September 14, 2020

Office of the Information and Privacy Commissioner for British Columbia

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ATT’N: Michael McEvoy, Commissioner

Dear Mr. McEvoy,

Re: Complaint and/or review concerning non-compliance by the Ministry of Health with FIPPA s. 25(1)(a)

We write on behalf of Heiltsuk Tribal Council, Tsilhqot’in National Government, and Nuu-chah-nulth Tribal Council. These bodies are the Indigenous governments for Heiltsuk Nation, Tsilhqot’in Nation, and the fourteen Nuu-Chah-Nulth First Nations, respectively (the “Nations”). Throughout the summer of 2020, the Nations have repeatedly requested that the Ministry of Health (the "Ministry" or "MOH") disclose specific information relating to cases of presumptive and confirmed COVID cases "proximate" to the Nations' rural Indigenous communities. The Nations have made these requests pursuant to, inter alia, s. 25 of the Freedom of Information and Protection of Privacy Act ("FIPPA"). The Nations have met with the Ministry on two occasions about this matter. The Ministry has, however, repeatedly refused the requests. The same request has been made to the BC Centre for Disease Control, and to specific health authorities – Vancouver Coastal Health, Vancouver Island Health, Northern Health, and Interior Health (the “Health Authorities”) – and the Nations are awaiting responses. The Nations therefore request that the Commissioner determine a complaint of the Nations (or perform a review, as appropriate) concerning the head of the Ministry, currently the Honourable Adrian Dix, failing to comply with a duty under FIPPA s. 25(1)(a). The Nations make the same request with respect to the duties of the CDC and the Health Authorities under FIPPA s. 25. The Nations assert that information about presumptive or confirmed COVID-19 cases proximate to
the Nations' rural Indigenous communities is information “about” risks of significant harm to the health or safety of groups of peoples, and must be disclosed in response to a direct request from the Nations.

To accelerate the process, the Nations have provided evidence and submissions as part of their request to the OIPC. However, should the Commissioner require additional evidence, the Nations request that the Commissioner advise them, so that they may seek to provide it. The Nations also request opportunity to review and respond or reply to the evidence and the legal submissions of the Ministry (and any other of the public bodies implicated by this request).

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1.0 Overview

1.1. The s. 25 information sought by the Nations

[1] The Nations say that s. 25(1)(a) imposes a duty on the Ministry (and/or another relevant health body [see Note #1]) to disclose to the Nations, without delay and whether or not a request for access is made, the following types of information, all of which the Nations say is information "about a risk of significant harm to... the health or safety of... a group of people...":

- **ITEM #1:** the location (not the personal identity) of proximate [see Note #2] presumptive and confirmed COVID cases;
- **ITEM #2:** whether the proximate case involves a person that has travelled to one of the Nations, e.g., a yes or no answer to whether the person has travelled to a particular Nation's territory within the last 14 days; and
- **ITEM #3:** the name of a person infected by COVID who is a member of one of the Nations, to be used only for the purposes of culturally-safe contact-tracing (where the contact tracer is a member of the infected person's Nation, and will need to know the name of the infected person to conduct contact-tracing).

(collectively the "Items").

[2] In relation to Item #3, the Nations have no issue with disclosure of the identity of Nation members being contingent on the consent of each member (to the Ministry or any health authority disclosing their medical status to their Nation, should the member become, or where the member has become, a presumptive or confirmed COVID case). If consent is a necessary element or a persuasive factor for disclosure, the Nations will arrange for advance consent from their members.

- [Note #1] As noted above, other relevant health bodies may be the British Columbia Centre for Disease Control and Prevention Society Branch (listed in FIPPA Schedule 2), Vancouver Coastal Health (VCH), Vancouver Island Health Authority, Northern Health Authority, and Interior Health Authority (all health authorities under the Health Authorities Act and the Regional Health Boards Regulation).
- [Note #2] The term "proximate" refers to cases located in specific areas near to the rural communities of the Nations, in terms of transportation links, e.g., highway, ferry, or air transport, with which members of one of the Nations may have significant contact. For example:
  - Heiltsuk Nation considers the following areas a "proximate" for purposes of its need for information: Port Hardy, Haida Gwaii, Vancouver, Kletmu, Ocean Falls, Denny Island, Nanaimo, Campbell River and Prince Rupert.
  - Tšilhqot’in Nation and Tšilhqot’in communities consider proximate communities as including Williams Lake and Quesnel.
• The Nuu-Chah-Nulth First Nations consider proximate communities as including Bamfield, Port Alberni, Ucluelet, Tofino, Campbell River, Duncan, and Tahsis.

1.2. **Meetings with and denial by the Ministry**

[3] The Nations have requested the Items on a government-to-government basis, and have been engaging in discussions with the Ministry as part of larger discussions concerning the Items, and other COVID-related issues. The Nations met with government representatives, including representatives of the Ministry of Health, on July 17 and August 7, 2020. The following notes summarize those discussions (although these versions are edited to refer only to discussions relevant to information sharing).

**SCHEDULE A** (extracts of letter dated 2020-07-21 re: July 17 Health Table)

**SCHEDULE B** (extracts of letter dated 2020-08-12 re: August 7 Health Table)

[4] Counsel also engaged in an exchange with counsel for British Columbia, Ms. Gow, concerning disclosure under FIPPA s. 25.

**SCHEDULE C** (Email exchange with BC counsel re: information sharing request)

[5] Ultimately, the Ministry has refused to disclose the Items. As Associate Deputy Minister, Mr. David Byres, noted on August 7, 2020 (as recorded in Schedule B): "...our position is that we will not disclose that information... Remains our position that s. 25 of FIPPA does not operate to compel disclosure of information; it is within the discretion of the PHO under the Public Health Act ("PHA") to consider risks and decide what disclosure is necessary in the public interest."

[6] As noted above, the Nations have now made the same information requests under FIPPA s. 25(1) to the BC Centre for Disease Control, and to the Health Authorities (i.e., VCHA, VIHA, NHA and IHA). The Nations are awaiting responses.

**SCHEDULE D** (Letters to BCCDC and Health Authorities)

[7] For clarity, the Nations’ request to the Ministry, and the Ministry’s denial, was the culmination of repeated requests by First Nations for information from health authorities or the Ministry, made either directly or publicly. For example, on May 7, 2020, Heiltsuk Nation, Nuxalk Nation and Kitasoo/Xai’xais Nation wrote to Dr. Daly, the Chief Medical officer for Vancouver Coastal Health (VCH), about the health authority’s decision to not disclose the location of COVID cases to Indigenous governments.

**SCHEDULE E** (Letter to Dr. Daly dated May 7, 2020)

[8] Nuu-chah-nulth also issued a press release on June 9th, asking the BC Government publicly that “Communications protocols are established between the Nuu-chah-nulth Nations and Vancouver Island and Provincial Health Authorities to ensure the early and prompt reporting by the Health Authorities to the Nuu-chah-nulth Nations, under appropriate confidentiality protections, of all relevant information relating to suspected and confirmed cases of Covid19 in Vancouver Island communities, including indigenous communities”.


SCHEDULE F (Nuu-chah-nulth Press Release dated June 9, 2020)

[9] On May 8, 2020, the Chief Councillors of Heiltsuk, Nuxalk, Kitasoo/Xai’xais and Wuikinuxv Nations publicly addressed, in the Globe and Mail, the refusal of the First Nations Health Authority and Vancouver Coastal Health to disclose where COVID cases are occurring to Indigenous governments.

SCHEDULE G (Globe & Mail, “How B.C. Health authorities are undermining Indigenous governments”) (also linked here)

[10] On June 24, 2020, the Nations publicly called on government to implement four basic safety measures, including an information-sharing agreement to ensure early reporting of suspected and confirmed cases in nearby regions to Indigenous governments.

SCHEDULE H (Globe & Mail, “B.C.’s COVID-19 reopening plans continue to put Indigenous people at risk”) (also linked here)

[11] Also see the June 26, 2020 CBC article, “Indigenous leaders say they should have been consulted before B.C. government eased pandemic restrictions”:


[12] The Ministry’s non-disclosure position, established at the meetings of July 17 and August 7, 2020, is ongoing. For example, on August 15, 2020, with respect to Item #3, the First Nations Health Authority (“FNHA”) [see Note #3] advised Nuu-chah-nulth Tribal Council (“NTC”) that a member of NTC had COVID, but did not provide that member’s name or location. Without that information, NTC was unable to take immediate action to address the member’s contact with other NTC members, such as family or friends.

• [Note #3] FNHA is not a health authority under the Health Authorities Act, but is rather a non-profit, non-statutory legal entity formed under the British Columbia Tripartite Framework Agreement on First Nation Health Governance, dated October 13, 2011 and between Canada, British Columbia and the First Nations Health Society (link).

[13] In brief, the Ministry’s position is that since the Provincial Health Officer (the "PHO") has decided, under the Public Health Act, against public disclosure, "there is no need for a decision to be made under section 25". (For clarity, the PHO is not a public body, or the head of a public body. Rather, the PHO is the "senior public health official for British Columbia" who advises the minister and public officials on public health issues, pursuant to ss. 64 and 66(1) of the Public Health Act. The PHO may also act as a "health officer" during an emergency (PHA s. 67(2)). The PHO thus advises the Minister of Health, and must report to the Minister (PHA s. 62(2)). Under FIPPA, the head of the Ministry of Health (which is a public body under FIPPA Schedule 1 "public body") is the Minister of Health (see FIPPA Schedule 1 definition of "head").

[14] More specifically, Ms. Gow advised on August 6 (Schedule C) that the PHO has responsibility under the Public Health Act for determining “what information should or should not be disclosed about an infected person for the purpose of preventing or addressing potential
harm to the public posed by a infected person.” Accordingly, once the PHO has “made a decision that the disclosure of certain information is not necessary in order to address a risk of significant harm to the public, or a group of people, posed by an infected person, it is difficult to imagine on what basis the Minister of Health could arrive at the conclusion that it was clearly in the public interest to disclose this information.” In other words, for purposes of deciding what it thinks FIPPA s. 25 demands, the Minister of Health (as head of the Ministry of Health) adopts the reasoning and what the PHO decides for purposes of the Public Health Act.

[15] What is less apparent is why the PHO believes that the conditions for disclosure under FIPPA s. 25, in particular, are not met. On August 7 (Schedule B), the PHO advised that she was not at all saying that there is no significant harm to health or safety of Nations - a statement implicitly admitting that proximate COVID infections represent a risk of significant harm. Rather, her reasoning was to the effect that she had overriding discretion under the PHA to mitigate harms while protecting personal health information (see Schedule B):

"Not saying no significant harm; it's how do I mitigate those harms and protect personal health information."

[16] But this approach is problematic because it does not separately address how powers under the PHA and duties under FIPPA s. 25 may coexist. As we will address below, Part 5 of the PHA — which addresses the powers and duties of health officers during an emergency — is neither inconsistent nor conflicting with any positive duty of the head of a public body under FIPPA s. 25. In other words, the permissive authority of a health officer to disclose information in specific circumstances under the PHA, including under Part 5, does not, and indeed cannot, override a duty of an entirely different office, i.e., the head of a public body, to disclose information under FIPPA.

[17] The position of the Minister (which adopts the position of the PHO) also appears to confuse how a duty under FIPPA s. 25 and the basis on which the PHO may decide to disclose information under the PHA may involve different factors. For example, Ms. Gow refers to a consideration by the PHO as to whether disclosure of information is "necessary in order to address a risk of significant harm to the public" — implicitly referring to the necessity of the government addressing a risk. But while this may be a reasonable test for the PHO to apply when acting under the PHA, that is not the test that applies to the head of a public body under FIPPA s. 25(1)(a), which as whether the information that the Nations have requested (which the Ministry clearly has under its possession or control) is "information (a) about a risk of significant harm to... the health or safety of the public or a group of people...."

[18] Similarly, the PHO has referred to the privacy interests of patients, but putting aside the fact that geographical information of cases divorced from the identity of the patients is not personal information, privacy more generally is not a factor that the legislature has deemed relevant to the duty under FIPPA s. 25. Furthermore, speculation of stigma relating to disclosure of geographical information about COVID cases, in particular, seems especially non-compelling, given for example, a map of recent COVID cases in Toronto (i.e., occurring in the last 21 days), broken down by neighbourhood, which may be found here:
Said another way, the Ministry has declined the Nation's requests by citing discretion under the Public Health Act, and the privacy of COVID victims, but such factors do not override the duties of the Minister of Health under s. 25 of FIPPA.

1.3. The Ministry's refusal contravenes FIPPA s. 25

[19] We asked Ms. Gow to provide reasons for the decision against disclosure, but she declined. Respectfully, the Ministry's decision to withhold information is itself not justified, transparent and intelligible. But more importantly, any decision about whether s. 25 actually imposes a duty on the Minister is for the Commissioner to decide, not the Ministry.

[20] As the Nations clarify below (in section 2.1), the decision for the Commissioner is not whether the Minister was reasonable in deciding whether it owed a duty under FIPPA s. 25. This process is not a judicial review, and the Ministry does not have any statutory power to decide at first instance what duty it owes under FIPPA s. 25. Rather, where a dispute arises about the legal effect of s. 25, it is the Commissioner that must fulfil an adjudicative role to determine what duties arise under FIPPA s. 25, and whether a relevant public body has complied with the duties.

[21] Respectfully, the Minister's failure to provide some or all of the Items sought by the Nations contravenes FIPPA s. 25.

[22] FIPPA section 25 only has two components. First, with respect to the existence of a risk of significant harm to health or safety, and as illustrated by the discussion between the Nations and government officials on August 7, 2020, no serious dispute exists that proximate COVID cases create a risk of significant harm to the health or safety of Indigenous peoples. Second, and in that context of a clear risk of significant harm, the only remaining question is if any relevant public body (e.g., the Ministry) has information that is "about" such a risk. The question under FIPPA s. 25 is not, as Ms. Gow has suggested, whether the government considers disclosure necessary for government to address the risk. Rather — and as the OIPC has previously recognized (e.g., OIPC Investigation Report, F16-02, at p. 23)— information is "about a risk" if it allows the public (or in this case the Nations) to take action to meet the risk or mitigate or avoid harm.

[23] In this case, the Nations have requested the Items precisely so that they can take action — pursuant to their inherent rights of self-government, their Indigenous laws, and under Indian Act bylaw powers — to meet or mitigate imminent risks of significant harm arising from proximate COVID cases.

1.4. The need for a timely decision

[24] However one may define the "second wave" of the COVID pandemic, the "reopening" of the province has led to a continuing increase in the number of daily COVID cases. The number of COVID cases reported daily has increased from a low of 3 new cases on the day of June 28, 2020 to a high of 136 cases on the day of September 4, 2020. As cases that develop in coming
weeks may be proximate to the Nations (if not already), the Nations seek a start to ongoing disclosure of, *inter alia*, proximate COVID cases with some urgency.

[25] While the Nations have been engaging in government-to-government discussions with the Ministry throughout the summer, and will continue to do so, the Ministry has remained constant in refusing disclosure, which has necessitated the Nations coming to the Commissioner.

[26] The very purpose of the right under FIPPA s. 25 is so that groups of people who face a risk of significant harm may receive the information they need to allow for action that will meet or mitigate the risk, instead of dealing with consequences after harm to health or safety materializes. In this case, justice delayed is justice denied.

[27] The Nations accordingly seek a determination of their rights under FIPPA s. 25 as soon as practically possible, and ask that the Commissioner proceed with view to allowing the Nations to receive the information to which they are entitled sooner rather than later.

[28] That said, the Nations respect that the Commissioner may wish to consult with other bodies as part of its analysis. The Nations believe that the Commissioner could benefit by soliciting comments from (for example)

- The First Nations Leadership Council (FNLC);
  - the Union of British Columbia Indian Chiefs (UBCIC);
  - The First Nations Summit (FNS);
  - BC Assembly of First Nations (BCAFN);
- the Assembly of First Nations (AFN);
- the B.C. Freedom of Information and Privacy Association (FIPA);
- B.C. Civil Liberties Association.

Some of these organizations have kindly provided letters of support. For example, First Nations Leadership Council (“FNLC”), on behalf of First Nations Summit, the Union of B.C. Indian Chiefs, and the B.C. Assembly of First Nations, supports the Nations’ access to notification of nearby COVID cases, information about cases that have travelled to the Nations’ communities, and identity-based information for contact-tracing. The FNLC speaks to empowering Indigenous governments to help reduce the risk of transmission within communities.

**SCHEDULE I-1** (Letter from FNLC)

The Union of British Columbia Indian Chiefs has also provided its own support letter which speaks to proactive disclosure of case information as essential to not only track, mitigate and prevent the spread of COVID, but also to alleviate the immense burdens that First Nations are shouldering.

**SCHEDULE I-2** (Letter from UBCIC)

The B.C. Freedom of Information and Privacy Association has provided a joint letter of support with the B.C. Civil Liberties Association. They address the refusal by the Ministry of Health to
share information about proximate COVID cases as preventing First Nations communities from exercising the very rights that the province recognized when it enacted the Declaration on the Rights of Indigenous Peoples Act (2019).

SCHEDULE I-3 (Joint letter from FIPA and BCCLA)
Furthermore, the information requests of the Nations have been endorsed by Haida Nation, Kitasoo/Xai’xais Nation, Nuxulk Nation, Wuikinuxv Nation, and ‘Namgis First Nation. These First Nations express their need for such information to decide on actions to take, and to contact trace. They speak to their rights of self-determination, and to their need to access the same health datasets, with appropriate confidentiality provisions, to exercise their rights.

SCHEDULE I-4 (Letter of support from various First Nations dated September 14, 2020)

1.5. The structure of these submissions
[29] In the following sections, the Nations will address the following matters:
   1. the "test" under FIPPA s. 25(1)(a); and
   2. facts relating to why proximate COVID cases represent a risk of significant harm to the health or safety of the Nations’ rural Indigenous communities;
   3. facts relating to why information about proximate COVID cases is information "about a risk of significant harm to... the health or safety of" the rural Indigenous communities of the Nations; and
   4. submissions as to why FIPPA s. 25 is not overridden by any provision in Part 5 of the Public Health Act.

2.0 The "test" under FIPPA s. 25(1)(a)
[30] The Nations rely on the duty of the Ministry and/or relevant public health bodies to disclose information, with or without a request, under FIPPA s. 25(1)(a), which mandates disclosure of information to an affected group of people, or to an applicant, "about a risk of significant harm to... the health or safety of the public or a group of people...."

2.1. The nature of the inquiry
[31] FIPPA s. 25 imposes a statutory duty on the head of a public body in particular circumstances to provide information.
[32] FIPPA s. 42(1) authorizes the Commissioner to "(a) conduct investigations and audits to ensure compliance with any provision of this Act or the regulations...."
[33] FIPPA s. 42(2) authorizes the Commissioner to "investigate and attempt to resolve complaints that (a) a duty imposed under this Act has not been performed...." (emphasis added)
[34] FIPPA s. 52(1) provides that, "A person who makes a request to the head of a public body, other than the commissioner or the registrar under the Lobbyists Transparency Act, for
access to a record or for correction of personal information may ask the commissioner to review any decision, act or failure to act of the head that relates to that request, including any matter that could be the subject of a complaint under section 42 (2)." (emphasis added)

[35] Under FIPPA s. 56(1), "...the commissioner may conduct an inquiry and decide all questions of fact and law arising in the course of the inquiry."

[36] The inquiry of the Commissioner is not in the nature of a "review" in the sense of a judicial or tribunal review of a decision by the Ministry. FIPPA s. 25 does not involve any sort of statutory power of decision by a public body as to whether it has a duty under FIPPA s. 25; the public body either does or does not owe a duty in the circumstances, which is for the Commissioner to decide.

[37] More specifically, where the Nations have requested information pursuant to FIPPA s. 25, the issue is compliance with a duty under FIPPA, and not the propriety of any decision under the Public Health Act. See Order No. 37-1995; British Columbia (Labour Relations Board), [1995] B.C.I.P.C.D. No. 9 (March 31, 1995):

I have concluded, in short, that the parallel the Board has urged me to accept between the position of a court on a judicial review from a [Labour Relations] Board decision made under the [Labour Relations] Code, and my position on an investigation or inquiry under the Act [FIPPA] from a decision by the Board to refuse a request for access made under the Act, is not persuasive.

... I also find support for my conclusion in such cases as Worker's Compensation Board v. B.C. Council of Human Rights (1990), 47 B.C.L.R. (2d) 119 (C.A.) and Mans v. Council of Licensed Practical Nurses (British Columbia) (1993), 77 B.C.L.R. (2d) 47 (C.A.). Although not on point in all respects, those cases recognize generally that decisions of one statutory tribunal are not immunized from review by a second tribunal charged with determining whether or not the first tribunal has complied with or contravened an enactment. In those cases, the scrutiny of the Council of Human Rights was not considered analogous to a judicial review or a challenge to validity of the WCB or the CLPN's decisions, but rather a determination of whether those bodies had engaged in discriminatory conduct in contravention of Human Rights Act. Similarly, my role in this inquiry is not to displace the Board's jurisdiction to determine questions under the Code, but rather to review and inquire into whether the Board has complied, or failed to comply with the Act, in its response to the applicant's request for access to the IRO reports. (emphasis added)

Also see Order 02-38; British Columbia (Office of the Premier and Executive Council Operations), [2002] B.C.I.C.D. No. 38 (per Commissioner Loukidelis) at para. 39: "Section 25(1) either applies or it does not and in a Part 5 inquiry it is ultimately up to the commissioner to decide, in all the circumstances and on all of the evidence, whether or not it applies to particular information."
Accordingly, while the Commissioner has, in Investigation Report F13-05, looked to whether the head of a public body had "reasonably " come to conclusions, that reference cannot be taken to refer a "standard of review" in the sense of a public body having first made a decision, which the Commissioner then scrutinizes.

2.2. The special position of Indigenous governments

The relevance that the requesting bodies are Indigenous governments is also relevant. Canada is a signatory to the United Nations Declaration on the Rights of Indigenous Peoples ("UNDRIP"). The United Nations Department of Economic and Social Affairs describes UNDRIP as an instrument that, “…establishes a universal framework of minimum standards for the survival, dignity and well-being of the indigenous peoples of the world and it elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of indigenous peoples.” (emphasis added) (link [here](#)) UNDRIP is an international instrument that may inform the interpretation of domestic law: Ross River Dena Council v. Canada (Attorney General), 2017 YKSC 59 at para. 103. Furthermore, UNDRIP has now been legally implemented in British Columbia through the Declaration on the Rights of Indigenous Peoples Act, S.B.C. 2019, c. 44 (2019) ("DRIPA"). Accordingly, the Commissioner may and should interpret FIPPA s. 25 in a manner consistent with UNDRIP:

- UNDRIP Article 4 provides that, "Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions." (emphasis added)

- UNDRIP Article 7 provides that, “Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person.”

- UNDRIP Article 18 provides in part that, “Indigenous peoples have the right to participate in decision-making in matters which would affect their rights... as well as to maintain and develop their own indigenous decision-making institutions.”

- UNDRIP Article 21(1) and (2) provide in part that, “Indigenous peoples have the right, without discrimination, to the improvement of their… social conditions, including, inter alia, in the areas of… health...” and also that, “States shall take effective measures,” with particular attention to the rights and special needs of “indigenous elders....”

- UNDRIP Article 23 provides in part that, "...indigenous peoples have the right to be actively involved in developing and determining health... programmes affecting them and, as far as possible, to administer such programmes through their own institutions." (emphasis added)

- The implementation of UNDRIP through DRIPA now obligates Her Majesty the Queen in right of British Columbia (or "government" under s. 29 of the Interpretation Act) to support statutory interpretations that are consistent with UNDRIP. Section 3 of DRIPA requires that, "In consultation and cooperation with the Indigenous peoples in British
Columbia, the government must take all measures necessary to ensure the laws of British Columbia are consistent with the Declaration."

- DRIPA implements UNDRIP, which consists in whole or in part of human rights principles relating to Indigenous peoples: “[65] Special rules of construction apply to human rights statutes. The protections they offer are viewed not merely as statutory, but as quasi-constitutional. From this follows the principle that human rights legislation must be given a broad, purposive and liberal interpretation.” New Brunswick (Human Rights Commission) v. Potash Corporation of Saskatchewan Inc., 2008 SCC 45 (at para. 65 per Chief Justice McLachlin)

[40] Respectfully, FIPPA s. 25 must be interpreted in a manner that recognizes Indigenous governments, particularly when they seek access to information about what they consider to be risks of significant harm to the health or safety of their members.

[41] First, the Commissioner should recognize that part of the purpose of FIPPA s. 25 is to facilitate the ability of Indigenous governments, among others, to know about and address risks of significant harm to the health or safety of their members, where information about such risks come into a public body’s possession.

[42] Second, the Commissioner has in the past decided that in terms of any "burden of proof" under s. 25, "an applicant will be obliged, as a matter of common sense, to provide evidence and explanation for her or his assertion that s. 25(1) requires disclosure. This practical obligation may obviously be constrained, however, by the fact that the applicant does not have access to the disputed information." Order 02-38; British Columbia (Office of the Premier and Executive Council Operations), [2002] B.C.I.C.D. No. 38 at para. 37. However, and respectfully, where disclosure is actively sought by an Indigenous government, the Commissioner may and should, in applying FIPPA s. 25, give weight to the views of an Indigenous government that has decided — as part of exercising their Nation's right to self-government — what constitutes a risk of significant harm to the health or safety of their members, and whether information is actionable information "about" such a risk. An evidential burden should accordingly lie on the public body to prove that the factors set out under FIPPA s. 25 that warrant disclosure of information have not been met. An evidential burden on public bodies to rebut an assessment by an Indigenous government about a risk of significant harm to health or safety would be consistent with FIPPA s. 57(1), which provides that, "At an inquiry into a decision to refuse an applicant access to all or part of a record, it is up to the head of the public body to prove that the applicant has no right of access to the record or part." (emphasis added)

2.3. What "risk of significant harm" means

[43] The FIPPA does not define the term "risk", but the Oxford English Dictionary provides several definitions, including this one:

"1. (Exposure to) the the possibility of loss, injury, or other adverse or unwelcome circumstance; a chance or situation involving such a possibility. Frequently with of."
A risk therefore refers to the possibility of "significant harm" to the health of safety a group of people. FIPPA does not specify that "risk" only refers to a high" risk. Accordingly, even a "low" risk may qualify, where the risk may entail "significant harm".

Respectfully, a risk of serious illness or death to part of a population clearly amounts to a risk of "significant harm" to the health or safety of a group of people.

In OIPC Investigation Report F16-02, the Commissioner concluded that information about nitrate concentrations in an aquifer was about a risk of significant harm that requiring disclosure under s. 25(1)(a), where the range of consequences could include death:

"...information described below as to the existence of nitrate concentrations in excess of 10 mg/L in drinking water constitutes information about a risk of harm to the health of members of the public who source their drinking water from the aquifer. Further, the health risk posed to infants, which in the most severe instances may include death, constitutes a risk of 'significant' harm." (at p.25)

The Commissioner also determined that disclosure of information about the health risks posed by nitrate concentrations greater than 10 mg/L in drinking water would inform the public about the existence of that risk, the nature and extent of the risk, and would allow the public to take action necessary to mitigate that risk or to avoid harm." (at p.25)

2.4. **When information is "about a risk of significant harm"**

FIPPA s. 25 refers to "information" rather than to any "record". Accordingly, s. 25 may not require that a public body disclose records, but s. 25 also means that a public body must disclose information about a risk of significant harm, even if it is not contained in a disclosable record:

OPIC Investigation Report, F16-02 addresses the distinction between "information" and "records":

"...s. 25 applies to 'information', not to records. This is significant in that disclosure under Part 2 of FIPPA generally applies to 'records' in the context of an access to information request. While a public body is required by s. 4 of FIPPA to disclose an entire record (subject to legislated exceptions), there is no such requirement in s. 25. For example, where a record in the custody of a public body describes a risk of significant harm, the public body could conceivably satisfy its obligation under s. 25, in most cases, by disclosing an accurate summary of the information contained in the record. Section 25 may not require the disclosure of the record itself."

Furthermore, since FIPPA s. 25 imposes a duty respecting information "whether or not a request for access is made, the provision clearly imposes an ongoing duty that does not require that a group of people at risk of significant harm to their health or safety must continually make requests for information about such risks as they occur."
The OIPC has also previously decided that Information "about" a risk that may trigger disclosure under s. 25(1)(a) includes

- “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.” (emphasis added)

*OIPC Investigation Report, F16-02*, at p. 23, citing *Order 02-38*, 2002 CanLII 42472 (BCIPC), at para. 56.

Accordingly, information is especially “about” a risk if it is actionable information that would allow the public or a group of people to act to safeguard itself, independent of the acts of government.

The OIPC's interpretation of “information about a risk” that includes actionable information is particularly important in the context of a group of people who may not only act individually to safeguard themselves, but have a right to self-government that has been

- recognized by both Canada and British Columbia as an Aboriginal right under s. 35 of the *Constitution Act*, 1982, e.g., pursuant to
  - Principle 4 of Canada's "Principles respecting the Government of Canada's relationship with Indigenous peoples", and
  - Principle 4 of British Columbia's 2018 "Draft Principles that Guide the Province of British Columbia's Relationship with Indigenous Peoples";
- recognized in Article 4 of UNDRIP, which is in turn implemented in British Columbia through DRIPA; and
- addressed in various reconciliation framework agreements between the Nations, Canada and/or British Columbia, e.g.,
  - the Framework Agreement for Reconciliation between Heiltsuk Nation and British Columbia dated April 3, 2017;
  - the Nenqay Deni Accord: the People’s Accord between Tsilhqot'in Nation and British Columbia dated February 11, 2016; and
  - final or framework agreements signed by specific Nuu-chah-nulth Nations, such as the Maa-Nulth First Nations Final Agreement in effect on April 1, 2011, and the Agreement in Principle between the Ditidaht & Pacheedaht First Nations, British Columbia and Canada signed June 28, 2019.

Clarity on when information is about a risk of substantial harm, and public body compliance with FIPPA s. 25 is important to Indigenous communities, in the context of COVID, because compliance would not only allows Indigenous governments to address risks, but also
allow them to decide whether COVID occurrences in a particular proximate community are low enough (based on an absence of information) to warrant their allowing different levels of trade, travel, and safeguards.

2.5. The limited relevance of privacy interests

[55] The duty under s. 25 is not qualified by privacy concerns about personal information. Furthermore, no question of privacy under any other provision of FIPPA arises, because FIPPA s. 25(2) expressly provides that, "Subsection (1) applies despite any other provision of this Act." Privacy is not an issue under FIPPA s. 25(1)(a). The Commissioner has previously held that "if disclosure under s. 25(1) has been triggered, it is unnecessary to consider the exceptions under ss. 17 and 21 of the Act. I agree with the applicant that the application of s. 25(1) does not involve a weighing, from an evidentiary point of view, of the threshold in s. 2591) against the exceptions in Division 2 of Part 2 of the Act." Order 01-20; University of British Columbia, at para. 34.

[56] But even if privacy could be a factor in whether a public body has a duty to provide information under FIPPA s. 25, the request by the Nations does not amount to an unreasonable invasion of privacy:

- With respect to Items #1 and #2, the Nations are not seeking the identity of any non-member who is a presumptive or confirmed case. The Nations are only seeking geographic information, and if the person has a direct link to one of the Nations, disclosure of that fact. FIPPA Schedule 1 defines "personal information" as meaning "recorded information about an identifiable individual other than contact information...." (emphasis added) Accordingly, information about the location of a presumptive or confirmed COVID case, where that person cannot be identified, is not "personal information" under the FIPPA.

- With respect to Item #3, which includes the identity of any members of any of the Nations who are presumptive or confirmed COVID cases, as noted above the Nations have no issue with the disclosure of the identity of Nation members being subject to the consent of each member to the disclosure of their names by the Ministry, in the event the member becomes, or has become, a COVID case. Accordingly, no unreasonable invasion of privacy would arise, given FIPPA s. 22(4)(a): "A disclosure of personal information is not an unreasonable invasion of a third party's personal privacy if (a) the third party has, in writing, consented to or requested the disclosure...."

[57] The purpose of Item #3 is to enable Nations to take action to meet the risks of substantial harm relating to any member who has become infected with COVID, specifically by engaging in culturally-safe contact tracing with community members with whom the member might have had contact. The purpose of Item #3 is thus entirely consistent with the purpose of FIPPA s. 25. (The Nation and the government are currently engaged in discussions concerning culturally-safe contact tracing. Realistically, such a task is one that only the Nations may carry out, given barriers to effective contact tracing by health authorities involving language barriers, and/or members' distrust of colonial authorities. However, those discussions have not yet broached
(from the contact tracing perspective) the impossibility of culturally-safe contract tracing if the Ministry refuses to disclose the identity of members who are infected with COVID.)

3.0 Facts relating to a risk of significant harm

3.1. COVID-19 harms health and safety

[58] Respectfully, the presence of COVID-19 infections in communities proximate to the rural Indigenous communities of the Nations poses a risk of significant harm to members of those Indigenous communities, especially to Elders, other seniors, and people with underlying medical conditions.

[59] The transmissible nature of COVID-19: For completeness, the World Health Organization ("WHO") refers to the potentially serious consequences of COVID-19 (link):

Most people (about 80%) recover from the disease without needing hospital treatment. Around 1 out of every 5 people who gets COVID-19 becomes seriously ill and develops difficulty breathing. Older people, and those with underlying medical problems like high blood pressure, heart and lung problems, diabetes, or cancer, are at higher risk of developing serious illness. However, anyone can catch COVID-19 and become seriously ill. People of all ages who experience fever and/or cough associated with difficulty breathing/shortness of breath, chest pain/pressure, or loss of speech or movement should seek medical attention immediately. If possible, it is recommended to call the health care provider or facility first, so the patient can be directed to the right clinic.

[60] The WHO states that COVID-19 spreads "primarily from person to person through small droplets from the nose or mouth, which are expelled when a person with COVID-19 coughs, sneezes, or speaks." People may catch COVID-19 "if they breathe in these droplets from a person infected with the virus." Further, these droplets "can land on objects and surfaces around the person such as tables, doorknobs and handrails. People can become infected by touching these objects or surfaces, then touching their eyes, nose or mouth." Many people with COVID-19 may not know they have COVID-19: "Many people with COVID-19 experience only mild symptoms. This is particularly true in the early stages of the disease. It is possible to catch COVID-19 from someone who has just a mild cough and does not feel ill. Some reports have indicated that people with no symptoms can transmit the virus."

[61] In British Columbia: A publicly-available British Columbia “COVID-19 Dashboard” is available here (link):

https://experience.arcgis.com/experience/a6f23959a8b14bfa989e3cda29297ded

As of September 10, 2020, COVID-19 has resulted in 6,691 confirmed cases in British Columbia, and caused 213 confirmed deaths in BC.

[62] Additionally, the general health and safety hazard posed by COVID-19 is evident from the state of emergency declared by the Minister of Public Safety and Solicitor General under the Emergency Program Act, R.S.B.C. 1996, c. 111, on or about March 18, 2020 (see Ministerial
Order M073 here, which states in its preamble, “WHEREAS the COVID-19 pandemic poses a significant threat to the health, safety and welfare of the residents of British Columbia, and threatens to disproportionately impact the most vulnerable segments of society....” (emphasis added))

[63] Since the start of the reopening of British Columbia at the end of June (which is "Stage 3" of the government's response plan), and despite general measures involving social distancing and masks, the number of daily reports of COVID infections has steadily increased. For example, daily reporting data for July began with 10 new cases on July 1. The number of daily COVID cases has steadily increased, e.g., with 136 new cases on September 4, 2020 alone, and 139 cases on September 9, 2020. This publicly-available data clearly indicates that the risks relating to COVID are clearly not eliminated by such measures.

[64] In Canada: A publicly-available Canada "COVID-19" Outbreak update is available (link) as a link off of the following page:


And directly at the following page:


[65] As of September 10, 2020, COVID-19 has resulted in 134,294 cases in Canada, and caused 9,155 deaths in Canada. The Canadian government as noted as follows: "COVID-19 is a serious health threat, and the situation is evolving daily. The risk varies between and within communities, but given the number of cases in Canada, the risk to Canadians is considered high." (emphasis added)

[66] In the United States: As of September 10, 2020, according to the U.S. Centre for Disease Control (link), COVID has resulted in 6,343,562 cases in the U.S., and caused 190,262 deaths.

[67] Vulnerable populations: A Government of Canada Fact Sheet (link) states that some Canadians are more at risk of getting an infection and developing severe complications due to their health, social and economic circumstances. Vulnerable populations may include

Anyone who is:

- an older adult
- at risk due to underlying medical conditions (e.g. heart disease, hypertension, diabetes, chronic respiratory diseases, cancer)
- at risk due to a compromised immune system from a medical condition or treatment (e.g. chemotherapy)
Anyone who has:

- difficulty reading, speaking, understanding or communicating
- **difficulty accessing medical care or health advice**
- difficulty doing preventive activities, like frequent hand washing and covering coughs and sneezes
- ongoing specialized medical care or needs specific medical supplies
- ongoing supervision needs or support for maintaining independence
- **difficulty accessing transportation**
- **economic barriers**
- unstable employment or inflexible working conditions
- **social or geographic isolation, like in remote and isolated communities**
- **insecure, inadequate, or non-existent housing conditions**

(emphasis added).

### 3.2. Risks to Indigenous peoples

[68] Without addressing whether non-Indigenous communities also have rights under FIPPA s. 25 relating to proximate COVID cases, the Nations seek information about proximate COVID cases, and about cases involving their members, because they, like many other rural Indigenous communities, face disproportionate risks of significant harm to their health and safety from COVID infections:

- First Nations elders are at high risk of contracting and dying from COVID. These elders are critical to their Nations' survival as they carry the cultural knowledge, language, and memories of these Indigenous peoples. Indigenous communities also have significant populations of seniors with serious health issues including respiratory illnesses.
- First Nations generally are already at a lower level of health than other Canadians. They suffer more respiratory, cardiac and other serious health issues than other Canadians. They also suffer a higher level of mental health issues than other Canadians.
- Rural Indigenous communities have small populations where members live in close proximity to each other, so the spread of disease can occur very quickly. For example, many members live in one house with both their immediate and extended family, and some live with multiple, intergenerational families.
  - With respect to First Nations's housing nationally, a report by Indigenous and Northern Affairs Canada, *Evaluation of On-Reserve Housing* (Ottawa: Government of Canada, 2017) (linked [here](#)) notes (at p. 25) that, "population growth, coupled with a lack of capacity of First Nation administrations and community members to build and repair homes at a sufficient rate, has led to many instances of overcrowding."
With respect to First Nation's housing nationally, a report by Statistics Canada, The housing conditions of Aboriginal peoples in Canada, 2017 (Ottawa, Statistics Canada, 25 October 2017) (linked here) notes (at p.3) that in 2016, "close to one-fifth (18.3%) of the Aboriginal population lived in housing that was considered not suitable... for the number of people who lived there, according to the National Occupancy Standard." Households that are not "suitable housing" are considered to be crowded, which means a shortfall of bedrooms for adequately housing the number of people who live there.

With respect to First Nation's housing nationally, a report of the Native Women's Association of Canada (Indigenous Women, Girls, and LBGTQ2S: Engaging a National Framework for Housing Policy" (Ottawa, Native Women's Association of Canada, 2018) (linked here) notes, among other things,

- "Due to the shortage of housing units, inadequate buildings, and continued population growth, a significant number of First Nations women and girls report living in overcrowded units" (e.g., 18% of First Nations women and 39% of First Nations girls); and
- "almost half of homes on reserves have enough mould to cause serious respiratory problems" and that mould "is worsened by poor indoor ventilation and insulation, especially in communities under constant boil-water advisories".

In the case of the outbreak in Alert Bay, in Namgis territory, within one week, there were 29 cases, resulting in the death of one elder. In the recent case of the outbreak in Haida Gwaii, within a week, there were over 20 cases.

Past pandemics, including smallpox and Spanish flu, have resulted in significant harms, including death of significant parts of their populations:

- In 1780-82, 1831-34, 1862-63, and 1888-89, smallpox epidemics had catastrophic impacts upon First peoples in B.C. and across Canada. Heiltsuk’s oral histories, for example, tell of villages completely wiped out.
- From 1847-1850, an epidemic of measles took a great toll on First Peoples’ population in Canada.
- From 1847-1850, an epidemic of measles took a great toll on First Peoples’ population in Canada.
- In 1918, a Spanish flu epidemic further devastated First Peoples’ populations, with Heiltsuk’s oral histories recounting so many deaths per day that they could not perform proper burials, and resorted to mass burials with unmarked grave sites.

Hilistis (Pauline Waterfall), “Precedented times” (April 24, 2020)
Community medical resources are very limited, and would not be sufficient to address an outbreak of COVID. Many of these communities are only accessible by air or boat.

The compromised health of Indigenous communities, and the roots of these health issues in colonization, has been recognized by the Royal College of Physicians and Surgeons of Canada in its *Indigenous Health Primer* (2019):


"Social determinants of health include legislation and government policies, particularly as they relate to Indigenous status. The World Health Organization (2008) defines the social determinants of health as “the conditions in which people are born, grow, live, work and age.” They are the economic, social, political and infrastructural conditions that affect health." (p. 50)

"Indigenous-specific determinants of health — such as colonialism, racism, social exclusion and undermining self-determination — are the precursors (distal determinants) to several other more downstream (proximal determinants) (Reading & Wien, 2009). Government policies designed to assimilate Indigenous people acted via each of these determinants of health. The resultant legislation and policies continue to affect the health outcomes of Indigenous people and the quality of their physical, emotional, mental and spiritual health. This is echoed in the United Nations Human Development Index where First Nations people in Canada ranked 68th in the world on dimensions such as poverty, income, housing and education — all of which are known, important determinants of health (Reading & Wien, 2009)." (p. 50)

"Due to racist colonial policies, many Indigenous Peoples have suffered the loss of connections to their land, languages and traditional ways of life. Health disparities among the Indigenous and non-Indigenous population are rooted in colonial practices that resulted in forced relocation, the reservation system, residential schools, child apprehensions and endangered languages (National Collaborating Centre for Aboriginal Health, 2013). These profound human rights violations aimed to eliminate Indigenous languages, cultural practices, and their identities as distinct peoples. The subsequent trauma has resulted in higher rates of suicide, mental health and addictions issues, and significant health disparities (Assembly of First Nations & Health Canada, 2015)" (p. 68)

"Indigenous Peoples, across what is now referred to as Canada, have survived the federal government’s many attempts at cultural assimilation (Aboriginal Healing Foundation, 2003). Indigenous Peoples have survived multiple forms of genocide, including: physical genocide, committed through mass and targeted killings; biological genocide through destroying the reproductive capacity of groups of people; and cultural genocide through destruction of structures and practices, seizing land, banning languages, persecuting spiritual leaders and forbidding spiritual practices (Makokis & Greenwood, 2017). This has resulted in historical trauma, which has been described as cumulative emotional and
psychological wounding over one’s lifespan and across generations, emanating from massive group trauma experiences (Yellow Horse Brave Heart, 2003)." (p. 17)

- "Colonization continues to result in intergenerational transmission of varied degrees of post-traumatic stress, higher rates of ill-health, systematic violence and sexual exploitation against Indigenous Peoples." (p. 18)

- "Legislation and policies are important interventions to close the gap in health disparities. Such legislation and policies not only include improvements to health care service access, but also address more upstream determinants of health. In particular, self-determination has been identified as essential to improving the health of Indigenous people (Assembly, 2007)" (p. 50)

[70] The vulnerability of Indigenous communities to COVID has been confirmed by the experience of Indigenous peoples in Alaska, who have been reported as "more than one-and-a-half times as likely to contract the coronavirus and have been hospitalized almost twice as much", "Indigenous communities in Alaska harder hit by COVID-19" CBC, August 26, 2020 (link here).

[71] We have also discussed the risks presented by COVID-19 to the Nations with Dr. Iglesias and Dr. Shearer, who are both rural physicians. Dr. Iglesias served Bella Bella's hospital for over a decade, and Dr. Shearer is Bella Bella's current hospital doctor. Dr. Iglesias won the rural physician leadership award in 2020, for outstanding contribution to rural medicine on a national level in Canada. Both physicians see Bella Bella as extremely vulnerable to COVID-19 and ill prepared to address and mitigate its harm, given health and socio-economic factors common to First Nation reserves; limited local health resources; pre-existing health conditions; and crowded multi-generational and multi-family homes. Drs. Shearer and Iglesias have kindly provided a supporting letter.

SCHEDULE J-1 (Letter from Drs. Shearer and Iglesias)

[72] The Nations have also obtained a letter from support from Dr. Don Wilson, a physician and a member of Heiltsuk Nation. Dr. Wilson speaks to the impacts of COVID on pregnant women, patients with underlying health conditions, and the elderly, in terms of both the potential for serious physical illness and death, and the potential social and psychological harm which can occur due to the required isolation precautions and loss of social networks during the acute phase of the illness. Dr. Wilson also speaks to the special position of Indigenous communities like Bella Bella and factors supporting disclosure of information about COVID cases.

SCHEDULE J-2 (Letter from Dr. Don Wilson)

[73] The Nations have to date mitigated the risks of COVID, absent the information they have sought from the Ministry, in part by mandating general measures (e.g., social distancing, masks, and self-isolation), and also through general governmental measures (i.e., banning unnecessary travel, regulating travellers from other communities, and imposing quarantine requirements). However, this level of response is ultimately unsustainable, which leads to the issue of how the
Nations may allow inter-community travel and trade in a way that allows them to manage the risks of COVID.

3.3. **Risks relating to the Nations specifically**

[74] The following information is to provide more specific information on communities of the Nations, to illustrate they are rural communities with communal living arrangements, and at-risk populations including Elders and seniors, that would suffer disproportionate harm from COVID in their communities.

3.3.1. **Location and self-governing nature**

[75] **Heiltsuk Nation:** Heiltsuk Nation, comprising of five tribes, is a self-governing nation of Indigenous peoples. Heiltsuk Nation has owned and exercised sovereignty over traditional Heiltsuk territory, which is located on the central coast of what is now British Columbia ("Heiltsuk Territory"), since before European contact and since before the Imperial Crown’s assertion of sovereignty in 1846. Heiltsuk Nation is also an “Indian band” under the *Indian Act*, R.S.C. 1985, c. I 5.

[76] The existence of Heiltsuk Nation as a society engaged in inter-tribal trading and barter since before European contact was recognized by the Supreme Court of Canada in *R. v. Gladstone*, [1996] 2 S.C.R. 723.

[77] A video introduction to Heiltsuk as a self-governing First Nation, created to celebrate their creation of a written constitution for their peoples, is available here:

https://www.youtube.com/watch?v=dw_YAck7CBw

[78] The Heiltsuk community is centred on Bella Bella, located within Heiltsuk Territory on the east coast of Campbell Island. Bella Bella is not accessible from the mainland by road; it is only accessible by boat, plane, and limited ferry access. Bella Bella is a small community and reserve with one grocery store, one gas station, no restaurant, no hotel, and no bank.

[79] **Tšilhqot'in Nation and Tšilhqot'in communities:** The Tšilhqot'in National Government was established in 1989 to meet the needs and represent the Tšilhqot’in Nation and Tšilhqot'in communities of T'el'tin, ʔEsdilagh, Yunešit’in, T'śideldel, Tl'esqox and Xeni Gwet'in.

[80] The Tšilhqot'in Nation's traditional territory is located in central British Columbia. It includes the Tšilhqot'in communities of T'el'tin, ʔEsdilagh, Yunešit’in, T'śideldel, Tl'esqox and Xeni Gwet'in, which are located in predominantly rural areas, with most members being an hour or more by car from larger towns such as Williams Lake.

[81] The occupation by Tšilhqot’in Nation of lands within their traditional territories since before Crown sovereignty was recognized by the Supreme Court of Canada in *Tšilhqot'in Nation v. British Columbia*, 2014 SCC 44.

[82] **Nuu-chah-nulth First Nations:** Nuu-chah-nulth Tribal Council (NTC) is a not-for-profit society that provides a wide variety of services and supports to fourteen Nuu-chah-nulth First Nations with approximately 10,000 members.
The 14 Nuu-chah-nulth First Nations are divided into three regions:

- **Southern Region:** Ditidaht, Huu-ay-aht, Hupacasath, Tse-shaht, and Uchucklesaht
- **Central Region:** Ahousaht, Hesquiaht, Tla-o-qui-aht, Toquaht, and Yuu-cluth-aht
- **Northern Region:** Ehattesaht, Kyuquot/Cheklesaht, Mowachaht/Muchalaht, and Nuchatlaht.

Each of the Nuu-chah-nulth Nations operate independently, while the NTC provides services and supports the 14 Nations politically as requested by them to work together collectively on various issues.

The existence of Nuu-chah-nulth First Nations as Indigenous peoples engaging in fishing and trading since before European contact has been recognized in such cases as *Ahousaht Indian Band v. Canada (Attorney General)*, 2013 BCCA 300.

### 3.3.2. Factors relevant to risks of significant harm to health or safety

Vulnerable populations facing disproportionate impact: The populations of rural Indigenous communities include Elders, seniors, and other members with pre-existing health conditions that would be most vulnerable to COVID.

- For example, in the case of Heiltsuk Nation, 1,236 Heiltsuk live on-reserve in Bella Bella:
  - The 1,236 on-reserve members include 376 members 50 or over (the higher risk group for contracting COVID-19) and 216 children (members under 19 years old). The large majority of Heiltsuk living on-reserve in Bella Bella are low income earners or unemployed and live in rental housing. Approximately 48% are women, and more than 9% are over 70 years old.
  - Many senior Heiltsuk have elevated medical risks or have disabilities including heart conditions, diabetes, and cancer.
  - The senior Heiltsuk population includes a significant number of Heiltsuk's traditional chiefs, the Hemas, and elders. These chiefs and elders hold the history and culture of the Nation, and alongside their counterparts in urban areas are the cultural core for Heiltsuk. Heiltsuk has approximately 30 knowledge and culture keepers. Furthermore, due to the Crown's past attempts to extinguish Indigenous cultures, Heiltsuk has only 15 people who remain fluent in the Heiltsuk language, and 13 of the 15 are Elders. COVID represents an existential threat to Heiltsuk's maintenance of its history and culture.
  - Since the inception of the COVID pandemic, mental health issues have been on the rise. Community data shows increasing reports of mental health issues, including suicidal ideations and attempts, in both adults and youths. Based on a recent survey, 40.4 percent of respondents indicated mental health as a primary concern. The risks of COVID spreading within a community like Bella Bella would include the exacerbation of such issues.
• For the Tsilhqot'in Nation's communities:
  o Many members with underlying health conditions, such as diabetes, heart disease, cancer, and chronic obstructive pulmonary disease (COPD), as well as mental health disorders, including alcohol and drug disorders.
  o They have approximately 210 Tsilhqot'in Elders who speak Tsilhqot'in as their first language. These Elders are considered particularly critical knowledge-keepers of Tsilhqot'in culture.

• Similarly, for Nuu-chah-nulth First Nations:
  o Many members have underlying health conditions, such as diabetes, heart disease, cancer and cardiovascular issues, just to name some.
  o The Nuu-chah-nulth First Nations also have a limited number of (elder) members still fluent in their traditional language, histories, protocols and traditional ecological knowledge ("TEK", or indigenous wisdom).

[87] Housing conditions: Elders will often live with many family members who leave home to work. A lack of housing on reserve creating over-crowding is also a significant problem which contributes to conditions where COVID may rapidly spread within the community. For example:
  • For a survey of Heiltsuk members (between August 15 and 27) with 222 responses, 25% of respondents reported overcrowded housing as a specific concern.
  • Tsilhqot'in Nation also reports overcrowding as an issue in all communities. It also notes that many Elders live in homes with many family members who may be exposed to COVID in their workplaces in cities, and bring it back home.
  • For Nuu-chah-nulth Nations, the median number of people per household for the Tse-shaht First Nation, for example, is four people, and for the Tla-o-qui-aht First Nation, the median number of people per household is six people.

[88] Limited access to any necessary treatments: The rural location of these Indigenous communities means that treatment for COVID infections may be more difficult. For example, for the Heiltsuk, while BC Emergency Health Services conducted 75 air transports out of Bella Bella in 2018/2019, another 23 flights could not occur due to weather. Delayed or cancelled flights due to weather conditions (such as fog, wind, or snow) are not uncommon at Bella Bella. With respect to the 14 Nuu-chah-nulth First Nations, many of the member Nations are located in rural traditional territories along the west coast of what is now called Vancouver Island. Some individuals must travel by floatplanes, ferry boats, and/or logging roads to reach a location where they can be tested for COVID. Individuals may need to travel several hours to get to a hospital. Mariah Charleson has stated that "...our rural and remote communities do not have the capacity to handle [an] outbreak if it were to happen... It's a real concern." ("Visitors entering closed territory despite protective COVID-19 measures", August 6, 2020) (here)

[89] Heiltsuk has R.W. Large Memorial Hospital ("RW Large") in Bella Bella. However, this facility has limited resources. The facility has only 4 acute beds, 7 long-term care beds, and a 3-
bed emergency department. RW Large serves not only Bella Bella, but also the communities of Ocean Falls, Denny Island and Kitasoo/Xai'xais, as well as transient patients from fishing lodges, logging camps, and tourist boats. The facility would not be able to handle an outbreak of COVID in the community.

[90] Similarly, the Tsilhqot’in Nations has a limited capacity to address a significant number of people needing 24-hour care, and such patients would have to be sent out to Williams Lake or Quesnel.

[91] Links with proximate communities: Indigenous communities ordinarily operate with significant traffic between themselves and proximate communities. Members travel to proximate communities, and Indigenous communities also receive traffic from proximate communities, including significant tourist traffic. Community members will ordinarily travel between communities to buy hardware, food, fuel or supplies; to have boats and motors serviced or repaired; to trade in harvested fish; to obtain medical services; to work in another community; to attend funerals; for other social reasons; and so on.

[92] Which communities are "proximate" communities will depend on transport links. For example:

- Heiltsuk community members, for example, travel to and from proximate communities through via B.C. Ferries (which links Bella Bella to Port Hardy, Klemtu, Bella Coola, Ocean Falls, and Shearwater, and further to Prince Rupert and Haida Gwaii), via air (on Pacific Coastal Airlines, which links Bella Bella to Port Hardy, Campbell River and Vancouver), and via private boats.

- Tsalhqot’in communities are linked to surrounding communities, especially Williams Lake and Quesnel, through highways, e.g., Highway 20.

- Similarly, the Nuu-Chah-Nulth First Nations are linked to surrounding communities, e.g., Bamfield, Port Alberni, Ucluelet, Tofino, etc., by highway, air, and water travel.

Proximate communities may also include other Indigenous communities, due to trade in traditional foods, such as spawn-on-kelp (SOK), sockeye salmon, chinook salmon, halibut, crab, and so on.

[93] The risks of COVID in proximate communities (including destinations like fishing lodges) is exacerbated by tourism, either seasonally or year-round, e.g., in Tofino and Ucluelet (year-round), Bamfield (May-October).

[94] As an example of the additional issue of tourism, Hot Springs Cove is a popular tourist attraction in the Tofino area, part of the traditional territories of the Hesquiaht First Nation. Although Hesquiaht band council and NTC and Ahousaht have currently closed the territory to non-essential travel, many non-residents continue to show up in private boats. Bernard Charleson, Hesquiaht emergency co-ordinator, says that "They are here on a daily basis – from day break to evening... It’s just another way that the virus is going to get into the community. They do come to the village and they do tie up at the dock. On occasion, they will walk into the village when there’s nobody around to stop them.” ([Source](Hot Springs Cove is a popular...))
tourist attraction in the Tofino area, part of the traditional territories of the Hesquiaht First Nation. Although Hesquiaht band council and NTC and Ahousaht have closed the territory to non-essential travel, many visitors continue to show up in private boats.); Source

[95] Knowledge of a significant number of COVID cases in proximate communities would allow the Nations to assess risks relating to their continuing to allow members to travel to (or through) proximate communities; to allow travellers from proximate communities; or to use particular kinds of common carriers (e.g., ferries or planes) connected to particular communities.

[96] Special factors relating to Indigenous members: Indigenous members infected by COVID, or travelling from populations with what the Nations may consider to have a significant number of COVID infections, represent a specific risk, as they are likely to contact family members or friends within their community, in the absence of specific restrictions imposed by their Indigenous governments. For example, in April, a Tsilhqot’in member was released from Mission Institution (where over a third of inmates became infected) and was transferring to a half-way house when he stopped in the community along the way. The Indigenous government was not given any advance notice. He later tested positive for COVID.

3.4. Supporting media information about risks

[97] Various media articles, including public statements by government, confirm

- the general risks of COVID to health and safety generally, and
- greater risks to vulnerable groups, e.g., risks to Elders, and
- the speed at which infections may spread within Indigenous communities, such as occurred in Alert Bay and Haida Gwaii.

[98] While government may say that infections to date illustrate that government has moved to address these outbreaks once they occur, response efforts do not justify a failure of the Minister of Health to comply with any duty to provide information that would give the Nations the knowledge to also act proactively, as well as reactively.

* “Joint statement on Province of B.C.’s COVID-19 response, latest updates”

   BC Gov News (April 25, 2020)
   - “We have two public health emergencies in our province, the overdose crisis and now COVID-19, making daily life an even greater struggle for many.”

* “Joint statement on B.C.’s COVID-19 response, latest updates”

   BC Gov News (August 12, 2020)
   - Adrian Dix and Bonnie Henry state [not stated who exactly states it], “Regardless of your age, we know that COVID-19 can cause severe and serious illness.”

* “Joint statement on Province of B.C.’s COVID-19 response, latest updates”

   BC Gov News (April 15, 2020)
• “One thing that we all have in common is the understanding that Elders and seniors hold and preserve our history and culture. We also know that they are most vulnerable to COVID-19 and we must do all we can to protect them.

• “We also recognize that every community in B.C. is unique – with different health-care services and required support. Smaller communities have limited health services, which makes managing and responding to COVID-19 all the more challenging.”

• “This is especially the case for many Indigenous communities and why we have been working to increase options for patient care and clinical support.”

* “COVID-19 kills Alert Bay woman after outbreak on small B.C. island”
CBC News (April 26, 2020)

• "Included in the deaths in the last 24 hours, is our first death in one of B.C.’s First Nations communities. Along with the many lives we have lost to COVID-19, this is a tragedy that’s beyond just us. This is a tragedy for all of us. Our Elders, in particular, in our First Nations communities are culture and history keepers. When they become ill and when they die, we all lose and I want you to know that we feel that collective loss today."

* “UN/DESA Policy Brief #70: The Impact of COVID-19 on Indigenous Peoples”
United Nations Department of Economic and Social Affairs (8 May 2020)

• “COVID-19 presents a new threat to the health and survival of indigenous peoples. Indigenous peoples in nearly all countries fall into the most “vulnerable” health category. They have significantly higher rates of communicable and non-communicable diseases than their non-indigenous counterparts, high mortality rates and lower life expectancies. Contributing factors that increase the potential for high mortality rates caused by COVID-19 in indigenous communities include mal – and under-nutrition, poor access to sanitation, lack of clean water, and inadequate medical services. Additionally, indigenous peoples often experience widespread stigma and discrimination in healthcare settings such as stereotyping and a lack of quality in the care provided, thus compromising standards of care and discouraging them from accessing health care, if and when available.

• “Indigenous peoples largely fall outside any formal social protection systems and few have access to medical and financial support in times of crisis. As lockdowns continue to expand with no timeline in sight, indigenous peoples who already face food insecurity as a result of the ongoing dispossession and loss of their traditional lands and territories also now face loss of their livelihoods, which form the main base for their subsistence.”

• “At great risk in this pandemic are indigenous elders. This is due to the devastating impact of the virus on older persons generally and, in the case of some indigenous communities, to crowded and multi-generational housing that is commonly experienced, which facilitates the spread of COVID-19. The impact of COVID-19 on indigenous elders has cultural implications for their communities, as elders play a key role in keeping
and transmitting indigenous traditional knowledge and culture and practices. These include conservation of biodiversity, upholding traditions and customs, leading community gatherings and ceremonies, and as custodians of customary law and governance. Indigenous elders are often the last remaining bastions of traditional knowledge and have a key role in teaching and transmitting their indigenous languages to future generations.”

Policy recommendations and guidelines include the following:

**Governments and Representative Institutions**

- Recognize indigenous peoples’ representative institutions, authorities and governments as the legitimate representatives of indigenous peoples
- Include indigenous peoples’ representatives, leaders and traditional authorities in the planning and design of health services and responses to the COVID-19 pandemic as well as in dealing with its repercussions
- Provide effective support to indigenous communities that have imposed lockdowns or other restrictions to stop the spread of the COVID-19

*“COVID-19 checkpoints ‘up to them,’ Bonnie Henry says of remote B.C. villages”*

Nelson Star (May 25, 2020)

- “The only caveat I have is that we have many communities, small communities, particularly our First Nations communities, who have understandably a greater degree of risk and loss that could happen if this virus was introduced in those communities . . . So I would leave it to them to determine whether it is safe for people to travel to their communities and it is their – it’s up to them to determine when they’re ready for that, if at all, this summer. And it may be that some areas will not be appropriate for us to visit unless we’re invited in.”

*“First Nations Health Authority COVID-19 Update”*

(COVID Update with Dr. Bonnie Henry and Dr. Shannon McDonald) (26 June 2020)

- Bonnie Henry: “We just need to think about the impact on First Nations Elders and knowledge keepers and the deep tragic loss. . . for all of us.” (9m 00s)

*“Joint statement on B.C.’s COVID-19 response, latest updates”*

BC Gov News (July 24, 2020)

- “There is one new community outbreak on Haida Gwaii, with 13 total confirmed cases of COVID-19 to date. Of the 13 people who have tested positive, one person has recovered and 12 are active cases. At this time cases are all local residents. While the initial source of transmission is still being investigated, the cases are all epidemiologically linked. Some are related residents who had recently travelled off island, and others are from exposure to known cases.”
* “Tensions remain as Haida Gwaii copes with COVID-19 pandemic”
Haida Gwaii Observer (July 27, 2020)

- Haida Gwaii community members start to tighten up their approach to pandemic. The disparity between the 12 hospital beds and the 5000 residents living there is creating increased tension.

* Haida Gwaii (COVID-19) Order (Ministerial Order No. M257)
BC Laws (July 30, 2020)

- The order sets out travel restrictions, requirements for documentation, and the implementation of emergency measures in response to the COVID-19 outbreak on Haida Gwaii.

* “Haida Gwaii supports travel ban to island amid COVID-19 outbreak”
APTN National News (July 31, 2020)

- Haida Nation supports province’s imposed travel ban to Haida Territory for all non-residents.
  - “It’s critical that we come together at this time of crisis. BC’s order is an important step towards a renewed partnership in emergency management, “said President of The Haida Nation Gaagwiis, Jason Alsop in a statement released yesterday.
  - “The province’s work to enact an order that aligns with the Haida Nation’s State of Emergency is a respectful act and recognition of Haida jurisdiction and our responsibility as governments to work together to protect all communities and residents of Haida Gwaii from the threat of COVID-19.”
  - “I’m grateful to BC for this provincial order, it will help our local efforts in controlling the outbreak of COVID-19. The order will be a reset button for our local governments on Haida Gwaii to commit to working together to free us all from this virus as soon as possible,” William “Billy” Yovanovich, chief councillor of the Skidegate Band Council in a press release.
  - “Leaders of Haida Gwaii have done all that we can to keep COVID-19 from coming to our communities,” he said. “Our EOC and health teams have been preparing for this day. I’m glad to hear BC has aligned with Haida Gwaii’s measures and we are all working together on this pandemic response.
  - “Keeping our Elders and communities safe is our top priority during these difficult times.”

* “Masks mandatory in Old Massett as Haida Gwaii COVID cases today 26”
Haida Gwaii Observer (August 7, 2020)

- Those who violate orders will be tracked by Haida Gwaii Restorative Justice Program.
* “Government of Canada announces funding for Indigenous communities and organizations to support community-based responses to COVID-19”

Canada News Releases (August 12, 2020)

- “The Government of Canada recognizes that First Nation, Inuit and Métis are among the most at risk and face unique challenges in addressing COVID-19. It also recognizes that Indigenous leadership, governments and organizations are best placed to determine the needs of Indigenous Peoples and to develop community-based solutions that respond to these challenges.” (emphasis added)

* Finally, the speed at which COVID may spread through an Indigenous community is illustrated by Tla’amin Nation, which had seven confirmed cases of COVID on Wednesday, September 9: https://www.tlaaminnation.com/seven-confirmed-covid-19-cases-at-tlaamin-nation/

As of this writing (Monday, September 14, 2020), Tla’amin Nation advises that it has about twenty COVID cases.

4.0 Why information about proximate cases is "about" a risk

[99] Information is about a risk not only if it discloses the fact of a risk, but especially if it is actionable information, meaning it allows the public or a group of people to "meet the risk or mitigate or avoid harm".

[100] Indigenous communities differ from the general public because their Indigenous governments may respond to information using powers of self-government, including Indigenous laws and bylaw powers under the Indian Act. For example, Heiltsuk has a Disease Emergency Bylaw pursuant to which Heiltsuk Tribal Council may declare a temporary "disease emergency" and exercise authority on reserve lands to mandate self-isolation or quarantine, restrict travel, and restrict access to public spaces or businesses.

[101] Information about proximate cases allows Indigenous governments to not only encourage or mandate that members take "universal" measures (e.g., to engage in social distancing, to use masks, or to self-isolate after travel), but to impose other measures that may address how Nations and their members have contact with proximate communities.

[102] Said another way, to manage the significant risks posed by COVID infections to Indigenous communities, the Nations' leaderships seek information about COVID presumptive and confirmed cases in order to better decide

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

[103] The Nations are of the view that they cannot effectively govern without knowing about proximate COVID cases, so that they may tailor measures to address specific risks.

[104] One of the impacts of the Ministry failing to disclose information to First Nations about a risk of significant harm from proximate COVID cases, or from members with COVID, is to undermine the rights of Indigenous peoples to "self-government" in matters relating to their internal and local affairs (UNDPR Article 4). The rights of the Nations include their right to be actively involved in developing, determining, and administering through their own institutions, health programmes that affect them - including programmes for responding to COVID risks (UNDPR Article 24).

5.0 Why FIPPA s. 25 is not overridden by the Public Health Act, including Part 5

[105] On August 7, the PHO, Dr. Henry, specifically asserted that s. 25 of FIPPA is not applicable "because of concerns and responsibilities under the PHA [Public Health Act]." and that, "it's the PHA I must adhere to". She reiterated that, "What you ask for - personal identifiable information - is not what I can release under the PHA...."

[106] Ms. Gow, as counsel for the Ministry, stated in her email of August 6, 2020 that, "section 25 of FIPPA does not come into play in the circumstances at hand and, therefore, no obligation under it arises on the part of the Minister of Health. That being the case, there is no need for a decision to be made under section 25."

[107] Respectfully, these arguments intertwine two different issues:

1. A lack of distinction between the PHO exercising powers and fulfilling responsibilities under the Public Health Act, and the duties of the Minister of Health under FIPPA; and
2. An unwarranted presumption that the PHO's powers under the Public Health Act during an emergency automatically supersedes a duty (of the Minister) under FIPPA s. 25.

[108] Although the Minister has not, at this time, provided details of its legal theory that underlies its position, the Nations believe it prudent to closely examine the interrelationship of FIPPA and the Public Health Act in more detail - an exercise that shows that the powers of the
PHO under the Public Health Act do not actually override any duty of the Minister of Health under FIPPA.

5.1. **Two distinct offices**

[109] A first and major point is that the PHO and the Minister of Health are two different offices, each with different positions under different statutes. While their powers and duties may pertain to the same situation (say, a case of COVID occurring in a community that is proximate to one of the Nations), the emergency powers of the PHO (even if they are taken to preclude any disclosure duties of the PHO under other statutes) do not say anything about the powers or duties of the Minister of Health. The Minister of Health can certainly choose to adopt the same reasoning of the PHO, but that does not change the fact that the Minister cannot say that the statutory power of some other office can override his own legal duties.

[110] The balance of this section goes on to address, for purposes of argument, the situation where the powers of the PHO could, in theory, conflict with the duties of the Minister. But that scenario is moot without some legal explanation for why the powers of the PHO under the Public Health Act have anything to do, legally, with the duties of the Minister of Health, as the head of a public body, under FIPPA.

5.2. **Statutory background**

[111] **The general pre-eminence of FIPPA:** FIPPA s. 79 provides that any obligation under the FIPPA supersedes any inconsistent or conflicting provision under any other statute, unless the other statute expressly provides that it applies despite the FIPPA:

"79. If a provision of this Act is inconsistent or in conflict with a provision of another Act, the provision of this Act prevails unless the other Act expressly provides that it, or a provision of it, applies despite this Act."

[112] Section 79 creates "an unequivocal and absolute expectation of express reference before an inconsistent or conflicting statutory provision will prevail." **College of Physicians and Surgeons of British Columbia v. British Columbia (Information and Privacy Commissioner),** 2001 BCSC 726 at para. 119. This is important because, while Part 5 of the Public Health Act has the benefit of an override provision, the rest of the Public Health Act does not. For example, regulations created by the Lieutenant Governor in Council, under a provision outside of Part 5, clearly cannot override any FIPPA provision.

[113] **The specific pre-eminence of Part of the PHA:** Only one part of the Public Health Act may expressly override FIPPA s. 25, and that is Part 5 (sections 51-60), pursuant to PHO s. 53. However, on a closer examination of the wording of the Public Health Act, e.g.,

- provisions within Part 5 (including ss. 53 and 54(1)(b) and (k), and also s. 58 (emergency Ministerial regulations)) and
- provisions outside Part 5 (especially s. 113 (Lieutenant Governor in Council regulations) and s. 13 of the Reporting Information Affecting Public Health Regulation),
PHA provisions outside of Part 5 cannot override FIPPA at all, and Part 5 only overrides to the extent of some inconsistency or conflict.

Respectfully, no inconsistency or conflict arises between a duty (of a head of a public body) under FIPPA s. 25 (e.g., the Minister of Health, as the head of the Ministry of Health) and any permissive powers (of health officers, including the provincial health officer) under Part 5 of the Public Health Act.

Relevant provisions of FIPPA: FIPPA s. 25 establishes a right of specific members of the public, in particular circumstances, to information from a head of a public body, and the provision therefore creates both (a) an implied power of the head of a public body to disclose specific information, coupled with (b) a duty of disclosure.

FIPPA s. 33 limits disclosure of personal information to specified situations, but s. 33.1(1)(c) permits disclosure by a public body “in accordance with an enactment of British Columbia… that authorizes or requires its disclosure….”

Non-emergency provisions of the PHA: Regardless of any emergency, the Reporting Information Affecting Public Health Regulation (the “Regulation”) is a regulation made under Part 9 of the Public Health Act, and specifically, under PHA s. 113, which authorizes the Lieutenant Governor in Council to make regulations respecting reporting of disease etc.

One Regulation that the Ministry has referenced is the Reporting Information Affecting Public Health Regulation (the "Regulation"). Section 13(1) of the Regulation provides that “The provincial health officer or a medical health officer” who receives a report “may disclose information contained in the report… to a person referred to in subsection (2)” and s. 13(2) clarifies the scope of this permissive power in terms of the persons to whom a health officer may disclose information. (Notably, under Interpretation Act, R.S.B.C. 1996, c. 238, s. 29, “ ‘may’ is to be construed as permissive and empowering”.) The Regulation was made, however, through an Order in Council, and was not a Ministerial order (i.e., it is indexed as O.C. 427/2018), and it was clearly not made during the COVID state of emergency (i.e., it was deposited July 27, 2018 and effective January 1, 2019).

Emergency provisions of the PHA: Public Health Act (PHA) s. 53 provides that in an emergency, Part 5 “applies” despite any provision of any enactment, but only “to the extent there is any inconsistency or conflict with the provision or other enactment” (emphasis added).

Note, however, that the legislature has distinguished, within s. PHA 53, between (a) a provision relating to “the collection, use or disclosure of personal information” under FIPPA, and (b) a provision that “would impose a specific duty… in respect of a specific person or thing.”

The SCC addressed the meaning of “inconsistency” as involving contradictory enactments, i.e., where compliance with one involves breach of the other, in ***Friends of the Oldman River Society v. Canada (Minister of Transport)***, [1992] 1 S.C.R. 3 at para. 42:

… Ordinarily, an Act of Parliament must prevail over inconsistency or conflicting subordinate legislation. However, as a matter of construction a court
will, where possible, prefer an interpretation that permits reconciliation of the two. ‘Inconsistency’ in this context refers to a situation where two legislative enactments cannot stand together; see Daniels v. White, [1968] S.C.R. 517. The rule in that case was stated in respect of two inconsistent statutes where one was deemed to repeal the other by virtue of the inconsistency. However, the underlying rationale is the same as where subordinate legislation is said to be inconsistent with another Act of Parliament -- there is a presumption that the legislature did not intend to make or empower the making of contradictory enactments. There is also some doctrinal similarity to the principle of paramountcy in constitutional division of powers cases where inconsistency has also been defined in terms of contradiction - i.e., “compliance with one law involves breach of the other”; see Smith v. The Queen, [1960] S.C.R. 776, at p. 800. (emphasis added)

Accordingly, “inconsistency” does not appear substantially different from “conflict”. Conflict may of course involve either (1) an operational conflict, where compliance with both laws is impossible, or (2) frustration of purpose, where one law thwarts the purpose of the other law: Saskatchewan (Attorney General) v. Lemare Lake Logging Ltd., [2015] 3 S.C.R. 419 at para. 17. However, nothing about a duty of the head of a public body to disclose information about a risk of substantial harm to health or safety frustrates the purpose of Part 5 of the PHA, which is to “allow the medical health officer or the provincial health officer to act quickly to deal with an extraordinary and dangerous situation. [...] [T]here will be times of extraordinary emergency where people need to move very quickly and do the things they need to do to contain an emergency. That’s the reason for the section [referring to PHA s. 54].” (per the Honourable G. Abbott; see Hansard, Vol. 34, No. 7 (2008 Legislative Session: Fourth Session, 38th Parliament) (available online here).

Operational conflict requires an actual conflict, that is, “the same citizens are being told to do inconsistent things” (Lemare Lake at para. 18).

During an emergency:

- Under PHA s. 54(1)(k), “a health officer may… (k) collect, use or disclose information” that could not otherwise be collected, used or disclosed, in any form or manner other than the form or manner required.” This provision therefore permissively authorizes collection, use or disclosure. This provision does not, however, give rise to any conflict with Part 3 of FIPPA, since FIPPA s. 33.1(1)(c) permits disclosure as an enactment authorizes. As addressed below, nothing about this permissive power contradicts a duty in specific circumstances to disclose information.

- Under PHA s. 58(2), the minister (not the Lieutenant Governor in Council) may, in an emergency, make regulations. The Regulation is not, however, a regulation made pursuant to this ministerial power. Furthermore, the specified subject matters of ministerial regulations under s. 58(2) only extend to exempting persons from “a provision
of this Act or the regulations made under it…” or modifying “a requirement of this Act or the regulations made under it….”

5.3. **The Regulation is not an aspect of Part 5**

Pursuant to PHA s. 53, the legislature has provided that Part 5 will override any other enactments “to the extent there is any inconsistency or conflict”. The Regulation does not, however, arise under Part 5. Said another way, Part 5 does not authorize the Lieutenant Governor in Council (as distinct from the Minister of Health) to make emergency regulations. Only Ministerial regulations under s. 58 are regulations made pursuant to a power under part 5.

5.4. **No Part 5 power qualifies consistent duties of disclosure under other enactments**

PHA s. 54(1)(k) is an aspect of Part 5, and it “extends” the power of a health officer to “collect, use or disclose” information. Functionally, however, this power may operate independently of Regulation s. 13 – if Regulation s. 13 were wholly repealed, a health officer could still, during an emergency, make all the disclosures permitted by Regulation s. 13, and more, pursuant to PHA s. 54(1)(k).

However, PHA s. 54(1)(k) is not inconsistent or in conflict with FIPPA s. 25.

**First, as addressed above, they apply to different individuals.** This is not a trivial issue. Even if a health officer had an absolute discretion override other duties of disclosure, this would have no impact on any duty of an entirely different office, i.e., the Minister, to disclose information.

**Second, even if the power and the duty applied to the same individual, PHA s. 54(1)(k) operates permissively, and does not purport to limit positive duties of disclosure.**

Section 54(1)(k) does not say that a health officer may “not provide disclosure that is otherwise required”. Had the legislature intended such a scope of authority, such that the discretion would actually oust affirmative disclosure duties, it could have easily included such language (as illustrated by PHA s. 54(1)(b), which provides that a health officer may “not provide a notice that is otherwise required”).

Furthermore, even if PHA s. 54(1)(k) were to somehow give effect to Regulation s. 13 as an aspect of Part 5, Regulation s. 13 also operates permissively, and does not purport to limit positive duties of disclosure.

Where one provision is permissive of disclosure (i.e., it creates a power to disclose that a person may exercise with discretion), and another provision creates a duty to disclose (which implies a power to disclose, coupled with a duty), a **presumption of overlap applies**, unless the presumption is rebutted by an intention that the discretion apply exhaustively. Where provisions are intended to overlap, no conflict arises:

“§11.7 Presumption of overlap. When two provisions are applicable without conflict to the same facts, it is presumed that each is meant to operate fully according to its terms. So long as overlapping provisions can apply, it is presumed that they are meant to apply. The only issue for the court is whether the presumption
is rebutted by evidence that one of the provisions was intended to apply exhaustively to facts of the sort in question.

...  

§11.11 Generally, a specific provision applies to the exclusion of a general one only if there is conflict between the two provisions or there is cogent evidence that the legislature intended the more specific provision to be exhaustive. The fact that one provision is more general than another is not in itself evidence that the specific provision was intended to exclude the more general.”

Sullivan on the Construction of Statutes, 6th ed., sections 11.7 and 11.11

[134] Permissive language is thus presumptively consistent with a duty:

“Both conceptually and in practice, permission and obligation are overlapping categories. An official who is obliged to do a thing is implicitly permitted to do it; an official who is permitted to do a thing may, in addition, be obliged to do it.”

Sullivan, supra, at s. 4.57.

[135] A permissive power under the PHA may clearly be coupled with a duty (under another statute), even if one disregards the distinct offices to which the power and the duty relate (i.e., the PHO and the Minister of Health, respectively).

6.0 Summary

[136] The Ministry’s failure to disclose even the limited, non-personal information that the Nations have requested (i.e., the geographic location of proximate COVID cases), is unjustified, and contravenes FIPPA s. 25(1)(a).

[137] Respectfully, the circumstances establish a prima facie case that the Ministry has, and continues to acquire, information about a risk of significant harm to the health or safety of Indigenous communities within the meaning of s. 25(1)(a):

- COVID clearly represents a risk of (disproportionately) significant harm to the health or safety of the Nations’ rural Indigenous communities. By extension, COVID represents a risk where it occurs in communities that are proximate to the Nations. Despite general measures (like social distancing and masks), and despite government taking measures to contain COVID outbreaks, the number of daily reported infections in the province is currently growing.

- Information about proximate COVID cases is clearly actionable, and therefore "about" the risk that such cases present to the Nations. The Nations have recognized powers specific to Indigenous governments to address such risks, provided they know of such risks.
The preconditions for a duty under s. 25 of FIPPA are met, and the duty is not superseded by the provisions of Part 5 of the *Public Health Act*. The government's refusal to disclose the Items contravenes s. 25 of FIPPA.

Sincerely,

NG ARISS FONG
Per:

Lisa C. Fong, Q.C.

Cc: clients

Enclosures
- Schedule A (extracts of health table letter dated 2020-07-21)
- Schedule B (extracts of health table letter dated 2020-08-12)
- Schedule C (email exchange re: disclosure under FIPPA s. 25)
- Schedule D (various letters to BCCDC and Health Authorities)
- Schedule E (letter to Dr. Daly)
- Schedule F (Nuu-chah-nulth press release dated June 9, 2020)
- Schedule G (Globe & Mail article)
- Schedule H (Globe & Mail article)
- Schedule I-1 (supporting letter from FNLC)
- Schedule I-2 (supporting letter from UBCIC)
- Schedule I-3 (supporting letter from FIPA-BCCLA)
- Schedule I-4 (supporting letter from Haida Nation, Kitasoo/Xai’xais Nation, Nuxulk Nation, Wuikinuxv Nation, and ‘Namgis First Nation)
- Schedule J-1 (letter from Drs. Shearer and Iglesias)
- Schedule J-2 (letter from Dr. Don Wilson)
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