Thomas A. Cromwell
T 604.632.3460
F 604.687.1415
tcromwell@blg.com

Borden Ladner Gervais LLP
1200 Waterfront Centre
200 Burrard St, P.O. Box 48600
Vancouver, BC, Canada V7X 1T2
T 604.687.5744
F 604.687.1415
blg.com

Borden Ladner Gervais

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By Email and Mail

Mr. Don Wright
Deputy Minister to the Premier, Cabinet Secretary and Head of the Public Service
Suite 272 West Annex – Parliament Buildings
Victoria, BC V8W 9E1

don.j.wright@gov.bc.ca
keira.higgins@gov.bc.ca

Dear Mr. Wright,

Re: Ombudsperson's Report, Misfire: The 2012 Ministry of Health Employment Terminations and Related Matters

I write to provide my second report as the independent monitor of the government's progress in implementing, or giving effect to, the recommendations in the Ombudsperson's Report.

In summary, government has done a great deal of work to move forward on the Ombudsperson's recommendations. All officials with whom I have dealt in carrying out my duties under my Terms of Reference have been models of professionalism, helpfulness and candour. I relay to them, through you, my appreciation and thanks. However, I continue to have reservations about government's implementation of some of the recommendations flagged in my first monitoring report delivered last October, and I have some matters to raise with you about the implementation of recommendations that have fallen due since then.

You appropriately note in your letter that the events described and analyzed by the Ombudsperson took a "significant toll" on the lives of affected individuals. I strongly endorse your view that these impacts must remain, as you put it, "top of mind and serve as a foundation" for change.

A. Follow up concerning my first monitoring report of October 12, 2017

Thank you for your letter of January 29, 2018 and the attachment giving responses to the questions that I raised in my first monitoring report last October. I am gratified that the government has taken note of and attempted to address the concerns that I expressed. I will provide some additional comments below.

R – 11: This recommendation relates to personal belongings of some of the harmed persons. I noted in my October 12th report that I had heard from some of them that certain files and papers had not been returned, and noted that I stood ready to be of assistance if necessary.

In the attachment to your January 29 letter, you express both government's commitment to resolving these concerns, and your willingness to work with me to do so. I can now report that I am not aware of any outstanding concerns and assure you that, if any are brought to my attention, I will work with your officials and the parties concerned to resolve them.

R – 21(a): This recommendation called for the Investigation and Forensic Unit (IU) to implement a program of ongoing professional development on administrative and procedural fairness for its investigators and any employees leading an investigation. I noted in my October 12th report that, on the basis of the material that I had seen, there was no such program in place.

The Ombudsperson documented a troubling lack of fairness in the investigation of the suspected data breaches and related matters. To respond to that fairness deficit, the Ombudsperson's recommendation aims to help ensure that all persons conducting investigations have a solid and current understanding of the requirements of administrative and procedural fairness. The overall objective is exactly the one that you endorse in your letter: "improving [government's] human resources … processes to ensure such events cannot ever happen again."

I remain concerned that the arrangements currently in place to assure training in administrative and procedural fairness of those leading investigations is neither detailed nor robust enough to provide the necessary assurance that investigations will be conducted fairly.

The attachment to your January 29th letter indicates that the Comptroller General "will continue to identify further training opportunities" and will ensure that the 2018/19 Investigation and Forensic Unit Professional Development Framework and Plan "underscores the importance of ongoing professional development on administrative and procedural fairness…". You also refer to "specific requirements" for investigative staff to achieve approved investigative qualifications and to include ongoing professional development in investigative techniques in annual employee performance and development plans. These plans are to include specific training objectives in the area of ethics, and administrative and procedural fairness.

These are no doubt useful steps. However, they do not adequately respond to the Ombudsperson's recommendation.

I have reviewed the OCG Investigation and Forensic Unit (IU) Professional Development Framework and Plan for Fiscal 2018/19. It is notable that in the List of Competencies, there is no mention of a thorough understanding of the requirements of administrative and procedural fairness. The Professional Development Plan and Framework ("PDPF"), which forms Appendix A to the document that I have reviewed, lists training opportunities according to three categories: required training for investigative staff; optional training involving investigative techniques etc.; and other professional development. It is unclear to what extent administrative and procedural fairness are part of any of the courses listed as required training for investigative staff. The PDPF lists courses for each of years one, two, three and four and onwards. The only specific reference to

administrative and procedural fairness is in the category of "webinars/ seminars that include but not limited to investigative techniques, administrative fairness, ethics and writing skills."

As I understand it, "a program of ongoing professional development on administrative and procedural fairness" recommended by the Ombudsperson is "a plan of future events" or "a course of study." I would have thought that "a program" would have specified elements or courses addressing administrative and procedural fairness, together with timing and likely some progression from introductory to more in-depth training. I would also have thought that a program of professional development on administrative and procedural fairness would ensure that all investigators and others leading an investigation have that training before they undertake an investigation. The PDPF that I have reviewed has none of this.

In short, some months after this Recommendation ought to have been implemented, I have still not seen anything that I could call "a program of ongoing professional development in administrative and procedural fairness." In my view, this is a significant gap in government's implementation of the Ombudsperson's recommendations.

Recommendation 33: This recommendation requires the Ministry of Health to develop and implement a carefully designed organizational reconciliation program which is to, among other things, include clear objectives and deliverables. In my October 2017 report, I expressed concern that it was not clear that the sort of program envisioned by the Ombudsperson was in place by the date set by the Ombudsperson, that is, the end of September. I note that the status of the implementation of Recommendation 33 is not included in the 2nd status update provided by government.

The attachment to your January 29, 2018 letter confirms that this recommendation had not been implemented by the end of September. That is in my view perfectly understandable given the size and complexity of the task. However, I remain concerned that there is still no carefully designed organizational reconciliation program with clear objectives and deliverables. I acknowledge the extensive efforts that have been made in the Ministry to address the Ombudsperson's recommendation. But several months after the target date set by the Ombudsperson, I have not yet seen the sort of program with objectives and deliverables as recommended by the Ombudsperson.

Recommendation 34: This recommendation requires the Ministry of Health to "review and assess the extent to which the termination of evidence-based programs during the internal investigation may have created gaps that now remain in providing evidence-informed, safe, effective and affordable drug therapy and related health care services to British Columbians."

This recommendation has, for practical purposes, been overtaken by the plan called for by Recommendation 35 and nothing would be served at this point by further comments about Recommendation 34. I note, however, that the Appendix 2 to the selected excerpt from *Putting our Minds Together: Research and Knowledge Management Strategy*, which has been released in response to Recommendation 35, presents in a comprehensive and transparent manner government's thinking in relation to all of the research projects that were planned or underway in 2012 supporting evidence-based (or as more frequently referred to, evidence-informed) programs.

Recommendation 39: This recommendation called on the Coroner's Service to develop a policy about disclosure to a deceased family or personal representative of documents discovered on the deceased's person's electronic devices, including password-protected and cloud stored documents. In my October 2017 report, I expressed the view that the Policy in relation to these sorts of information does not provide the "clear guidance" that the Ombudsperson thought was necessary, "on the steps a coroner can and should take to disclose documents obtained during an investigation to the deceased individual's family or personal representative". The policy, so far as I know, remains as it was when I reviewed it as part of the preparation of my October report.

The adequacy of this policy, as I see it, must be measured against the extent to which it achieves the Ombudsperson's objective in making this recommendation.

You will recall that this issue arose in the Ombudsperson's Report in relation to information on the laptop of the late Roderick MacIsaac and whether his surviving family could have access to that information as they requested. The Ombudsperson concluded that "the lack of clear policy direction to guide the Coroner's Service decisions about whether and how to disclose these kinds of materials … was the primary cause of the uncertainty that led to the family's concerns": p. 330. The Ombudsperson reviewed the policy then in place and noted that "it does not describe any criteria to be considered and applied in determining whether information should be released." The Ombudsperson concluded that the "Coroner's Service should develop more robust policies to provide clear guidance" to coroners and they ought to "consider how disclosure may occur" and should "clearly address disclosure of information both during and after an investigation."

While the term "information" is defined for the purposes of the entire Policy to include "digital records", the only part of the policy that relates specifically to "disclosure of information retrieved from electronic devices" is included in the portion of the Policy that deals with release of information from "closed files." As a result, my view is that the revised policy does not comply with the Ombudsperson's view that the policy in relation to information retrieved from electronic devices should address disclosure both during and after an investigation.

Moreover, the Policy in my view falls short of providing "clear policy direction to guide the Coroner's Service decisions about whether and how to disclose these kinds of materials." I see no basis for government's confidence that this policy provides the clarity coroners require to carry out their role. The relevant part of the revised Policy reads as follows:

Disclosure of information retrieved from Electronic Devices: The Coroner's Service may be able to retrieve information from an electronic device that would not easily be retrievable or found when the device is returned. This could also include a password to access information on the device. Where the information is relevant to the Coroner's Report findings or otherwise appropriate when balancing the circumstances and the deceased's right to privacy, the Chief Coroner may exercise discretion under FOIPPA and the regulation to provide that information to the personal representative, executor or nearest relative.

I recognize the challenges of devising a policy to meet the myriad circumstances that may arise. However, simply telling the Chief Coroner to balance "the circumstances and the deceased's right

to privacy", provides no useful guidance as to how or on what basis the discretion to provide or refuse to provide the information should be exercised.

B. Recommendations falling due since my first monitoring report

There are just two recommendations that have fallen due since my first monitoring report. Both were due by December 31, 2017. In my opinion, neither has been fully implemented.

Recommendation 24: This recommendation calls on the Ministry of Health, following consultation with the Information and Privacy Commissioner, to create new guidelines for making decisions about suspending access to administrative health data. The guidelines should address the flaws in Ministry practice that the Ombudsperson identified in his report, including better defining the threshold for data suspensions in cases where there is only an unconfirmed suspicion of a data breach.

The Guidelines that have been released in response to this recommendation appropriately recite not only the four flaws identified by the Ombudsperson in the recommendation section of his Report, but also other problems referred to in the course of his Report. The objective of the Guidelines is of course to address these flaws and problems.

I have considered the Guidelines in that light. In my view, there are some gaps in the Guidelines and some places in which they ought to be more explicit. I offer the following comments.

- The initial reviewer did not have the necessary training or experience to undertake the review and did not consult with anyone with subject matter knowledge relevant to the complaint.

The Guidelines leave it up to the access decision maker to decide if he or she lacks sufficient capacity, training, etc. I suggest that it would be preferable to make it the duty of the Associate Deputy Minister to be satisfied that the access decision maker is suitably qualified.

- During the initial review of the complaint there was a failure to clearly distinguish whether the purpose of the review was to clarify or evaluate the complaint.

This problem is not addressed in the Guidelines.

- There was an insufficient evidentiary basis for the decisions.

The Guidelines adopt as a Guiding Principle that suspension based on conjecture or mere suspicion is inappropriate. They also specify that access should only be suspended when there is "sufficient reliable, credible and relevant evidence on which to base a decision." This is fine as far as it goes. I suggest, however, that it would be more in tune with the Ombudsperson's Report and recommendations to have a clear statement in the Guiding Principles along the lines that data access should not be suspended on a provisional basis unless (a) there is evidence that, if proven, could support a conclusion that data may be misused or disclosed improperly, and (b.) it is believed on reasonable grounds that there is a risk of harm if access is not suspended immediately: see p. 99. It would also be helpful if the Guiding Principles clearly articulated the standard of proof required for a permanent data suspension.

- The Ministry of Health failed to notify individuals that their data access had been suspended, did not provide reasons for the suspension, and did not provide the individuals with an opportunity to respond to the allegations against them.

The Guidelines deal thoroughly with the issue of notice and in my opinion fully address the flaws identified in that area by the Ombudsperson. I suggest, however, that the Guidelines ought to make clearer the obligation to provide the person whose access is being considered or provisionally suspended with the reasons that suspension is being considered or ordered, subject to considerations of urgency.

- The investigation was not conducted in a timely way and, as a result, the suspensions went on for much longer than was reasonable or necessary

The Guidelines address the need for timeliness and set some rough outer limits, subject to extension. In my view this is a reasonable way to respond to the Ombudsperson's concerns in this regard.

- The Ministry of Health did not adequately consider the impacts of many of the data access suspensions on health research and whether and how those impacts could be mitigated or addressed.

This flaw is partially addressed by the Guidelines: they specify that impact on the person whose access is being suspended and other parties as well as mitigation strategies are factors to be considered in a Final and Interim Report. However, the Guidelines do not clearly address the concern in relation to the impact of the suspensions on health research.

In addition to these flaws, the Ombudsperson also identified the following problems:

- The decision-makers lacked knowledge of the factual underpinnings of many of the relevant Ministry projects and the data access arrangements in relation to individuals and the Ministry's projects: p. 97.
- There was a failure to conduct a preliminary assessment and to articulate specific concerns in relation to each person under review: p. 99.
- The Ministry had not gathered any information about the nature of the data access for the persons affected by the suspensions: p 99.

The Guidelines address some of these concerns indirectly. I suggest that they ought to address all of them directly.

Recommendation 35: This recommendation calls on the Ministry of Health to release a plan with a reasonable timeline and transparent objectives and deliverables to address any gaps identified in the assessment conducted in response to Recommendation 34.

The Ministry has not as yet developed a complete or comprehensive response to this recommendation. What has been released is referred to as an "excerpt" from a larger document that is under development.

In at least two important areas, implementation is still in the planning stages. With respect to the gap relating to rebuilding and strengthening the relationships between the Ministry and the research community, a strategy is under development and will be released later. With respect to assuring appropriate and timely data access, an expert review is underway and a "proof of concept" is scheduled to be delivered by March of 2018.

Given the complexity and magnitude of the task facing the Ministry, it is to me not surprising that the implementation of this recommendation has not been accomplished within the time mandated by the Ombudsperson. While of course the Ombudsperson may well take a different view of the timing issue than I do, I cannot fault government for needing more time to come to grips with this critically important recommendation.

Allow me make some comments with respect to the two particular areas to which I have referred.

Rebuilding and strengthening the relationship between the Ministry and the research community is crucial and, in my opinion, there is much work to be done to achieve that objective.

Over the past several months, I have had the opportunity to become more deeply familiar with the events giving rise to the Ombudsperson's report and to meet and communicate with many of the persons affected. As a result, the significance of the toll to which you refer in your letter has both impressed and saddened me. These events were career-ending for some who felt that early retirement or a change of career was their only option. Some feel that their previously stellar reputations have been irremediably damaged. Some want desperately to resume the important work to which they have devoted their careers. Some continue to encounter what they consider to be suspicion and reluctance to allow them to re-engage with this work.

I strongly support your recognition of the toll all of this has taken and, I would add, continues to take. Your commitment to keep the victims of these events "top of mind" and make their experiences the foundation for change is, in my respectful view, exactly the right approach.

However, and notwithstanding all of government's considerable efforts, I am sorry to say that a number of the persons affected do not feel that their situations have been given appropriate attention. Of course, I have the ability to address these situations through recommendations for additional ex gratia payments and am in the midst of doing so. But for many of the people I have dealt with, no amount of money can restore to them either the work they love or the unsullied reputations that they enjoyed. Restoring the ability to do that work would accomplish both and achieve much more than any money award that I could recommend. Making things right for these researchers is, in my view, an important aspect of rebuilding and strengthening relationships with the research community.

As a second example, I point to the goal of ensuring appropriate and timely access to linkable health data held across health organizations for research analytics. This too is a critically important part of filling the gaps left in the wake of the events of 2012. I have heard from some that data access for research purposes is too slow to be of practical use, in some cases resulting in research grants lapsing or having to be declined because required data cannot be accessed within the necessary timelines. I have also been told that there have been long delays in restoring data access

to those who had it before it was wrongly and unfairly suspended in 2012. One individual who is especially knowledgeable told me that the data access process is "broken."

All of this leads to me to three conclusions.

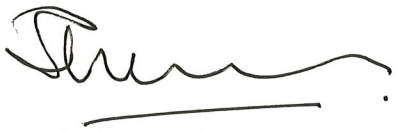
First, given the current status of government's implementation of Recommendation 35, it would be premature for me to provide a comprehensive assessment of how effectively government has implemented it.

Second, given the importance and complexity of the matters addressed by Recommendation 35, I cannot fault government for taking at least somewhat longer than the time envisioned by the Ombudsperson to fully implement this recommendation.

Finally, I strongly endorse your commitment to keeping the victims of these events "top of mind" as government moves forward with implementing this and all other recommendations.

Yours faithfully,

Borden Ladner Gervais LLP

by: 

Thomas A. Cromwell
TAC