Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

INTERIM ORDER MO-4166-I

Appeal MA20-00247

Haliburton, Kawartha, Pine Ridge District Health Unit

February 18, 2022

Summary: The appellant made an access request to the health unit for specific COVID-19 statistics for 12 municipalities and requested that the health unit publish these statistics daily on its website. The health unit denied the access request arguing that it does not have custody or control of responsive records, as they do not exist, and noting that it already publishes COVID-19 statistics on its website at the county level. The health unit also denied that it has an obligation to create responsive records or to publish them on its website.

In this interim order, the adjudicator finds that the health unit has control, under section 4(1) of the *Municipal Freedom of Information and Protection of Privacy Act*, of records responsive to the appellant's access request in a database of the Ministry of Health called the Provincial Case and Contact Management Solution; these records fall within paragraph (b) of the definition of "record" in section 2(1) of the *Act* because they can be produced from a machine readable record, by means of computer hardware and software and technical expertise normally used by the health unit, and without unreasonable interference with the health unit's operations. She orders the health unit to process the appellant's request and issue a new access decision under the *Act* for records responsive to the appellant's request for access to seven categories of COVID-19 statistics for 12 specific municipalities, having regard to the fee provisions of the *Act* as appropriate. She also offers guidance to the health unit in its determination of what information can be disclosed without identifying an individual.

The adjudicator defers her decision on whether the health unit is required to publish the information sought by the appellant on its website, and she invites the health unit to consider proactively publishing the information. Finally, she defers her determination of whether continuing access is available under section 17(3) of the *Act*, pending the health unit's further decision in response to this interim order.

Statutes Considered: *Municipal Freedom of Information and Protection of Privacy Act*, RSO, 1990, c. M.56, sections 2(1) (definition of "record") and 4(1); RRO 1990, Regulation 823 (under the *Municipal Freedom of Information and Protection of Privacy Act*), section 1; *Personal Health Information and Protection Act*, SO 2004, c 3, Sch A, section 3(1) (paragraphs 6 and 7).

Orders and Investigation Reports Considered: Orders 120, M-315, M-506, MO-1251, P-239, P-1572, PO-2151, PO-2306, PO-2386, PO-2683, PO-2730, PO-2752, and PO-3280.

Cases Considered: *Canada Post Corp. v Canada (Minister of Public Works)* (1995), 30 Admin LR (2d) 242 (Fed CA); *Ontario (Criminal Code Review Board) v Ontario (Information and Privacy Commissioner)*, [1999] OJ No 4072; *Greater Vancouver Mental Health Service Society v British Columbia (Information and Privacy Commissioner)*, [1999] BCJ No 198 (SC); *City of Ottawa v Ontario*, 2010 ONSC 6835 (CanLII); and *Ministry of the Attorney General v Information and Privacy Commissioner*, 2011 ONSC 172 (Div Ct).

OVERVIEW:

[1] This interim order addresses a request to a health unit for access to seven categories of specific COVID-19 statistics for 12 municipalities on a daily basis, and a further request that all of the requested information be published daily on the health unit's website.

[2] The appellant submitted a request to the Haliburton, Kawartha, Pine Ridge District Health Unit (the health unit) for access under the *Municipal Freedom of Information and Protection of Privacy Act* (*MFIPPA* or the *Act*) to COVID-19 data "by municipality." Specifically, the appellant sought:

> Total confirmed cases of COVID-19 by municipality, including total cases resolved, total deceased and the total of net "active cases" by municipality; plus, the total cases hospitalized and in home isolation for each municipality; plus, the number of cases under active investigation by municipality. Please post on your website and update daily.

[3] In response to the appellant's request, the health unit issued a decision stating that it does not create or maintain records that distill the requested data into the specific categories identified by the appellant. The health unit also responded that, since the *Act* does not require it to create new records or post and update information on a public platform, much of the appellant's request is outside the scope of the *Act*. The health unit denied the appellant access to the responsive records that it located and provided him with an index of those records. In its index of records, the health unit listed two categories of records; however, the appellant subsequently confirmed that he does not seek access to either of these two categories of records. Since these two categories of records are not at issue in this appeal, I do not address them.

[4] The appellant was dissatisfied with the health unit's decision and appealed it to the Information and Privacy Commissioner of Ontario (the IPC). The IPC attempted to

mediate the appeal. During mediation, the appellant confirmed that he seeks only COVID-19 data, and that he relies on section 17(3) of the *Act* in respect of his request for continuing access to records responsive to his request.

[5] Also during mediation, the health unit noted that it is a health information custodian within the meaning of the *Personal Health Information Protection Act* (*PHIPA*), and asserted that *PHIPA* applies to the records at issue. The health unit claimed that the records at issue in this appeal contain personal health information within the meaning of *PHIPA* and, therefore, *MFIPPA* does not apply to them. A mediated resolution of the appeal was not possible and the appeal was moved to the adjudication stage in which an adjudicator may conduct an inquiry.

[6] After reviewing the appeal file, I decided to conduct an inquiry. I sought and received representations from the appellant and the health unit on a variety of issues, including whether the information requested by the appellant is a "record" as defined in the *Act*, and whether the records are in the health unit's custody or control. I shared these representations with the parties in accordance with the IPC's *Practice Direction Number 7*. During my inquiry, the appellant clarified that he seeks access to records for the following twelve municipalities:

1. Kawartha Lakes

For Northumberland County:

2. Township of Alnwick/Haldimand
3. Municipality of Brighton
4. Town of Cobourg
5. Township of Cramahe
6. Township of Hamilton
7. Municipality of Port Hope
8. Municipality of Trent Hills

For Haliburton County:

9. Township of Algonquin Highlands
10. Municipality of Dysart et al
11. Municipality of Highlands East
12. Township of Minden Hills

[7] The appellant also clarified that he seeks access to daily records on a "go-forward basis" for each municipality of the total COVID-19:

- confirmed cases
- resolved cases
- deceased
- net "active cases"
- cases hospitalized
- in home isolation
- cases under active investigation.

[8] Also during my inquiry, the health unit confirmed that since July 2020, it has had access to specific COVID-19 case records through a database created and maintained by the Ministry of Health (the ministry) called the Provincial Case and Contact Management Solution (CCM).[1] The health unit explained that it compiles data from the CCM to produce the "COVID-19—Daily Epidemiological Summaries" (Daily Summaries) that it publishes on its website. After learning of the CCM, I sought and received representations from the ministry on whether the responsive information in the CCM is in the custody or under the control of the health unit. I shared the ministry's representations with the health unit and the appellant.

[9] In this interim order, I find that the health unit has control of responsive recorded information in the CCM for the purpose of responding to the access request under the *Act*. That information qualifies as a "record" under paragraph (b) of the definition of that term in section 2(1) of the *Act* because the health unit can produce responsive records from a machine readable record under its control by means of computer hardware and software and technical expertise normally used by the health unit and without unreasonable interference with its operations. I order the health unit to issue a new access decision in respect of the responsive records. I also order the health unit to address any applicable fee provisions in its new access decision and I provide some guidance regarding the health unit's determination of what information it can disclose without identifying an individual. In addition, I defer my decision on whether the health unit is required to publish the information sought by the appellant on its website, and I invite the health unit to consider proactively publishing the information. Finally, I defer my decision on whether continuing access is available,

[1] Prior to July 2020, at the time of the appellant's request, the health unit's process for receiving and compiling COVID-19 statistical information was different. This previous process is not relevant in this appeal because the appellant has confirmed that he seeks COVID-19 statistics on a "go-forward basis," which involves the health unit's current process using the CCM.

pending the health unit's decision in response to this interim order.

RECORDS:

[10] The health unit did not identify or locate any records responsive to the appellant's request for the seven categories of specific COVID-19 statistics for twelve municipalities. The health unit's position, addressed in detail below, is that no records responsive to the appellant's request exist. However, the health unit provided a series of Daily Summaries, each six or seven pages long, for the periods of April 14 to 30, 2020 (99 pages) and May 1 to 12, 2020 (77 pages).

[11] The Daily Summaries report COVID-19 confirmed cases, resolved cases, deaths, hospitalizations and outbreaks by county for Haliburton, Kawartha Lakes and Northumberland. They also report the gender and age distribution for confirmed COVID-19 cases and lab confirmed outbreaks by facility (hospitals, long-term care homes/retirement homes, daycares, or other community facilities). Finally, they provide COVID-19 statistics at the provincial, national and international levels. All of this information is reported daily on the health unit's website. However, as noted above, the appellant seeks information at the municipal, not the county, level.

ISSUES:

A. Is the requested information a "record" under the *Act*?

B. Is the responsive information in the CCM, that can be used to produce responsive records, "under the control" of the health unit?

DISCUSSION:

A. Is the requested information a "record" under the *Act*?

[12] Because the right of access in the *Act*[2] applies only to "records," I must determine whether responsive records exist. The health unit argues that no responsive records exist because it does not have records that compile the COVID-19 statistics as requested by the appellant. However, the health unit acknowledges that the CCM contains information that is responsive to the appellant's request. The appellant argues that responsive records exist because the health unit has the ability to use the CCM to generate records that contain the information he seeks in his access request. The question before me then is whether the information recorded in the CCM, that is responsive to the appellant's request, qualifies as a "record" under the *Act*.

[2] Section 4(1) of the Act states that, subject to certain exceptions, every person has a right of access to a record or part of a record in the custody or under the control of an institution.

[13] The term "record" is defined in section 2(1) of the *Act*, as follows:

> "record" means any record of information, however recorded, whether in printed form, on film, by electronic means or otherwise, and includes,
>
> (a) correspondence, a memorandum, a book, a plan, a map, a drawing, a diagram, a pictorial or graphic work, a photograph, a film, a microfilm, a sound recording, a videotape, a machine readable record, any other documentary materials, regardless of physical form or characteristic and any copy thereof, and
>
> (b) subject to the regulations, any record that is capable of being produced from a machine readable record under the control of an institution by means of computer hardware and software or any other information storage equipment and technical expertise normally used by the institution[.]

[14] The opening words of paragraph (b) confirm that it must be considered with the relevant regulations. Relevant, in this case, is section 1 of Regulation 823 of the *Act*, which states:

> A record capable of being produced from machine readable records is not included in the definition of "record" for the purposes of the Act if the process of producing it would unreasonably interfere with the operations of an institution.

Can responsive records be produced from the responsive information in the CCM within the meaning of paragraph (b) of the definition of a "record"?

[15] There is no dispute that the CCM qualifies as a machine readable record within the meaning of paragraph (a) of the definition of "record." However, although the CCM contains the information required to produce the records requested by the appellant, it is not the record at issue because the responsive information in it is not organized in the manner requested by the appellant. The health unit partly echoes this in its submission that the information in the CCM does not qualify as a record under paragraph (a) because records do not exist in the CCM that contain all of the information requested by the appellant.

[16] The issue that is in dispute is whether responsive records can be produced from the responsive information in the CCM within the meaning of paragraph (b) of the definition of "record." In respect of paragraph (b), the health unit argues that it is not obligated to create records when such records do not exist. The health unit does not address paragraph (b) with any more specificity than that.

[17] Paragraph (b) of the definition of a "record" includes any record that can be produced from a machine readable record under the control of an institution using the

computer hardware, software or information storage equipment and technical expertise normally used by that institution. Taking the definition of "record" in paragraph (b) together with section 1 of Regulation 823, the responsive information in the CCM will qualify as a "record" under the *Act* if two conditions are met. First, if it can be produced from the CCM using computer hardware and software or any other information storage equipment and technical expertise normally used by the health unit.[3] Second, if the process of producing it would not unreasonably interfere with the health unit's operations.

[18] During my inquiry, I asked the health unit about its ability to produce responsive records from the CCM. I also asked the health unit whether the process of producing responsive records from the CCM would unreasonably interfere with its operations. I referred the health unit to previous IPC orders and court decisions that considered these questions.

Can the requested information be produced from the CCM using computer hardware and software or any other information storage equipment and technical expertise normally used by the health unit?

[19] The health unit acknowledges that it is capable of analyzing the data in the CCM and compiling it in computer-generated records. However, the health unit maintains that it should not be required to produce responsive records because of the many steps that would entail and the resulting unreasonable interference with its operations. The health unit states that it cannot directly print or download, from the CCM, daily numbers for the 12 municipalities for each of the seven categories of information that the appellant seeks because the CCM does not contain records categorized by the 12 municipalities noted by the appellant. It explains that it would have to take the following five steps to generate responsive records, which would cause a "significant and untenable strain" on its limited administrative resources:

> Step 1: Extract a list of confirmed cases of COVID-19 from the CCM.
>
> Step 2: Extract a list of confirmed cases of COVID-19 with an intervention record type of "hospitalization" from the CCM.
>
> Step 3: Import the records of confirmed cases of COVID-19 and merge them with Hospitalized records by their assigned Case Investigation Number. This would require the use of a statistical software package, which the health unit confirms it has. Based on the date entered for the applicable variable/data item in the CCM, or through calculating a derived variable using statistical software, the records would then be categorized as: confirmed cases, resolved cases, deceased, net "active cases," cases hospitalized, in home isolation, and cases under active investigation.

[3] The machine readable record must also be "under the control" of the health unit to fit within the meaning of paragraph (b) of the definition of "record." I address this under issue B, below.

> Step 4: Merge the records using the postal code associated with the record with Canada Post's Postal Code Conversion File using statistical software that the health unit has.
>
> Step 5: Provide the results as separate tables for each of the requested categories or as a single table by lower tier municipality with multiple columns. A single table would require additional data processing to merge the multiple tables.

[20] The health unit explains that, to obtain the requested information from the data in the CCM, it would need to categorize and compile the information outside of the CCM because "municipality" is not a listed variable in the CCM. The listed variables for each case record in the CCM include the street address, city, province, postal code and county. The health unit adds that the postal codes do not align with municipal boundaries, particularly in rural areas where postal codes often cover several lower tier municipalities; accordingly, it would need to assign a lower tier municipality to the data as an additional step.

[21] Because the health unit's description of the five-step process was not entirely clear, I asked it follow-up questions. Specifically, I asked the health unit to describe Step 4 in greater detail, and to explain what the Canada Post Postal Code Conversion File and the statistical software were and how they would be used to produce responsive records. In response, the health unit explains that the Postal Code Conversion File is a digital file that provides a correspondence between postal codes and Statistics Canada's standard geographic areas for census data. The health unit submits that if it uses the Postal Code Conversion File with the CCM to produce responsive records, there may be inaccurate results due to postal code discrepancies that must be checked to ensure that the municipal address information aligns with the lower tier municipality geographic limits. The health unit did not respond to my follow-up question to provide additional information about the statistical software.

The requested information can be produced from the CCM using computer hardware and software and technical expertise normally used by the health unit

[22] There is no dispute that responsive information can be produced from the CCM by means of computer hardware and software, and technical expertise that the health unit normally uses.[4] In fact, in all of its representations, the health unit acknowledges that it is possible to generate the requested information from the CCM. The health unit's representations confirm, and I emphasize, that all of the responsive information is entirely within CCM, but not organized in a way that is immediately responsive to the request. The health unit also confirms in its representations that it can produce

[4] Based on the health unit's description of the process it would have to follow to produce responsive records, the "any other information storage equipment" part of the definition of "record" in paragraph (b) is not engaged. Because it is not relevant, I exclude that part of the definition.

responsive records through a five-step process, and that it can do so using computer hardware (its existing computer equipment) and software (Canada Post's Postal Code Conversion File and the statistical software), and technical expertise that it normally uses.

[23] The health unit's representations on the five-step process and the use of the Postal Code Conversion File and statistical software describe a process akin to filters or search terms being applied to the information in the CCM to produce responsive records. As for the health unit's submission that "municipality" is not a specific field in the CCM, this does not mean that information on the municipality of each COVID-19 case is not included in the CCM. The health unit's representations confirm that municipal information (in the form of street address, city, province, postal code and county) is included in the CCM. However, this municipal information needs to be filtered and organized. As a result, I find that responsive records are capable of being produced from the information in the CCM by means of computer hardware and software, and technical expertise normally used by the health unit.

Would the process of producing responsive records unreasonably interfere with the health unit's operations?

[24] The only dispute that remains to be resolved, with respect to whether the requested information is a "record,"[5] is whether the process of producing responsive records would unreasonably interfere with the health unit's operations within the meaning of section 1 of Regulation 823 of the *Act*. The health unit argues that producing responsive records would be a "significant and untenable strain" on its administrative resources. The appellant asserts that other health units provide the type of information he seeks, which means that the health unit can "obviously" produce this information "easily."

[25] Since the health unit itself is uniquely placed to explain how generating responsive records would unreasonably interfere with its operations, I invited it to further explain its claim of unreasonable interference with its operations. Specifically, I asked the health unit to describe the precise time, effort and resources that would be required to produce the responsive records, and whether and how these would obstruct or hinder the range of effectiveness of the health unit's activities. Finally, I asked it to describe whether and how the time, effort and resources required to produce responsive records differ from those currently used by the health unit to produce COVID-19 statistics on its website at the county level.

[26] In response, the health unit states that if it uses the Postal Code Conversion File with the CCM to produce responsive records, as described in its five-step process, it will have to check any postal code discrepancies to ensure that the municipal address information for those cases aligns with the lower tier municipality geographic limits. The

[5] I address the requirement that the record be "under the control" of the health unit in Issue B, below.

health unit adds that the municipal address data in the CCM may also contain spelling and other errors that limit the reliability of the information; therefore, the health unit's epidemiology team, which would be tasked with producing the responsive records, would have to check all responsive records to ensure accuracy. The health unit submits that it would take "one hour per case to produce accurate data."

[27] The health unit further submits that its epidemiology team is "fully tapped" by its pandemic response: spearheading booster rollout, and facing an escalation in cases and contacts. The health unit explains that, generally, its epidemiologists are responsible for daily case/contact/outbreak reporting, daily COVID-19 vaccination reporting, epidemiology support for the case/contact/outbreak management team, COVax quality control management, and other infectious disease surveillance and reporting. It argues that "there are no unutilized hours" in the epidemiologists' days and it is unable to recruit additional epidemiologists during a pandemic. The health unit states that its epidemiologists cannot take on additional duties without failing to perform regular duties critical to pandemic management and booster distribution. It asserts that if its epidemiologists were compelled to perform such work, the cost would be significant.

[28] Finally, the health unit states that it cannot produce accurate data on the number of individuals "isolating" in its jurisdiction because it does not have this information. It explains that there are many COVID-19 cases that originate in the jurisdictions of other health units but have contacts (individuals) who are isolating in the health unit's jurisdiction, and it is not informed by other health units of these isolating contacts; it is aware only of the individuals in its jurisdiction whom it has directed to isolate.

[29] In his response to the health unit's position and arguments, the appellant accuses the health unit of throwing up "every roadblock possible to avoid, delay or otherwise obfuscate" its duty to provide the specific public health information he seeks. He criticizes the health unit for not participating in the IPC's mediation process in good faith, and he suggests that the issues related to the time, cost and effort to produce responsive records could have been negotiated to find a "win-win solution." He asserts that the information to which he seeks access is information that is being provided by other public health units; this, he argues, means it can be produced easily. In support of his assertion, the appellant states that during a media scrum on February 10, 2021, the acting Medical Officer of Health for the health unit "openly and readily provided the new weekly COVID-19 cases for some lower tier municipalities within Northumberland County by referring to his computer screen." The appellant provides a link to the recorded YouTube video of the acting Medical Officer of Health sharing COVID-19 information at the lower tier municipality level and he argues that it demonstrates that the responsive information is not difficult to access.

[30] The appellant also challenges the health unit's submissions on the seriousness and frequency of postal code discrepancies. He notes that many public health units are providing lower tier municipality COVID-19 statistics, seemingly, with no problem, and

he asserts it is unclear why this is such a problem for this health unit. The appellant points out that the City of Kawartha Lakes does not have any lower tier municipalities, so no change to this portion of the data is required. He also notes that, to date, over 52% of the total confirmed COVID-19 cases are in the City of Kawartha Lakes, thus reducing the health unit's projected workload considerably. Furthermore, the appellant argues that requiring epidemiologists to separate and check the postal code discrepancy cases by lower tier municipality would be "completely unnecessary and a misuse of their time" since this kind of work could easily be completed by administrative staff. He adds that these jurisdictional discrepancy cases are likely "exceptions" that would require no further analysis. Regarding the health unit's stated inability to accurately track people who are isolating in the health unit's jurisdiction, the appellant suggests "this issue can be revisited" if he is successful in his appeal.

[31] The appellant concludes by noting that there may be no issue more compelling than a once-in-a-century pandemic where it is in the public interest to release the information he is requesting. He asserts that the constituents of Haliburton, Kawartha and Pine Ridge District should have the same free access to public health information as those residing in other health units' jurisdictions in Ontario to protect their personal health.

The process of producing responsive records would not unreasonably interfere with the health unit's operations

[32] I recognize that producing responsive records would take time and effort on the part of health unit staff and that the health unit is occupied with pandemic-related matters. However, for the reasons that follow, I am not satisfied that producing records responsive to the appellant's request would unreasonably interfere with its operations.

[33] Previous IPC orders have considered the question of whether the process of producing a record would unreasonably interfere with the operations of an institution.[6] Order PO-2151 determined that in order to establish "interference," an institution must, at a minimum, provide evidence that responding to a request would "obstruct or hinder the range of effectiveness of the institution's activities." I apply this approach in my consideration of the health unit's representations that follows.

[34] The health unit's assertion that it would take an hour to check and confirm the accuracy of each record whose postal code does not align with the 12 named municipalities, and, moreover, its suggestion that epidemiologists would have to perform this check and confirmation, are not reasonable. I agree with the appellant that the health unit appears to overstate the frequency of postal code discrepancies and the time required to check them for accuracy. The health unit does not explain why it would take "one hour per case to produce accurate data" and it provides no evidence to support this submission. I also agree with the appellant that confirming that a postal

[6] See Orders P-1572, PO-2730, PO-2752, and PO-3280.

code falls within a municipality is an administrative task that can be performed by administrative staff. Again, the health unit does not explain why it would employ an epidemiologist to perform this task, or why epidemiologists would be "compelled" to perform this task. It simply declares that its epidemiology team would be tasked with producing the responsive records. Despite my specific related questions, the health unit does not address how providing the requested information would be significantly different, in terms of interference, from its current process of producing the Daily Summaries, which does not appear to unreasonably interfere with its operations. Finally, the health unit's submission that it cannot be asked to take on additional duties without failing to perform regular duties critical to pandemic management and booster distribution seems to overstate the discrepancy with its normal operations. Without so deciding, I would think that the information being requested would seem to align squarely with the type of information that would enhance, rather than hinder, the health unit's capacity to understand outbreak patterns and manage the pandemic.

[35] The health unit's assertion of a "significant and untenable strain" on its limited administrative resources, with nothing more to support it, is also not sufficient for me to find that producing the responsive records would obstruct or hinder the range of effectiveness of its activities. As noted above, the IPC has determined that to establish "interference," the institution must, at minimum, provide evidence that responding to a request would "obstruct or hinder the range of effectiveness of the institution's activities." The health unit's representations on this issue do not satisfy that minimal threshold. Accordingly, I find that the process of producing responsive records would not unreasonably interfere with the health unit's operations and that section 1 of Regulation 823 of the *Act* is not engaged in this appeal.

B. Is the responsive information in the CCM, that can be used to produce responsive records, "under the control" of the health unit?

[36] Having found that responsive records are capable of being produced from the information in the CCM by means of computer hardware and software and technical expertise normally used by the health unit, and that the process of producing such responsive records would not unreasonably interfere with the health unit's operations, I now turn to examine whether the requested information constitutes a "record" under the *Act*. To do so, I must further determine that the responsive information in the CCM is "under the control" of the health unit. The requirement that an institution have control (or custody) of a record is also a prerequisite to the right of access in section 4(1) of the *Act*.

[37] Section 4(1) of the *Act* stipulates that the right of access applies only to records that are "in the custody" or "under the control" of an institution. Accordingly, a record will be subject to the *Act* if it is in the custody or under the control of an institution; it

need not be both.[7] The health unit maintains that the requested records are not within its "care and control" under section 4(1) of the *Act* because they do not exist. I sought and received representations from the health unit and the ministry on the issue of custody or control. Because I find below that the responsive information in the CCM is under the control of the health unit, I set out the representations and my analysis only on that aspect, below.

[38] The courts and the IPC have applied a broad and liberal approach to the custody or control question.[8] Based on this approach, the IPC has developed a non-exhaustive list of factors to consider in determining whether a record is in the custody or control of an institution, including:[9]

- whether the institution created the record, has physical possession of the record[10] that is more than "bare possession"[11]
- whether it has the authority to regulate the record's content, use and disposal[12]
- whether the institution has a statutory power or duty to carry out the activity that resulted in the creation of the record[13]
- whether the content of the record relates to the institution's mandate and functions[14]
- whether there are limits on the use to which the institution may put the record, what those limits are, and why they apply to the record[15]
- the intended use of the record[16]
- the institution's reliance on the record[17]
- the customary practice of institutions similar to the institution in relation to possession or control of records of this nature, in similar circumstances.[18]

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[7] Order P-239 and *Ministry of the Attorney General v Information and Privacy Commissioner*, 2011 ONSC 172 (Div Ct). (MAG v IPC)
[8] *Ontario (Criminal Code Review Board) v Ontario (Information and Privacy Commissioner)*, [1999] OJ No 4072; *Canada Post Corp. v Canada (Minister of Public Works)* (1995), 30 Admin LR (2d) 242 (Fed CA). and Order MO-1251.
[9] Orders 120, MO-1251, PO-2306 and PO-2683.
[10] Orders 120 and P-239.
[11] Order P-239 and MAG v IPC, cited above.
[12] Orders 120 and P-239.
[13] Orders 120 and P-239.
[14] Ministry of the Attorney General v Information and Privacy Commissioner, cited above; *City of Ottawa v Ontario*, 2010 ONSC 6835 (CanLII) (*City of Ottawa*), and Orders 120 and P-239.
[15] MAG v IPC, cited above.
[16] Orders 120 and P-239.
[17] MAG v IPC, cited above and Orders 120 and P-239.

[39] Where an organization other than the institution holds the record, the IPC considers:

- the ownership of the record[19]
- who paid for the creation of the record[20]
- the circumstances surrounding the creation, use and retention of the record[21]
- provisions in any contracts between the institution and the creator of the record in relation to the activity that resulted in the creation of the record, which expressly or by implication gives the institution the right to possess or otherwise control the record,[22] or which affect the control of the record by the institution.

[40] In determining whether records are in the "custody or control" of an institution, the factors above must be considered contextually in light of the purpose of the legislation.[23]

The representations of the health unit, the ministry and the appellant

[41] The health unit maintains that the requested records are not within its "care and control" under section 4(1) of the *Act* because they do not exist in the specific form requested by the appellant. However, the health unit confirms that it "has" individual health records, or "case records," that contain some of the data points sought by the appellant. The health unit acknowledges that it has the ability to access and use the responsive information in the CCM, and it confirms that it currently accesses, uses and extracts CCM data to compile the Daily Summaries by county that it publishes on its website.

[42] The health unit explains that the CCM is a provincial data system, whose design, development, implementation and maintenance are funded by the ministry. It explains that the ministry also funds the generation of case records in the CCM, including any work by health unit staff to create or add to case records. The health unit states that it has entered into an agreement (the Agreement)[24] with the ministry that grants the health unit access to and use of the CCM, subject to the terms and conditions of the Agreement, to perform case and contact management for diseases of public health significance or other purposes permitted or required by law. It adds that the Agreement

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[18] Order MO-1251.
[19] Order M-315.
[20] Order M-506.
[21] Order PO-2386.
[22] *Greater Vancouver Mental Health Service Society v British Columbia (Information and Privacy Commissioner)*, [1999] BCJ No 198 (SC).
[23] *City of Ottawa*, cited above.
[24] The health unit provided me with a copy of the Agreement and asked me not to share it with the appellant because it is confidential. I reviewed the Agreement but did not share it with the appellant.

reflects their (the ministry's and the health unit's) status as health information custodians under *PHIPA*[25] with respect to the personal health information in the CCM, and the ministry's status as the health information network provider in accordance with section 6(2) of Ontario Regulation 329/04 of *PHIPA*. It explains that in the capacity of a health information network provider, the ministry provides access to the CCM to enable the disclosure of information between it and the ministry and other medical officers of health of boards of health within the meaning of the *Health Protection and Promotion Act* (*HPPA*).

[43] The health unit acknowledges that the information responsive to the appellant's request generally accords with the information that is to be reported to the health unit under Part IV of the *HPPA* (Communicable Diseases), and that information concerning each of the seven categories identified in the appellant's request "can be obtained from the data in the CCM."

[44] In its representations, the ministry confirms that the health unit has the right to access and use the CCM to perform case and contact management for "Diseases of Public Health Significance" or other purposes permitted or required by law, and that the health unit retains responsibility for case, contact and outbreak management through the use of the CCM under the authority of section 7 of the *HPPA*. The ministry explains that the CCM consists of individual health records and is organized by case, not at the aggregate level. The ministry adds that, for the individual health records in the CCM, the health unit is a health information custodian "with respect to the personal health information within its custody and control for the purposes of the *HPPA* and *PHIPA*."

[45] The appellant asserts that the health unit has access to the information he seeks, and that it can and should produce that information in the form of daily responsive records. In support of this assertion, the appellant refers again to the media scrum of February 10, 2021, during which the acting Medical Officer of Health for the health unit consulted his laptop to instantly provide COVID-19 statistics at the municipal level.

The health unit has control of the responsive information in the CCM that can be used to produce responsive records

[46] The representations of the health unit and the ministry, and the terms of the

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[25] Section 3(1) of *PHIPA* defines a "health information custodian" and paragraphs 6 and 7 of that section address the health unit's and the ministry's status as health information custodians in this appeal. These sections state:

> 3(1) In this Act,
> "health information custodian", subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:
> 6. A medical officer of health of a board of health within the meaning of the *Health Protection and Promotion Act*.
> 7. The Minister, together with the Ministry of the Minister if the context so requires.

Agreement, all confirm that the health unit is a health information custodian with respect to the information in the CCM that relates to the health unit's jurisdiction. The representations of the health unit and the ministry, and the terms of the Agreement, also confirm that the health unit has the right to access and use this information in the CCM for public health purposes in accordance with its statutory mandate and function under the *HPPA* with respect to COVID-19. Finally, the health unit confirms that it currently accesses, uses and extracts information from the CCM to produce its Daily Summaries, while the ministry confirms that the health unit retains responsibility for case, contact and outbreak management through the use of the CCM under the authority of section 7 of the *HPPA*.

[47] Neither the health unit nor the ministry suggests that the health unit is prohibited from extracting information from the CCM that is responsive to the appellant's request. Rather, the health unit objects to extracting information responsive to the request from the CCM on the basis that this information does not exist as a compiled and available record because the health unit has chosen instead to extract information and create records, the Daily Summaries, compiled at the county level rather than the municipal level.

[48] Taking into account the health unit's status as a health information custodian of the information in the CCM that relates to its geographic jurisdiction, its rights under the Agreement to access, use and extract information in the CCM, and its statutory mandate and function under the *HPPA* with respect to managing diseases of public health significance and performing case, contact and outbreak management through the use of the CCM for COVID-19, I find that the health unit has control, for the purpose of section 4(1) of the *Act*, of responsive information in the CCM that can be used to produce responsive records.

Summary conclusions in the issues of "record" and "control"

[49] I have concluded above that the health unit has control of responsive information in the CCM that can be used to produce records responsive to the appellant's request, by means of computer hardware and software and technical expertise it normally uses, and without unreasonable interference in its operations. Based on these conclusions, I find that responsive records exist within the meaning of a "record" in paragraph (b) of the definition of that term under section 2(1) of the *Act*. Accordingly, I will order the health unit to process the appellant's request and issue a new access decision in respect of the responsive records.

Two issues for the health unit to consider in issuing its new access decision

Fees

[50] I note that fees for access to responsive records are mandatory under the *Act*, unless a fee waiver is justified on the basis that it is fair and equitable to grant it. The

health unit does not appear to have turned its mind to estimating fees relating to the production of responsive records or to giving the appellant this fee estimate. A fee estimate would enable the appellant to decide whether to proceed with his request as is or to narrow it down to the most essential information being sought. If he decides to proceed after receiving a fee estimate, the appellant would pay a deposit, assuming the fee estimate is $100 or more, and the health unit would work to process his request. The appellant may also request a fee waiver.[26]

[51] The relevant fee provisions for the health unit and the appellant to consider are section 45 of the *Act* and sections 6, 7, 8 and 9 of Regulation 823 of the *Act*, which address fees for access requests. Under section 45(1) of the *Act*, the health unit must charge fees for access to records in the amounts prescribed by Regulation 823 of the *Act*. Section 45(3) requires the health unit to give the appellant a reasonable estimate of the amount that will be required to be paid (over $25), while section 45(4) requires the health unit to waive the fees in part or in whole if, in the head's opinion, it is fair and equitable to do so after considering certain factors, including whether dissemination of the record will benefit public health or safety. Paragraphs 5 and 6 of section 6 of Regulation 823 of the Act require the health unit to charge fees for producing computer-generated records. Finally, section 45(5) allows the appellant to appeal the health unit's fee estimate or fee waiver decision to the IPC.

[52] I refer the health unit and the appellant to these sections of the *Act*, and to the IPC's guidance document, "Fees, Fee Estimates and Fee Waivers."[27]

Identifiability

[53] Although the health unit has "records" that are responsive to the appellant's request within the meaning of the *Act*, it has raised the issue of the potential identifiability of individuals to whom the COVID-19 data relates. By raising the identifiability issue, the health unit raises the issue of whether section 8(4) of *PHIPA*, which I discuss below, may be triggered. The health unit asks me to provide guidance on its obligations under *PHIPA* with respect to any personal health information in the responsive records and how much statistical information it can disclose in response to the appellant's request without identifying individuals. In the circumstances of this appeal, where I do not have any records before me or detailed information about the specific information the health unit thinks could lead to an individual being identified by disclosure of the responsive records, I am only able to provide general guidance on the issue of identifiability.

[54] To begin, the CCM clearly contains personal health information as defined in

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[26] The appellant may appeal the fee estimate or fee waiver decision, and I may adjudicate any such appeal at a later date, if necessary. However, I encourage the parties to work together collaboratively to resolve such matters without recourse the IPC.

[27] Accessible at https://www.ipc.on.ca/wp-content/uploads/2018/06/fees-fee_estimates-fee_waivers-e.pdf.

section 4 of *PHIPA*, since the COVID-19 information in it is recorded by the name of the individual and relates to the physical health of the individual. However, the appellant does not seek access to personal health information. As a result, section 8(4) of *PHIPA*, referred to by the health unit, is relevant. Sections 8(4) and 4 of *PHIPA* state:

> 8. (4) This Act does not limit a person's right of access under section 10 of the *Freedom of Information and Protection of Privacy Act* or section 4 of the *Municipal Freedom of Information and Protection of Privacy Act* to a record of personal health information if all the types of information referred to in subsection 4 (1) are reasonably severed from the record.
>
> . . .
>
> 4.(1) In this Act,
>
> "personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,
>
> (a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
>
> (b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,
>
> (c) is a plan of service within the meaning of the *Home Care and Community Services Act*, 1994 for the individual,
>
> (d) relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual,
>
> (e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,
>
> (f) is the individual's health number, or
>
> (g) identifies an individual's substitute decision-maker.
>
> (2) In this section,
>
> "identifying information" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

> (3) Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.

[55] Given its concerns about identifiability, in issuing its new access decision the health unit should consider section 8(4) of *PHIPA* and turn its mind to reasonably severing any personal health information in the responsive records.[28] The health unit should also consider the various categories of responsive COVID-19 statistics for each lower tier municipality and determine if it is reasonably foreseeable in the circumstances that any particular statistic, either alone or with other available information, could be used to identify an individual.

[56] In its representations on identifiability, the health unit explains that although the Daily Summaries do not contain information that would reasonably be construed as "personal health information" under *PHIPA*, the same information modified to show the lower tier municipality in which an individual resides could amount to "identifying information" as defined in section 4(2) of *PHIPA*. The health unit states that this is because the low populations of certain communities (500 being the lowest and fewer than 7000 residents being the most common) within its jurisdiction would make it possible to identify specific individuals by combining data points from the health unit and the ministry relating to age, gender, and date of test or symptom onset.

[57] Considering the health unit's concern and the population information the health unit provided, I refer the health unit to the following IPC and court decisions, and other resources regarding "identifiability" and "small cell count."

[58] The Divisional Court in *Ontario (Attorney General) v Pascoe*[29] has explained the relationship between personal information and identification in the following terms:

> The test then for whether a record can give personal information asks if there is a reasonable expectation that, when the information in it is combined with information from sources otherwise available, the individual can be identified. A person is also identifiable from a record where he or she could be identified by those familiar with the particular circumstances or events contained in the records.

[59] The small cell count concept has been canvassed in previous IPC orders that considered whether numerical data could reasonably be expected to identify individuals. It was succinctly set out in Order PO-2811, which was upheld by the Supreme Court of

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[28] Within the meaning of sections 4(1) and (2) of *PHIPA*.
[29] 2001 CanLII 32755 (ON SCDC).

Canada[30] and stated:

> The term "small cell" count refers to a situation where the pool of possible choices to identify a particular individual is so small that it becomes possible to guess who the individual might be, and the number that would qualify as a "small cell" count varies depending on the situation. The Ministry has misapplied the concept of "small cell" count here. If, as the Ministry argues, 5 individuals is a "small cell" count, this would mean a person was looking for one individual in a pool of 5. By contrast, the evidence in this case indicates that one would be looking for 5 individuals in a pool of anywhere from 396 to 113,918. This is not a "small cell" count.

[60] More recently, in Order PO-3643, I considered small cell count and identifiability arguments in determining whether the disclosure of statistical information on hospital suicides could identify individuals and whether the statistical information qualified as personal information. My analysis at paragraphs 51 to 69 of Order PO-3643 may be of assistance to the health unit.

[61] Most recently, the Nunavut Information and Privacy Commissioner issued a decision addressing the small cell count concept in the context of statistical information on tuberculosis and COVID-19 infections.[31] Although that decision is based on different legislation, the analysis, starting at paragraph 77, may assist the health unit here. Additional resources, which the Nunavut Information and Privacy Commissioner relied on in its decision and which the health unit may also rely on here, are two publications of the IPC that address the appropriate methodology for de-identification: "De-identification Guidelines for Structured Data" (June 2016)[32] and "Use and Disclosure of Personal Health Information for Broader Public Health Purposes" (July 2021). [33]

[62] Of course, I may have to adjudicate the identifiability issue respecting the responsive records, including the applicability of section 8(4) of *PHIPA*, at a later date, and I make no findings on those issues here.

Deferral of decisions regarding continuing access and publication

[63] I defer my decisions on whether continuing access is available under section 17(3) and whether publication can be ordered under section 43(3) of the *Act*, pending my receipt of the health unit's new access decision or any other response to this interim

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[30] *Ontario (Community Safety and Correctional Services) v Ontario (Information and Privacy Commissioner)*, 2014 SCC 31 (CanLII), [2014] 1 SCR 674.
[31] Department of Health (Re), 2022 NUIPC 4 (CanLII).
[32] Accessible at https://www.ipc.on.ca/wp-content/uploads/2021/07/use_disclosure-personal-health-information-for-broader-public-health-purposes.pdf.
[33] Accessible at https://www.ipc.on.ca/wp-content/uploads/2021/07/use_disclosure-personal-health-information-for-broader-public-health-purposes.pdf.

order. I do so because the possible outcomes of this interim order may obviate the need to determine these issues. For example, if the health unit decides to proactively publish the responsive records daily on its website, in place of the Daily Summaries that it currently publishes, decisions on continuing access and ordering publication may not be necessary.

Proactive publication

[64] While I have deferred my decision on publication, I take this opportunity to invite the health unit to consider proactive publication. In the context of the ongoing COVID-19 pandemic, the IPC has urged public health units and government organizations to provide as much information as is necessary to protect public health, without naming individuals. In an open letter dated April 16, 2020, former Commissioner Brian Beamish stated that this non-identifying information could include numbers of affected individuals, demographic data such as approximate age and gender, as well as geographic locations of infected or deceased individuals, including long term care facilities or workplaces, especially if they are in a location where large numbers of people might have gathered.

[65] In her Commissioner's Message from the IPC's 2020 Annual Report, Commissioner Patricia Kosseim offered these instructive words:

> It is essential to inform citizens about the public health risks of COVID-19 as the evidence evolves, and to establish confidence in the government decisions and actions affecting them and their loved ones. Our office received many media and public enquiries about the level of information public institutions could or should release to keep Ontarians safe during the pandemic. The direction from my office on this matter has been consistent — Ontario privacy laws do not prevent health authorities from sharing as much non-personal information as is necessary to protect public health, without identifying individuals. Public health units and government organizations should provide as much non-identifying information as possible to explain the risk profile of community spread and protect public health. Depending on the context, this information could include numbers of affected individuals, demographic data about infected or deceased individuals, and in some cases, even names and locations of organizations experiencing outbreaks.

[66] I agree with and echo the general views expressed by the current and former Commissioners. Of course, these general views do not dictate the extent of the appellant's right to access to the requested information in the context of the current appeal.

INTERIM ORDER:

1. I find that the requested records are records in the health unit's control within the meaning of section 4(1) of the *Act*. I order the health unit to process the appellant's access request and issue a new decision under the *Act* for records responsive to the appellant's request for access to the seven categories of COVID-19 statistics for the 12 municipalities set out in paragraphs 6 and 7 above, having regard to the fee provisions as appropriate, and treating the date of this order as the date of the request for the purposes of the procedural requirements of the *Act*.

2. I remain seized to address any issues arising from the health unit's decision.

3. I also remain seized to address whether continuing access is available under section 17(3) and ordering publication is available under section 43(3) of the *Act*, should a determination of those issues be necessary.

Original Signed by: February 18, 2022

Stella Ball
Adjudicator