately and remain open till the dam is breached or reconstructed.”
- After a 1985 inspection, a professional engineer stated in a report that “This structure, in its present condition, is a hazard and the Water Management Program recommends that it be replaced by a new dam.”

- After a 1988 inspection, a professional engineer stated in a report that “... this structure is in a very poor state of repair. The dam has reached the end of its lifespan and should be replaced by a new one. Most of the repairs listed on this report have been requested previously; see our letter of September 23, 1985. No attempt has been made to carry out our instructions.”
- The 1992 inspection report consists entirely of a checklist of areas inspected, which constituted only part of previous inspection reports. The report makes no reference to whether the dam should be replaced or not.

There does not appear to have been any further inspections after this date, with the exception of a site visit by a Ministry inspector in 1999. As was the case with the 1992 inspection report, there is no record of any conclusions regarding the dam drawn from this 1999 site visit. In fact, the Ministry confirms that the 1999 site visit did not result in a report.

In June 2010, the dam failed, releasing a torrent of mud and debris from the reservoir, seriously damaging houses and farmland situated below.

Issue

The issue in this case study is whether, prior to the collapse of the Testalinden Dam, the Ministry had an obligation under ss. 25(1)(a) or (b) to disclose information to the public or to an affected group of people.

ELC's Position

The ELC asserts that a significant risk to people and the environment had been identified during routine inspections of the Testalinden Dam, and that the Ministry was obliged to notify the affected group when FIPPA came into force in 1993.

The ELC further asserts that when the Ministry raised concerns during an informal site visit in 1999, it was required by s. 25(1) to notify the residents below the dam of a risk to their health and safety.

The Ministry's Position

The Ministry's position is that s. 25(1) of FIPPA did not require the head of the public body to disclose information about the Testalinden Dam at the material times because the evidence available did not indicate that there was a level of safety or environmental risk in relation to the dam that approached the threshold

required. When FIPPA came into force the most recent information available was the 1992 report. That report did not indicate an imminent risk of failure; nor did the 1999 site visit.

The Ministry asserts that the Dam Safety Officer conducting the 1992 inspection and the 1999 site visit believed at the time that there was no imminent danger of failure of the dam. Although there are no contemporaneous records that corroborate this, the Ministry provided my office with a letter from the Dam Safety Officer dated November 28, 2013 stating that this was the case.

In the Ministry's view, the validity of these conclusions is supported by the fact the dam did not breach until 2010. The Ministry submits there was no temporal urgency at the material times.

The Ministry also states that Elkink Ranch Ltd., as the water rights licensee and owner of the dam, was responsible for the maintenance of the dam since the early 1980s and it did not report the constricted overflow culvert, which caused the breach to the Ministry.

Finally, I note the Ministry's belief that the cause of the dam's failure was a combination of factors including higher than normal snowpack, twice the normal rainfall and a constriction of the overflow pipe led to the dam's breach. Causation of the dam's failure is not at issue in this investigation. Instead, the issue before me is simply whether the Ministry had an obligation under ss. 25(1)(a) or (b) to disclose information to the public or to an affected group of people.

Analysis

It is correct to say that the Ministry's obligation to consider s. 25(1) first arose when FIPPA came into force in 1993. This does not mean, however, that it was free to ignore information that had come to the Ministry's attention before that time.

The Ministry provided our office with copies of inspection reports from 1977 to 1992. In five of these reports, the Ministry recommended to the dam's owners that they replace the Testalinden Dam. However the Ministry's submissions did not explain what, if any, consideration it gave to the reports prior to 1992 in relation to their obligations under s. 25. Instead, the Ministry relied on the 1992 inspection report and the 1999 site visit as well as the Dam Safety Officer's opinion that was not documented until November 28, 2013 that there was no imminent risk of failure.

There is no question that the 1977 to 1992 inspection reports provided the Ministry with comprehensive information about the dam when FIPPA came into force in 1993 and the Ministry was obligated to consider those as relevant to its assessment of matters as those related to s. 25. In this regard, there were various Ministry inspection reports that state the dam needed to be replaced. The 1978 report was unmistakably direct in stating:

The dam in its present condition is a hazard to life and property to some of the settled areas along the Osoyoos-Oliver Highway which lies downstream of the Testalinden Lake dam.

The 1985 report referred to it as a “hazard” and in 1988 the Ministry was told that “[t]he dam has reached the end of its lifespan and should be replaced by a new one.”

In applying s. 25(1)(a) of FIPPA, I conclude from the totality of the reports conducted on behalf of the Ministry from 1977 to 1992, that there was an urgent and compelling need for public disclosure of information about a risk of significant harm to the environment or to the health or safety of residents downstream of the dam along the Osoyoos-Oliver Highway. The Ministry’s inspection reports from 1977 to 1988 consistently state that the dam needed to be replaced and refer to the potential hazard to individuals and to property. Nothing in the 1992 inspection report or from the 1999 site visit contradicts these findings. In fact, the Ministry did not even address the findings of the previous reports in 1992 or 1999.

In my view, it was not reasonable for the Ministry to rely on the Dam Safety Officer’s observations about the 1992 inspection and the 1999 site visit, which were only documented in 2013, excluding earlier, more thorough reports indicating an imminent risk of the dam’s failure.

Similarly, it is not reasonable for the Ministry to suggest that because the dam did not breach until 2010, there was no imminent risk of failure in 1993. A public body cannot rely on hindsight in assessing whether it has met its obligations under s. 25. Instead, it must rely on information that it has at that time.

I believe that disclosure of the information the Ministry possessed from its various reports would have been clearly in the public interest under s. 25(1)(b). The information about the risk of failure of the dam was information that the public did not know and that would have likely resulted in the local citizenry, at the very least, pressuring government to take remedial action.

Conclusion

I find that when FIPPA came into force in 1993, the Ministry had an obligation under ss. 25(1)(a) and (b) to disclose information about the compromised state of the Testalinden Dam to residents downstream of the dam along the Osoyoos-Oliver Highway because there was an urgent and compelling need for public disclosure of this information. I also find that the Ministry did not meet this obligation.

4.2 Ministry of Environment: Prince George Air Quality

Background

The City of Prince George is situated in a northern BC valley. Prince George has faced ongoing issues with air pollution, in part due to industrial, residential and commercial sources and in part due to its location within a valley, where winter inversions tend to trap pollutants.

One of the air pollutants of concern is formaldehyde. It is a pungent, colourless gas emitted by pulp and paper mills and other forestry product plants, which breaks down and dissipates quickly in the air. Acute exposure to formaldehyde causes a burning sensation in the eyes, nose, and throat. Studies have shown that chronic exposure can result in asthma, an elevated sensitivity to allergens, and an increased risk of nose and throat cancer.¹⁵

In 2008, the Ministry of Environment began an odour study in Prince George. Its goal was to identify odour management actions to help reduce odour emissions in the Prince George air shed (“Odour Study”). The Prince George Air Improvement Roundtable (“PGAIR”), a non-profit organization made up of multiple stakeholders that was established to monitor and improve the city’s air quality, commissioned the Ministry to conduct the Odour Study.

In July and August 2008, the Ministry took five air samples. The analysis on the data outputs from these samples was not completed until April 2009. The Ministry’s later analysis of the 2008 samplings showed formaldehyde levels significantly higher than previous samples taken between 1994 and 1997. The Ministry presented the Odour Study data to PGAIR in April 2009. For various reasons that are set out below, the Ministry believes the test results were inaccurate.

¹⁵ See Health Canada, *Residential Indoor Air Quality Guide – Formaldehyde*, April 15 2006, online: http://www.hc-sc.gc.ca/ewh-semt/alt_formats/hecs-sesc/pdf/pubs/air/formaldehyde-eng.pdf

On May 29, 2009, PGAIR issued a press release on matters discussed at its May 26, 2009 meeting. The press release referred to the Odour Study and noted the elevated test levels and that the Ministry was preparing an interpretive report.¹⁶ PGAIR did not mention the possibility of a sampling error nor did it warn the public of a potential health risk.

In March 2010, PGAIR held a public meeting in which it explained the significance of the Odour Study test results. The Ministry carried out follow-up tests between April 2010 and March 2011. These test results showed that airborne formaldehyde was within acceptable levels.

Issue

The issue in this case study is whether the Ministry had an obligation under ss. 25(1)(a) or (b) to disclose the Odour Study results to the public or to an affected group of people.

ELC's Position

ELC submits that the Ministry should have disclosed the results of the Odour Study to the residents of Prince George in April 2009. It cites as its reasons high levels of formaldehyde detected in some of the air samples, and that the highest concentration of formaldehyde was obtained from a sample near a children's outdoor play area.

ELC asserts that disclosure should have taken place regardless of the Ministry's decision not to conduct additional testing at that time, and that the Ministry could have included the caution that the results were possibly inaccurate.

ELC further argues that presenting the test results as it did to the community-based non-profit society, PGAIR, and PGAIR's subsequent press release did not fulfill the Ministry's obligations to disclose information about a risk of harm to the public.

Ministry of Environment's Position

The Ministry asserts that it did not design the Odour Study to be a real-time reading of air quality, but rather to provide PGAIR with information to identify odour sources and develop and prioritize odour management actions. The Ministry received test results from the lab more than six weeks after it collected the samples and the Ministry subsequently required many months of analysis to better understand the results, which it believed were in error. It is the Ministry's

¹⁶ See PGAIR's May 29, 2009 press release at http://www.pgairquality.com/uploads/files/pdf/mediareleases/PGAIR_MediaBriefing_ProgressReport_09-05-28.pdf.

position that immediate communication of the results in a meaningful manner to the general public was impossible.

Further, the Ministry asserts that because formaldehyde breaks down and dissipates quickly in the air, information on air samples from July and August 2008, is of little relevance to the air quality in April 2009, and does not give rise to an immediate need for disclosure.

While the Ministry disclosed the test results to PGAIR, it did not inform the general public of the test results analyzed in April 2009, because it believed they were inaccurate and it did not want to cause unnecessary concern among Prince George residents. The Ministry considered the test results to be inaccurate for various reasons—there was no increase in odour complaints or hospitalizations at the time the samples were taken; there had been no additional identified sources of air pollution constructed in the valley that would cause an increase in formaldehyde levels; and local industrial emitters had been implementing technology to reduce emissions responsible for formaldehyde. In addition, the Ministry says the samples may have been contaminated or affected by construction in the local Ministry office where they were initially stored and also by the absence of immediate refrigeration.

Analysis

It is of considerable significance that the Ministry did not design the Odour Study to obtain air quality measurements in real time. Instead, the objective of the Odour Study was to collect information on which to base odour reduction measures. This helps to explain why the Ministry did not know the results of its July and August 2008 air samples until April 2009. Even had this explanation for the delay not existed, s. 25(1) does not impose on public bodies a duty to act in an expedient manner to acquire or create information. Instead, it addresses a public body's obligation to disclose information that it already has acquired in its operations.

Further, I believe the Ministry had a reasonable basis to consider that the air samples were inaccurate for the reasons I have set out above. These reasons include the fact that, despite the air samples showing a considerable elevation in formaldehyde levels, there had been no increase in odour complaints or hospitalizations concurrent with the time the samples were taken. There is also the fact that no additional identified sources of air pollution had been constructed in the Prince George area that would cause an increase in formaldehyde levels

Given the circumstances, I accept the Ministry's conclusion that the test results were inaccurate and that there was no imminent risk at the time the information came into the Ministry's hands. It follows from this that there was no public interest in disclosing inaccurate information without delay.

Conclusion

I find that the Ministry did not have an obligation under ss. 25(1)(a) or (b) to disclose the Odour Study results to the public or to an affected group of people because there was no urgent and compelling need for public disclosure of this information.

4.3 Disclosure Regarding Lyme Disease

Background

Lyme disease is caused by bites from bacteria-infected ticks living in Southern British Columbia, Vancouver Island, the Sunshine Coast, the Lower Mainland, and the Kootenay region. Lyme disease symptoms include a signature bulls-eye rash as well as fever, headaches, central and peripheral nervous system disorders, arthritis, extreme fatigue, general weakness and other pain. If diagnosed early, treatment with antibiotics can be quite effective. If left undiagnosed, Lyme disease can permanently impact an individual's joints, heart and nervous system.

When a physician diagnoses a case of Lyme disease, the *Public Health Act*¹⁷ requires the physician to report that diagnosis to a regional Medical Health Officer. The *Public Health Act* requires these officers to then report incidents of communicable diseases to the Provincial Health Officer. The BC Centre for Disease Control ("BCCDC") acts on behalf of the Provincial Health Officer to receive the reports. This enables BCCDC, on behalf of the Provincial Health Officer, to track incidents of communicable diseases, issue reports and provide advice and support for prevention initiatives.

When a physician diagnoses a case of Lyme disease, the *Public Health Act* requires the physician to report that diagnosis to a regional medical health officer. The *Public Health Act* requires these officers to then report incidents of communicable diseases to the Provincial Health Officer.

BCCDC is responsible for analyzing reportable communicable disease events and, in consultation with the Provincial Health Officer, deciding whether to issue health risk advisories. BCCDC reports to the Provincial Health Officer in all matters relating to public health, and reports to the Provincial Health Services Authority ("PHSA") in all other matters. The PHSA is a public body under FIPPA. In 2011, BCCDC was added to Schedule 2 of FIPPA as a separate public body distinct from the PHSA.

¹⁷ Division 3 of the *Public Health Act* sets out the mandatory reporting requirements. The *Act* can be found in full online at:
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_08028_01

According to BCCDC records, incidents of Lyme disease in BC are relatively low. Advocacy groups believe, however, that a considerably higher incidence of Lyme disease remains unreported in BC.

A 2008-2009 study of the results of a research survey of physicians conducted by BCCDC showed that a substantial proportion of Lyme disease cases are not reported to health authorities.¹⁸ This study was published in the *BC Medical Journal* in 2011. A subsequent study commissioned by the Ministry of Health under an arrangement with a PHSA employee was completed in May 2010. It indicated that the true level of Lyme disease in BC is unknown and many general practitioners are uninformed about this disease.¹⁹

The 2010 study made several recommendations for improving the diagnosis and treatment of those infected with Lyme disease. While both studies revealed significant underreporting by physicians, they did not conclude this meant there was a substantial increase in the occurrence of Lyme disease.

Following release of the 2010 study, the BC Government announced that it would open a new clinic specializing in the treatment of this and other complex, chronic diseases.

Issue

The issue in this case study is whether BCCDC, PHSA or the Provincial Health Officer had an obligation under ss. 25(1)(a) or (b) to disclose either the 2009 study or the 2010 study to the public or an affected group of people.

ELC's Position

The ELC takes the position that PHSA and BCCDC should have immediately disclosed to the public the results of the 2009 study, which indicated a serious underreporting of Lyme disease by BC physicians. It submits that the information in the 2009 study related to a significant public health risk whose disclosure was clearly in the public interest.

The ELC further asserts that BCCDC should have also disclosed the 2010 study to the public. BCCDC disclosed the 2010 study in response to a 2011 access request by a Lyme disease awareness advocacy group, but the ELC submits this was insufficient for the purposes of s. 25. It states that "PHSA's failure to proactively disclose this information denied the public and Lyme disease

¹⁸ Bonnie Henry and M. Morshed, "Lyme disease in British Columbia: Are we missing an epidemic?", online: (2011) 53:5 BC Medical Journal.

¹⁹ Brian Schmidt, "Chronic Lyme disease in British Columbia: A Review of Strategic and Policy Issues" 31 May 2010 online Provincial Health Services authority http://www.canlyme.com/Schmidt_2011.pdf.

advocates an opportunity to fully discuss the need for better patient diagnosis and care.”²⁰ The ELC further submits that the disclosure of this information “would have helped BC residents and doctors to educate themselves about the risks posed by Lyme disease, empowered people to take preventative measures to reduce their risks of contracting Lyme disease, and contributed to an important discussion about the changes to medical practice, policy and law that may be needed to grapple with the risks posed by Lyme disease.”²¹

PHSA’s Position on Behalf of BCCDC

PHSA responded to the allegations in the ELC report on behalf of BCCDC. We also contacted the Provincial Health Officer, who elaborated on some aspects of the PHSA response.

PHSA submits that BCCDC shared its initial 2009 findings with the Provincial Health Officer, who agreed with its assessment that disclosure under s. 25 was not necessary. The intention was that the 2009 study would be published as a research paper in a medical journal.

PHSA explains that delays in publishing research papers are not unusual, and that it can take up to 18 months for reports to be finalized and published in a peer-reviewed journal. The extended delay in publication of the 2009 study was due to an intervening H1N1 pandemic.

PHSA states that while the 2009 study showed that physicians tend to treat considerably more patients for Lyme disease than they officially report, this is true for most reportable communicable diseases. PHSA points out that the findings did not indicate either an increased risk of Lyme disease or a significant gap in access to treatment that warranted public notification.

PHSA also states that, contrary to the ELC’s assertions, BCCDC widely shared the data compiled from the research study with Lyme disease advocacy groups; it presented the data at several physician conferences, and included it in ongoing public awareness communications.

Analysis

I do not believe there was the necessary temporal urgency in this case to warrant public notification. While I agree that the 2009 and 2010 studies indicated an underreporting of the disease, there is no evidence of increased incidence of Lyme disease such that there would be an urgent and compelling need to disclose either study to the public.

²⁰ ELC Report, at p. 29.

²¹ ELC Report, at page 29.

Conclusion

I find that the information contained in the 2009 and 2010 studies was not of an urgent and compelling nature and therefore neither the PHSA nor the Provincial Health Officer had an obligation under ss. 25(1)(a) or (b) to disclose it.

4.4 Cowichan Valley Regional District: Well Water Test Results

Background

The Cowichan Valley Regional District (“CVRD”) extends from the east to west coasts of Vancouver Island, and contains several unincorporated communities, including Cobble Hill. One of the ELC’s case studies sets out concerns about Aquifer 197, the main source of groundwater in the Cobble Hill area.

A number of residences and small businesses in Cobble Hill and surrounding areas rely on wells connected to Aquifer 197 for their residential, commercial, agricultural and industrial water. Two wells which draw from Aquifer 197 have had tests in which nitrate levels are higher than recommended by Health Canada for drinking water.²² However, neither well is used for drinking water.

Local residents have expressed concern that contamination from one of the contaminated wells will negatively impact the health of the aquifer and therefore contaminate other wells in the area.

Issue

The issue in this case study is whether CVRD had an obligation under ss. 25(1)(a) or (b) to disclose well water test results to the public or to an affected group of people.

ELC’s Position

The ELC submits that CVRD should have released the well water results under s. 25(1) and that in failing to do so, it put private concerns ahead of public health and safety. ELC also states that there was significant public interest in the well water test results.

ELC asserts that, had the information been provided, the community members “would have had the opportunity to educate themselves about the possible risks

²² Canadian Drinking Water Guidelines can be found online at the Health Canada website at: <http://www.hc-sc.gc.ca/ewh-semt/water-eau/drink-potab/guide/index-eng.php>.

to their health and well-being and taken steps to mitigate them”. Examples of mitigation include more regular testing of residents’ private wells.

CVRD’s Position

CVRD states that it relies upon the Groundwater Protection Unit, Forest, Lands and Natural Resource Operations of the Ministry of Environment and the Vancouver Island Health Authority to assess public health risks in relation to groundwater contamination. CVRD states that s. 25 requires an urgent and compelling risk or an imminent and substantial risk where there is an unmistakable public interest. CVRD refers to the results of Ministry and Vancouver Island Health Authority testing that indicated nearby water systems did not show any signs of elevated nitrate levels.

Analysis

Neither of the wells with elevated nitrates was a public well nor a source of potable water. Also, there is no evidence these wells contaminated Aquifer 197.

The test results did not reveal a significant risk of harm to the environment or to public safety and therefore did not meet the high threshold necessary to trigger s. 25(1)(a). Similarly, as there was no indication of aquifer contamination, the public interest test for disclosure under s. 25(1)(b) is not met.

Conclusion

I find that CVRD did not have an obligation under ss. 25(1)(a) or (b) to disclose the well water test results because there was no urgent and compelling need for public disclosure of the information.

4.5 Simon Fraser University: Mould in Student Residence

Background

Hamilton Hall is a student residence located on Simon Fraser University’s Burnaby Mountain campus. It was constructed in 1992 as a four-level, wood-frame building housing approximately 100 graduate students.

In October 1998, SFU commissioned a visual inspection of the building envelope in Hamilton Hall. The engineering firm that conducted the inspection noted areas in the building envelope that were susceptible to water penetration and recommended repairs. The 1998 report made no comment on fungus or mould in the building.

All parties agree that while mould is a form of fungus; not all fungi are moulds. It is also important to note that not all fungi are harmful to the health or safety of people.

In January 2003, a Building Envelope Assessment engineering report revealed severe water penetration and rot damage to Hamilton Hall. The report identified structural and building envelope issues and made repair recommendations such as removal of wood siding and rot damaged framing. The 2003 report did not assess risks to health and safety of the residents, but it did recommend that SFU should not delay repairs beyond mid-summer of that year.

No repairs were undertaken, and in November 2005, SFU commissioned a follow-up report. The Building Envelope Survey: Interior Moisture Probes & Exploratory Openings engineering report stated that the water penetration problem in Hamilton Hall was most likely systemic. It identified extensive advanced structural deterioration and rot at windows and fungal growth in many areas of the building's sheathing. It stated that the partial repair option suggested in the 2003 report was no longer viable. The 2005 report neither mentioned the presence of mould, nor made any recommendations to test for it.

The 2005 report did however make these findings about a specific unit in the residence in which a student with a suppressed immune system later resided:

Interior Exploratory Openings

South wall in SW corner & east wall adjacent to kitchen – fungal growth and advanced deterioration of exterior sheathing and high moisture content

Exterior Exploratory Openings

High moisture content in exterior exploratory openings;
Advanced deterioration of wall studs at corner;
Wall studs saturated.

In November 2006, SFU Facilities Management prepared its own Building Needs Assessment: Hamilton Hall Residence report. This report acknowledged that Hamilton Hall suffered from “[a]rchitectural deficiencies including rotting cladding, fungal growth in the building envelope, damaged insulation, and visible water damage to the ceilings.”

In 2007, an SFU graduate student with significant health concerns applied for housing in Hamilton Hall. Prior to moving in, he provided SFU with details of his condition and requested housing for disabled students. SFU approved the student's application and in May 2007, he moved into the unit in Hamilton Hall specifically addressed in the 2005 report. SFU did not inform the student about the presence of fungus in the building or in the unit that it rented to him.

Later in May 2007, SFU received the Building Enclosure Investigation and Design Report which stated that a comprehensive reconstruction of the exterior siding and masonry walls was required. That report also revealed extensive wood decay under a window in the unit of the student with health concerns. Many of the exploratory openings done to the exterior of that particular unit revealed moisture levels that the 2007 report stated represents "conditions under which fungal spores will germinate".

In September 2007, the graduate student moved out of Hamilton Hall. While moving, the student found "... a large outgrowth of mould..." on the carpet in his rental unit. He complained to SFU, who then commissioned an environmental consulting firm to test the unit for mould ("Environmental Report").

The Environmental Report contained results of its spore-trap sampling tests for different types of airborne fungal spores in the unit at issue. The air test samples taken after lifting up the stained carpet revealed significantly elevated levels of fungal spores, including the potentially harmful *Stachybotrys*.²³ *Stachybotrys* is a type of mould. Four days later, spore trap sampling did not identify any elevated concentrations of fungal spores within the unit.

In the fall of 2007, SFU initiated substantial renovations and repairs to Hamilton Hall.

Issue

The issue in this case study is whether, prior to the graduate student moving into Hamilton Hall in 2007, SFU had information about the presence of mould that it had an obligation under ss. 25(1)(a) or (b) to disclose to the graduate student or to other student residents with relevant health sensitivities.

ELC's Position

ELC asserts that SFU Residence and Housing was aware of the risk of mould to Hamilton Hall and had been aware of the risk of water leakage since 1998. It further asserts that SFU had knowledge of rot in 2003, and of fungal growth in

²³ Health Canada issues guidelines for residential indoor air quality. *Stachybotrys chartarum* is cited as one of the moulds with toxic properties that are a concern for human health: <http://www.hc-sc.gc.ca/ewh-semt/pubs/air/mould-moisissure-eng.php>.

2005, and that it failed to disclose information about a risk of significant harm to the health and safety of present and future tenants in contravention of s. 25(1)(a) of FIPPA.

ELC submits that prior to moving into Hamilton Hall, the graduate student made his specific health concerns known to SFU and asked if it had suitable housing for him. Despite having reports that a vacant unit had fungal growth in the walls, SFU offered that unit to the student.

ELC points out that Health Canada states “it is not possible to establish a safe limit for mould in human residences”,²⁴ and asserts that SFU should have known that extensive water damage within the building created a risk of widespread mould. In this regard, ELC submits that SFU failed to disclose a significant risk to the health or safety of Hamilton Hall residents, and further that it failed to disclose a significant risk to the health of a particular class of student residents with relevant health sensitivities.

SFU’s Position

SFU argues that the problems with Hamilton Hall did not meet the threshold requirement for an actual risk of significant harm. It contends that the purpose of s. 25(1)(a) is not to oblige public bodies to conduct further investigations or remedial testing in order to determine whether or not a significant risk exists, and that circumstances that *may* lead to a risk are not sufficient to trigger obligations to disclose under s. 25(1)(a).

In early 2007, SFU says that it did not have conclusive evidence that a systemic building envelope failure in Hamilton Hall would result in a significant risk of mould forming. SFU states that the engineering reports it commissioned between 1998 and 2005 did not identify concerns about mould or the health or safety of the residents of Hamilton Hall. SFU said that neither its Environmental Health and Safety Unit nor 11 local joint health and safety committees at SFU dealt with the issue of water ingress and fungal growth as a health or safety issue. It maintains that at the time it received the complaint in September 2007 from the student with the suppressed immune system, it had no knowledge of mould being a potential health issue in Hamilton Hall.

SFU submits that the environmental consulting firm it retained to test for mould in the student’s unit after he had moved out in 2007 did not raise concerns of a significant risk to the health or safety of the student resident. SFU understood that the initial elevated reading of *Stachybotrys* was likely due to the disturbance of the carpet, but the subsequent testing was more indicative of normal levels in the unit.

²⁴ Health Canada, “Effects of Mould on Health”: <http://www.hc-sc.gc.ca/ewh-semt/air/in/poll/mould-moisissure/effects-effets-eng.php>.

SFU refers to WorkSafeBC's guidelines under the *Workers' Compensation Act* and the Occupational Health and Safety Regulation, which address moulds and indoor air quality.²⁵ SFU points out that those guidelines state that most people suffer no ill effects from mould exposure, however, they do acknowledge that for individuals with compromised immune systems, exposure to moulds can result in serious adverse health effects.

SFU submits that all of the engineering reports and the Environmental Report support a conclusion that the presence of fungal growth in Hamilton Hall did not present an actual risk of significant harm to the student residents. Other rooms in Hamilton Hall were visually inspected at the time of the air sample testing and no significant fungal staining was noted in the other units.

Analysis

In my investigators' review of the engineering reports completed between 1998 and 2005, and SFU's own 2006 report, they found several references to fungal growth (2003, 2005, and 2006 reports). However, the first relevant reference to mould in any of the engineering reports was in the Environmental Report commissioned after the graduate student had moved out. In that report there is reference to temporarily elevated *Stachybotrys* levels, likely as a result of a disturbance of the carpet in the unit.

The factual information known to SFU before the graduate student moved into Hamilton Hall was that there was a water ingress problem and there was fungal growth or staining in some areas. SFU did not have knowledge of the presence of mould. It is very important to my analysis that s. 25(1) is about what the public body knew, not about information that it ought to have known. A public body cannot disclose information that some might consider it ought to have known, but did not.

SFU points out that not all fungus is mould and that, in this instance, prior to the student moving out the only thing it knew was that fungus was present. There was no evidence that mould existed that would harm a student. Based on this, it was reasonable for SFU to conclude there was no imminent health danger present. And while some might question SFU's failure to do more extensive testing for mould, SFU is correct to say s. 25 does not place this responsibility upon them

This does not mean that there has to be certainty of a health danger, for example, before a public body is obligated to make a public disclosure under s. 25. Sufficient factors might be present in a given set of circumstances to

²⁵ The Occupational Health and Safety Guidelines can be found in full online [OHS Guidelines]: <http://www2.worksafebc.com/Publications/OHSRegulation/Guidelines.asp>.

suggest that, while not certain, there is a real and probable risk of a significant health or safety harm. Public bodies should be alert to this in considering whether they have a responsibility to disclose information under s. 25. However, in this case that threshold was not reached.

My final observation relates to SFU's comment that most people suffer no ill effects of mould exposure. I take this to mean that, even if mould were found to have existed in this case, SFU would not have been required to disclose its presence. This is not a correct interpretation of what is required by s. 25. Even if it were the case that mould did not affect most members of the public, this would not have relieved SFU of its s. 25 obligations in this case. Section 25 specifically contemplates that the risk of significant harm need only apply to an "affected group of people or to an applicant" to trigger the obligation to disclose information. Had I determined here that SFU had knowledge of the existence of mould, combined with SFU's awareness of the graduate student's health sensitivity; I would have found SFU should have disclosed that information to him and perhaps others who may have been in a similar situation to the graduate student.

Conclusion

I find that prior to the graduate student moving into Hamilton Hall, SFU did not have information that was of an urgent and compelling nature that would have necessitated disclosure to the graduate student or other student residents with relevant health sensitivities. As a result, I find that SFU did not have an obligation to disclose information under ss. 25(1)(a) or (b).

4.6 Ministry of Agriculture and Lands: Sea Lice Infestation of Salmon Farms

Sea lice are small parasites that infect the skin, fins, and gills of wild and farmed marine fish. A number of species of sea lice are found along the BC coast. Of those, the common salmon louse has generated the most concern and controversy.²⁶

In 2010, I conducted an inquiry into a decision of the Ministry of Agriculture and Lands to withhold records created under its Fish Health Audit and Surveillance Program.²⁷ Because my office has already issued Order F10-06 on this matter, I will not re-open it in this report. Instead, I provide a summary of the findings in that Order.

²⁶ Fisheries and Oceans Canada operate a Sea Lice management program. Information on this program can be found online at: <http://www.dfo-mpo.gc.ca/aquaculture/lice-pou-eng.htm>.

²⁷ Order F10-06 can be found at <http://www.oipc.bc.ca/orders/1030>.

Order F10-06²⁸ addressed the application of s. 25 to information about disease testing on fish farms that was in the custody or control of the Ministry of Agriculture and Lands. The adjudicator found that s. 25(1)(b) did not apply because that section was reserved for matters of urgency that require immediate disclosure of the information. There was no evidence that the records in this instance met the threshold of urgent and compelling circumstances under s. 25(1)(b). The adjudicator ultimately ordered that the information be disclosed, but on different grounds.

5.0 ANALYSIS: SURVEY OF PUBLIC BODIES

In the course of investigating the public bodies named in the ELC report, it became evident to me that, in a number of instances, the public bodies did not clearly understand their obligations under s. 25 of FIPPA. In other instances, the public bodies had policies and procedures in place, but there were gaps evident in their interpretation and application of s. 25.

These findings concerned me and I undertook a survey to determine whether these issues were widespread. I surveyed 11 other public bodies to see if they understood their responsibilities under s. 25 and, if they did, what measures they were taking to ensure compliance with this section.

I selected the 11 public bodies based on their likelihood of dealing with s. 25(1) issues, as a result of their mandate and the information in their possession.

The Survey

The questions and responses to our survey that were of the most assistance in helping me determine the level of public bodies' understanding of s. 25 are set out below.

1. Does the public body have any policies, procedures, or guidelines in place regarding s. 25?

Of the 11 public bodies surveyed, only three referenced s. 25 in reporting they have public disclosure policies. Six others have policies that in some form address notification of the public where harm may exist. Most policies seem to treat these responsibilities as discretionary. Indeed, some of these six public bodies surveyed refer to s. 33.1(1)(m) of FIPPA in discussing notification. That section allows a public body to disclose personal information at its discretion. Other public bodies refer to specific statutes that govern them in matters related

²⁸ See footnote 26.

to public notification. However, those statutes do not remove s. 25 obligations or address the full range of requirements set out in s. 25.

The survey results also revealed two other significant issues. The first is that only one public body seemed to understand that it has an obligation to disclose information when the disclosure is clearly in the public interest under s. 25(1)(b). The second issue is that two of the public bodies did not reference s. 25 or have any public notification policy in place about matters of significant harm or in the public interest.

2. To the best of your knowledge, has the public body made any public disclosures on grounds of public interest?

Each of the surveyed public bodies that have a public notification policy stated that they have issued public notifications about a risk of harm. The types of information that have been disclosed under these public notifications included dangerous offender notices, water and air quality advisories, and notice of communicable disease outbreaks. No public body indicated that it had issued a public notification under s. 25(1)(b), which mandates disclosure when it is clearly in the public interest.

3. Please provide any other information you feel is relevant regarding how the public body makes decisions about whether to disclose information to an individual or a group of individuals about environmental or safety risks, or information that is otherwise in the public interest to disclose.

Some public bodies indicated that they had considered the application of s. 25 in response to access to information requests. Other public bodies, as noted above, relied on s. 33.1(1)(m) of FIPPA, which permits a public body to disclose personal information in compelling circumstances. Others referred to different statutes that also impose notification requirements on them.

Conclusion

The results of the survey were that the public bodies clearly did not fully understand their obligations under s. 25. Only three respondents have policies that explicitly reference those obligations. Only one has considered specifically the requirement to disclose information under s. 25(1)(b), when the disclosure is clearly in the public interest.

A number of the public bodies have policies regarding public notification of risks of harm that may overlap with those harms identified in s. 25. However, notification under some of those policies is discretionary, while notification under s. 25 is mandatory. I am also concerned that public bodies that rely on policies

founded in other statutes, or in s. 33.1(1)(m) of FIPPA, as a proxy for compliance with s. 25, may not be meeting their obligations under that section. This is because, in most instances, these policies will not encompass the wider range of harms, and matters in the public interest, prescribed by s. 25.

6.0 RECOMMENDATIONS FOR PUBLIC BODIES TO ENSURE COMPLIANCE WITH SECTION 25

As a result of the case studies and survey results considered in this investigation, I have the following recommendations for public bodies to help ensure their compliance with s. 25 of FIPPA.

Section 25 Policy

All public bodies should develop policies that provide guidance to employees and officers about the public body's obligations under s. 25 of FIPPA. The policies should aid employees in determining what constitutes a risk of significant harm to the environment or to the health and safety of the public, or in determining whether disclosure is clearly in the public interest.

The policies should be tailored to specific program areas, anticipating the range of harms that may occur within each area.

The public body should also set out the specific steps an employee should take to escalate relevant information to the attention of the head of the public body.

In summary, to ensure a public body is compliant with its s. 25 responsibilities, its policies should clearly set out:

- criteria that define a risk of significant harm to the environment;
- criteria that define whether there is a risk of significant harm to the health or safety of the public;
- criteria that define when the disclosure of information is, for any other reason, clearly in the public interest;
- criteria to determine if there is an urgent and compelling need for disclosure of information;
- criteria to determine whether the head of the public body should notify the public or an affected group of people;
- procedures for communicating this information to the head of the public body;

- criteria to determine when to disclose the relevant information to the public or an affected group of people; and
- procedures to notify third parties and the Commissioner.

RECOMMENDATION 1:

Public bodies should develop policies that provide guidance to employees and officers about the public body's obligations under s. 25 of FIPPA.

It is not sufficient that a public body only have a s. 25 policy in place. It must also ensure that its employees and officers are informed of the existence of the policy and trained in its application. Employees should understand when notification pursuant to s. 25 is required and how to alert appropriate persons in the public body to ensure that timely notification takes place.

RECOMMENDATION 2:

Public bodies should ensure that employees and officers understand the public body's obligations under s. 25 of FIPPA and are provided with adequate training to ensure compliance with these obligations.

I will be following up with those public bodies surveyed that do not have adequate policies and training in place. My office will also undertake an audit of s. 25 compliance across a targeted number of public bodies in 2014/15.

7.0 PROPOSED AMENDMENT TO SECTION 25(1)(b)

As previously noted, my office must be notified of disclosures being made under s. 25(1)(a). From those notices, it appears that the most common type is disclosures by municipal police officers of a significant risk of harm due to the fact that a dangerous offender has been released from a correctional facility. These account for close to 90% of disclosures for which this office receives notification under s. 25(3).

Our office has never received notification of a disclosure under s. 25(1)(b). However, many applicants seeking access to records frequently cite the section. Despite this fact, there has not been a single instance where my office has ordered a public body to disclose information under this section. This is not surprising, given the requirement that disclosure under s. 25(1)(b) be both in the public interest and urgent.

The “public interest” under s. 25(1)(b) contemplates the disclosure of a wider scope of information than is canvassed in s. 25(1)(a). However, because of the temporal urgency requirement attached to the public interest disclosure, it has effectively been limited to cover the same circumstances in s. 25(1)(a).

In order to give effect to the intent of s. 25(1)(b), I believe that that the public interest disclosure provision should not require urgent circumstances. That is the approach taken in Ontario, where s. 23 of their *Freedom of Information and Protection of Privacy Act* (“Ontario Act”) addresses public interest disclosure. That section does not require that there be urgent circumstances, only that the public interest in disclosure outweighs the purpose of the exemption being overridden.

The Ontario Act allows for the disclosure of records to an applicant where it is in the public interest, by overriding provisions of the Act which would otherwise exempt the record from disclosure. Unlike in British Columbia, this is not a proactive obligation on a public body. Instead, the public body is obligated to consider the obligation in response to an access to information request.

However, the general approach taken to the concept of public interest in Ontario is in my view, a useful guide as to how a new approach to public interest might work in BC. Application of the public interest override in the Ontario Act requires that there be a public interest in disclosure, that the public interest be compelling, and that the compelling public interest clearly outweighs the purpose of the exemption. When a private individual in Ontario seeks the disclosure of a record solely for a private purpose, the public interest override cannot be successfully invoked; there must be a genuine public interest in disclosure of the record. Similarly, if sufficient records are already in the public domain, and the disclosure of additional records would not further assist public education or debate about the matter, then the public interest disclosure section cannot be applied. The public body must evaluate whether disclosure of the record is in the public interest based on specific circumstances of the request. In this manner, Ontario balances the public interest with the interest of the public body.

I believe a similar approach should be taken in British Columbia. There should be a mandatory obligation in FIPPA for a public body to proactively disclose information to the public or to an affected group of people when it is clearly in the public interest to disclose even without there being temporal urgency.

My predecessor recommended that this matter be addressed by legislative amendment that would require, in all cases, the disclosure of information concerning a matter of clear public interest.²⁹ This would clearly limit s. 25(1)(b) to an analysis of whether disclosure is within the public interest. It would require an assessment of whether the need to make the information available to the public or to an affected group of people is compelling. It must also be information that is not already in the public domain. The threshold should still be high given that the obligation overrides all exceptions to disclosure set out in FIPPA.

The requirement that the disclosure be clearly in the public interest means more than a general interest in public policy or policy debate. The information must be of substantial concern to the public or to an affected group of people such that they have a genuine stake in the issue, or disclosure would directly affect their actions and contribute to public understanding or debate on the issue.

RECOMMENDATION 3:

Government should amend s. 25(1)(b) of FIPPA to remove the requirement of temporal urgency so that there is a mandatory obligation for public bodies to disclose information of a non-urgent nature that is clearly in the public interest.

8.0 SUMMARY OF FINDINGS AND RECOMMENDATIONS

8.1 Summary of Findings

I have made the following findings in this investigation:

**Ministry of Forests, Lands and Natural Resource Operations:
The Testalinden Dam Collapse**

I find that when FIPPA came into force in 1993, the Ministry had an obligation under ss. 25(1)(a) or (b) to disclose information about the compromised state of the Testalinden Dam to residents downstream of the dam along the Osoyoos-Oliver Highway because there was an urgent and compelling need for public disclosure of this information. I also find that the Ministry did not meet this obligation.

²⁹ Supra note 13, at p. 21.

Ministry of Environment: Prince George Air Quality

I find that the Ministry did not have an obligation under ss. 25(1)(a) or (b) to disclose the Odour Study results to the public or to an affected group of people because there was no urgent and compelling need for public disclosure of this information.

Disclosure Regarding Lyme Disease

I find that the information in the 2009 and 2010 studies describing an underreporting of Lyme disease was not of an urgent and compelling nature and therefore neither the BCCDC, PHSA, nor the Provincial Health Officer had an obligation under ss. 25(1)(a) or (b) to disclose it.

Cowichan Valley Regional District: Well Water Test Results

I find that CVRD did not have an obligation under ss. 25(1)(a) or (b) to disclose the well water test results because there was no urgent and compelling need for public disclosure of the information.

Simon Fraser University: Mould in Student Residence

I find that prior to the graduate student moving into Hamilton Hall, SFU did not have information that was of an urgent and compelling nature that would have necessitated disclosure to the graduate student or other student residents with relevant health sensitivities. As a result, I find that SFU did not have an obligation to disclose information under ss. 25(1)(a) or (b).

8.2 Summary of Recommendations**RECOMMENDATION 1**

Public bodies should develop policies that provide guidance to employees and officers about the public body's obligations under s. 25 of FIPPA.

RECOMMENDATION 2

Public bodies should ensure that its employees and officers understand the public body's obligations under s. 25 of FIPPA and are provided with adequate training to ensure compliance with these obligations.

RECOMMENDATION 3

Government should amend s. 25(1)(b) of FIPPA to remove the requirement of temporal urgency so that there is a mandatory obligation for public bodies to disclose all information that is clearly in the public interest to disclose.

9.0 CONCLUSION

In this investigation, my office conducted a review of five case studies submitted by the ELC where the applicability of s. 25(1) was a relevant consideration; a survey of 11 public bodies to see if they understood their obligations under s. 25; and a review of the notifications this office receives from public bodies under s. 25(3).

The results of this investigation indicate that only a small number of public bodies are making disclosures under s. 25(1)(a) about a risk of significant harm to the environment or to the health or safety of the public.

Public bodies do not fully understand their obligations under s. 25(1) and are not always taking appropriate measures to ensure they meet these obligations. To address this problem, I have made recommendations that public bodies develop s. 25(1) policies and provide training to employees to ensure compliance with them.

My office will be following up with the public bodies that we surveyed as part of this investigation about gaps in their s. 25 policies. Starting next year, we will also undertake an audit of s. 25 compliance across a targeted number of public bodies.

As currently worded, s. 25(1)(b) has not been interpreted to impose an obligation on public bodies to proactively disclose information that it is clearly in the public interest to disclose. Instead, the requirement of temporal urgency is such a high threshold that, in practice, there is no actual obligation to disclose under s. 25(1)(b). The intention of the Legislature with respect to this provision is not being achieved.

My major recommendation is that government should amend s. 25(1)(b) to require proactive disclosure where it is clearly in the public interest without the requirement of temporal urgency.

I urge government to amend s. 25(1)(b) of FIPPA at the earliest opportunity.

10.0 ACKNOWLEDGEMENTS

I acknowledge that the various public bodies named in the case studies have cooperated fully with our office's investigation as have the public bodies we surveyed as part of this investigation. I also wish to acknowledge the contribution made by the Environmental Law Clinic of the University of Victoria to this investigation.

December 2, 2013

ORIGINAL SIGNED BY

Elizabeth Denham
Information and Privacy Commissioner
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