Report of Findings: 19/20-AP-050
Right to Information and Protection of Privacy Act
Vitalité Health Network

March 12, 2020

Note: 2019 amendments to New Brunswick legislation transferred the responsibility for the access and privacy mandates from the Office of the Integrity Commissioner to the Office of the Ombud for New Brunswick.

Summary: On March 25, 2019, the Applicant made an access request to Vitalité for records related to the death of patient at the Restigouche Hospital Centre on a certain date. Vitalité responded by saying that disclosure was not granted, as information concerning the circumstances of the incident would significantly facilitate identifying the individual, citing s. 21(1) (unreasonable invasion of privacy).

The Applicant was not satisfied with Vitalité's response and filed a complaint, arguing that Vitalité could have disclosed some information about this situation without identifying the individual, such as by redacting personal information in reports that discuss what could be done better in the future.

The Ombud found that personal health information about the individual cannot be disclosed as it would result in an unreasonable invasion of privacy and that other information provided to Vitalité's quality of care and safety of patient committee during a quality review of this situation falls within the scope of s. 6 of the *Health Quality and Patient Safety Act*. The Ombud did not agree that the *Evidence Act* applied. Finally, the Ombud recommended disclosure of the chronology of events of the steps that were immediately taken to address the situation and a chart setting out responsibilities and status of the recommendations that resulted from the quality review process. As Vitalité's current process for conducting quality reviews does not include preparation of a written report, the Ombud also recommended that Vitalité review this process in light of possible access rights and for transparency and accountability purposes.

Statutes Considered: *Right to Information and Protection of Privacy Act*, SNB, c. R-10.6, ss. 5, 21(1), 21(2)(a), 70(1), and 70(3); *Health Quality and Patient Safety Act*, RSNB 2016, c. 21, ss. 6 and 7; *Evidence Act*, RSNB 1973, c. E-11, ss. 43.1 and 43.3(2).

I INTRODUCTION

1. On March 25, 2019, the Applicant made an access request to Vitalité Health Network ("Vitalité") for the following:

> All records relating to the death of a patient at Restigouche Hospital Centre on [date].

2. The time frame of the request was from the date of the patient's death to the date of this request (March 25, 2019).

3. Vitalité responded by letter dated May 14, 2019, informing the Applicant that disclosure was not granted, as information concerning the circumstances of the incident would significantly facilitate identifying the individual, citing s. 21(1) (unreasonable invasion of privacy).

4. The Applicant was not satisfied with Vitalité's decision and made a complaint to this Office. In doing so, the Applicant questioned whether Vitalité could have disclosed some information about this situation without identifying the individual, such as by redacting personal information in reports that discuss what could be done better in the future and questioned whether disclosure of some information was in the public interest.

5. During the course of the informal resolution process, Vitalité agreed to disclose some information and subsequently provided the Applicant with a redacted version of the patient incident report, with redactions to protect the patient's personal health information under s. 21(1), and the recommendations that were made at the end of the quality review process that was undertaken after the patient's death. As a result, these records are no longer at issue.

6. The remainder of the issues raised in this matter were not resolved informally and the Ombud conducted a formal investigation pursuant to s. 68(3) of the *Act*.

II ISSUES

7. The issue before me is whether the Applicant has a right of access to the remainder of the requested information held by Vitalité. In its response to this request, Vitalité stated that information that could identify the patient was protected under s. 21(1) (unreasonable invasion of privacy). During the course of this investigation, Vitalité also raised the applicability of the *Health Quality and Patient Safety Act* and the *Evidence Act* as grounds to refuse access to information about the quality of care review that was conducted following the patient's death.

8. Under s. 84(1) of the *Right to Information and Protection of Privacy Act,* the burden is on the public body to prove that the Applicant has no right of access to the requested information.

III PRELIMINARY MATTER: PRODUCTION OF RECORDS DURING AN INVESTIGATION

9. Among the reasons why this matter was not able to be resolved during the informal resolution process and the investigation has taken so much time to complete is the fact that the relevant records in Vitalité's possession were not provided for our review until after the matter was escalated to a formal investigation.

10. Vitalité also initially challenged this Office's authority to require production of records that it identified as part of its internal quality review process, stating that it was declining to do so based on ss. 6 and 7 of the *Health Quality and Patient Safety Act* and ss. 43.1 and 43.3(2) of the *Evidence Act*.

11. During the formal investigation, Vitalité changed its position on this point and provided this Office with a copy of the relevant records, albeit nearly nine months after Vitalité was first notified of this complaint and when the initial request for records was issued. This is despite repeated requests that the information be provided throughout the informal resolution process. This is not the first time Vitalité has found itself the subject of an access complaint and it should be well aware of this Office's practice of requiring production of the relevant records at the outset of the investigation to assist in our review process.

12. The *Act* grants me a broad authority to require production of records that I deem relevant to an investigation, as per s. 70:

> 70(1) With the exception of Executive Council confidences and any document that contains information that is subject to solicitor-client privilege, the Ombud may require any record in the custody or under the control of a public body that the Ombud considers relevant an investigation to be produced to the Ombud and may examine any information in a record, including personal information.

13. The only information I am not authorized to require a public body to produce for my review are records over which a claim of Cabinet confidences or solicitor-client privilege is asserted by the public body. None of the information at issue in this case consists of Cabinet confidences or solicitor-client privileged information.

14. If this Office deems that certain information is relevant to an investigation, s. 70(3) also sets out further direction on the production of records:

> 70(3) Despite any other Act of the Legislature or any privilege of the law of evidence, a public body shall produce to the Ombud within 10 business days any record or copy of a record required under this section.
>
> [Emphasis added}

15. Under s. 70(3), my authority to compel production of records for the purposes of an investigation is not affected by any claim of privilege or possible applicability of the *Evidence Act* to those records. As such, I find that Vitalité's objection to providing records due to the potential applicability of the *Evidence Act* was not proper, nor was the fact that the records related to a quality review under the *Health Quality and Patient Safety Act* relevant to the question of production to this Office.

16. As Vitalité is aware, production of records to this Office for review as part of a complaint investigation does not mean that they will be disclosed to the applicant. Records are provided to this Office so that a confidential review can be undertaken to assess whether the applicant has a right of access to any of the relevant information in keeping with the applicable provisions of the *Act*.

17. Given the small number of relevant records that exist and the question of the Applicant's access rights are straightforward in this case, had the records been provided for our review at the outset of this matter as requested, it is likely that this complaint could have been addressed relatively quickly, and possibly without the need for a formal investigation.

18. In future complaint investigations with Vitalité, I am hopeful that this Office will receive better cooperation with respect to the production of relevant records to an investigation in a timely manner.

19. I will now address the question of the Applicant's access rights to the requested information.

IV DECISION

Section 21: Unreasonable invasion of third party privacy

20. Section 21(1) of the *Act* states:

> 21(1) The head of a public body shall refuse to disclose personal information to an applicant if the disclosure would be an unreasonable invasion of a third party's privacy.

21. Section 21(2) of the *Act* sets out the kinds of personal information that are deemed to be an unreasonable invasion of privacy if they were to be disclosed and includes personal health information of a third party (s. 21(2)(a)).

22. In this case, there is no question that some of the relevant documents contain personal and personal health information about the patient, and that this information is protected from disclosure under ss. 21(1) and 21(2)(a) of the *Act*. The Applicant is aware of this fact and, as indicated in the complaint documentation, is not seeking this kind of information; rather, the Applicant is seeking information that explains the steps taken by Vitalité as a result of this situation and whether any areas were identified for improvement.

23. The relevant records also contain information that is not personal or personal health information about the patient, which are the records that were generated by Vitalité in gathering information about the circumstances of the patient's death and during its internal quality review process under the *Health Quality and Patient Safety Act*.

Applicability of the *Health Quality and Patient Safety Act*

24. In 2016, the *Health Quality and Patient Safety Act* came into force. This law requires health care organizations to establish quality of care and safety of patient committees to conduct quality reviews of patient safety incidents. This statute also deems the information collected during a patient safety review as confidential and exempt from public disclosure.

25. Vitalité claims that, aside from the information in the patient's health record, the information that it has about the steps taken to address this situation are part of the quality review process that was commenced shortly after the patient's death by its quality review and safety of patients committee and that the records generated through this process are protected from disclosure under ss. 6 and 7 of the *Health Quality and Patient Safety Act.*

26. These provisions state:

> 6 Despite the *Right to Information and Protection of Privacy Act*, a statement, declaration, record or document provided to the quality of care and safety of patients committee in the course of a quality review is confidential and shall not be communicated to any person.
>
> 7 Except on the trial of any person for an offence in respect of the person's sworn testimony, no statement made or answer or evidence given by that or any other person in the course

> of any quality review by the quality of care and safety of patients committee is admissible in evidence against any person in any court or at any inquiry or in any other proceedings.

27. Section 6 includes a prevailing clause over the *Right to Information and Protection of Privacy Act* for certain kinds of information that may form part of a quality review under this statute. Specifically, s. 6 states that "a statement, declaration, record or document provided to the quality of care and safety of patients committee in the course of a quality review is confidential".

28. This provision allows a committee to gather relevant facts and evidence about an incident from those who may have been involved or have pertinent details to share on a confidential basis. The confidentiality of the information provided to the committee goes to the integrity of the process and allows individuals to frankly and freely provide details and information to the committee with an assurance that this will not be shared or otherwise communicated.

29. Section 7 restricts the use of statements made and evidence provided to a quality of care and safety of patient committee in court and other legal proceedings, except in one limited circumstance: where a person is on trial for an offence respecting that person's sworn testimony.

30. Given the above, I find that the information provided to the quality of care and safety of patient committee during the course of its quality review of this situation falls within the scope of s. 6 of the *Health Quality and Patient Safety Act*; however, this is not determinative of access rights, as a statute other than the *Act* can only apply with respect to access in certain circumstances, as per s. 5 of the *Right to Information and Protection of Privacy Act*.

31. Section 5 of the *Right to Information and Protection of Privacy Act* states:

> 5 If a provision of this Act is inconsistent with or in conflict with a provision of another Act of the Legislature, the provisions of this Act prevail unless the other Act of the Legislature expressly provides that it, or a provision of it, prevails despite this Act.

32. The *Right to Information and Protection of Privacy Act* is intended to be the primary regulator of access and privacy matters for public bodies, but also recognizes that another statute may override and apply in lieu of the *Act* where the following two conditions are met:
    - there is an actual conflict or inconsistency between the provisions of the *Act* and another Provincial law, and
    - the other Provincial statute has an express prevailing clause that states that it, or a provision of it, applies instead of the *Act*.

33. In this case, section 6 includes an express prevailing clause ("Despite the *Right to Information and Protection of Privacy Act*"), thus the second step has been met.

34. The next question to be determined is whether there is a conflict or inconsistency between s. 6 of the *Health Quality and Patient Safety Act* and the relevant provisions of the *Right to Information and Protection of Privacy Act* with respect to the Applicant's access rights to the relevant information. Where the access rights under both statutes are the same, there will be no conflict or inconsistency and the relevant provisions of the *Right to Information and Protection of Privacy Act* will apply. Where there is a conflict or inconsistency between the two statutes with respect to access rights, s. 6 of the *Health Quality and Patient Safety Act* will apply.

35. The records provided by Vitalité for my review include:
    - an email dated the day after the patient's death and accompanying attachment setting out the initial steps taken by the facility to address the situation;
    - a chronology of events that was generated from information in the patient's chart;
    - notes of interviews conducted with staff members at the facility;
    - a chronology of events summarized from surveillance cameras, which consists of information about the patient;
    - reference materials that were used in preparation for the quality review and documents containing general information about the quality review process;
    - Vitalité policies; and
    - two briefing notes that include general details about incidents reviewed by Vitalité and resulting recommendations (the majority of which is not relevant to this situation).

36. As for Vitalité's internal policies and reference materials and other resources of a general nature that were consulted as part of its quality review in these circumstances, I do not believe that this is the kind of information that the Applicant was seeking in making this request and thus will not consider these records further.

37. As for the email that was sent the day following the patient's death, it was sent by the Vice President of Community and Mental Health Services to other senior management officials within Vitalité. The attachment to this email contains a chronology of the steps taken by Vitalité officials immediately after learning of the patient's death. I note that one of the bullets in the attachments states that risk management would be establishing the chronology of events and conducting a review.

38. While this document may have been provided to the quality of care and safety of patient committee, I am not convinced that it constitutes the kinds of information that s. 6 of the *Health Quality and Patient Safety Act* intends to protect. As indicated by the contents of this record, it was prepared very shortly after the death occurred and was used to inform senior officials prior to the quality review process being undertaken. There is nothing in this record that reveals any details about the quality review undertaken in this case, and for this reason I do not agree that this record falls within the scope of s. 6 of this statute.

39. As such, I find this email and accompanying attachment should be disclosed to the Applicant, with redactions to the fourth and fifth bullet points to protect the personal information of the patient's family members under s. 21(1) (unreasonable invasion of privacy).

40. As for the chronology of events document that was generated from the patient's chart, I find that this record consists entirely of the patient's personal health information and thus cannot be disclosed, as this would be an unreasonable invasion of privacy under ss. 21(1) and 21(2)(a) of the *Right to Information and Protection of Privacy Act*. The same considerations apply to the chronology of events summarized from surveillance camera footage, as they describe details about the patient, which in my view constitutes personal health information. I also find that these records would be protected from disclosure under s. 6 of the *Health Quality and Patient Safety Act*, as they were provided to the quality of care of safety of patients committee during the quality review process. This means that there is no inconsistency or conflict between these two acts with respect to the Applicant's access rights.

41. As for the records that document the interviews with staff in the days following the patient's death, these were conducted immediately prior to the first meeting of the participants in the quality review process, which occurred six days after the death occurred.

42. It is not clear from the information provided by Vitalité whether these interviews were conducted as part of the quality review process. It appears from the timeline of events in this case that they were not, although it also appears that the notes from these interviews were provided to the quality of care and patient safety committee as part of the quality review process.

43. If the notes from the interviews with staff were provided to the quality of care and safety of patient committee during the quality review process, as I believe it is reasonable under the circumstances to assume, this constitutes records or documents that were provided to the committee for the purposes of its review and thus fall within the scope of s. 6 of the *Health Quality and Patient Safety Act* and thus are not subject to disclosure.

44. Even if I were to find that these records do not fall within the scope of s. 6 of the *Health Quality and Patient Safety Act*, I would not recommend disclosure in any event as the majority of the information in these records constitutes the personal health information of the patient and the personal opinions offered by staff about the patient, disclosure of which would be an unreasonable invasion of these individuals' privacy under s. 21(1) of the *Right to Information and Protection of Privacy Act*. This means that the Applicant's access rights in relation to these records are consistent under both statues.

45. As for the two briefing notes that were prepared the month after the patient's death, one was prepared for the purpose of seeking approval of Vitalité's Vice-Presidents in the implementation of recommendations issued by Vitalité's review committees, which includes its quality of care and patient safety committee. The other was prepared to inform Vitalité's committee members of the recommendations that resulted from the work conducted under the *Health Quality and Patient Safety Act*, since the last report three months prior. Both briefing notes set out general details about the work conducted by Vitalité's review committees, the recommendations that resulted from these reviews, and the status of the implementation of these recommendations. Neither of these records contain personal health information of identifiable individuals.

46. In my view, the two briefing notes do not fall within the scope of s. 6 of the *Health Quality and Patient Safety Act*, as they are not statements, declarations, records or documents provided to Vitalité's quality of care and safety of patients committee. Rather, they are the work product generated by the committee to inform Vitalité's review committee members and senior management of the outcome of its work and resulting recommendations. In this case, the end result of the quality review process was the issuance of two recommendations with respect to staffing and procedures at the facility, both of which were disclosed to the Applicant by Vitalité during the informal resolution process. The remainder of the information in these records is about other matters that were considered by Vitalité's review committees that are not directly relevant to this complaint.

47. While the Applicant is already aware of the two recommendations that were issued at the end of the quality review process, I find that there is some additional information about these recommendations that should also have been provided to the Applicant. One of the briefing notes includes a chart that lists the recommendations issued, the responsible Vitalité official, the time lines, and the current status of implementation for each recommendation for the three-month period that includes the patient's death. I recommend that Vitalité disclose this record to the Applicant, with redactions to protect the information on recommendations issued as a result of other quality reviews under s. 16(1.1) (not relevant to the request).

48. During my review of this matter, I was surprised to learn that the quality of care and safety of patients committee did not document its work and findings in a written report at the conclusion of its review of this matter. Vitalité officials informed us that this is in keeping with its established practice and directed us to its internal policies that establish its quality of care and safety of patients committee and how they are to conduct their work. Vitalité is of the view that it is not required to create a written report in these circumstances and stated that reports are presented orally at the end of a quality review process.

49. In looking to the provisions of the *Health Quality and Safety of Patients Act* that speak to reporting requirements of quality of care and safety of patient committees, the following are directly relevant:

> 2(3) A quality of care and safety of patients committee shall perform the following duties:
>
> (a) conduct quality reviews of patient safety incidents and other incidents reported to it under section 3; and
>
> (b) after a review has been conducted, report the relevant facts of the incident and its recommendations to the board of directors of the health care organization for the purposes of improving the quality of health care and the safety of patients and to prevent the occurrence of similar incidents.
>
> 2(4) A report made under paragraph 3(b) shall not contain personal information or personal health information.

50. Also, the General Regulation under the *Health Quality and Patient Safety Act* (General Regulation, NB Reg 2018-60), s. 5 further provides the timeline for reporting on quality reviews:

> 5 A quality of care and safety of patients committee shall submit its report to the board of directors of a health care organization not more than 180 days after the committee was notified that a patient safety incident or other incident had occurred.

51. While Vitalité's position is that it is not required to make a written report at the end of a quality review under the *Health Quality and Patient Safety Act*, I do not agree. While the statute does not make specific reference to a written report or expressly require that a report be written, the wording of s. 2(4) that states that such a report "shall not contain personal information or personal health information" suggests to me that the intent behind this provision was to have the committee prepare a written report setting out "the relevant facts of the incident and its recommendations," in keeping with s. 2(3)(b).

52. In my view, Vitalité's current practice of not documenting the results of quality review processes in a written report not only undermines potential access rights to information of this nature, as access cannot be granted if a document does not exist, but also Vitalité's ability to demonstrate accountability and the required level of transparency with respect to quality of care and patient safety reviews conducted under the *Health Quality and Patient Safety Act*. While this statute protects information provided to quality of care and safety of patient committees during the course of a quality review, this protection does not extend to the work product of such committees and thus may be subject to disclosure under the *Right to Information and Protection of Privacy Act*.

53. Based on my understanding of the general nature of the work conducted by quality of care and safety of patient committees under the *Health Quality and Patient Safety Act* and the provisions governing disclosure of information relating to such work, it does not appear that a report at the conclusion of a quality review process would be protected under s. 6 of the *Health Quality and Patient Safety Act*. As such reports are prohibited from containing personal information and personal health information under s. 2(4) of the *Health Quality and Patient Safety Act*, it also does not appear that a report would be protected from disclosure under s. 21 of the *Right to Information and Protection of Privacy Act* either, as there would be no need to protect patient privacy in this case. It may be that a report could fall, in whole or part, under other exceptions to disclosure under the *Act*; however, this is a moot point in this case as no such report exists.

54. As no written report was created at the end of the quality review process in this case, I cannot recommend that access be granted to the Applicant.

55. That being said, given the concerns raised in this case about the reporting requirements under the *Health Quality and Patient Safety Act* at the conclusion of a quality review, a recommendation under s. 64.1(1)(a) will follow for Vitalité to review its process with respect to documenting the work conducted by its quality of care and safety of patient committee and written reports.

Applicability of the *Evidence Act*

56. Vitalité also raised the applicability of ss. 43.1 and 43.3(2) of the *Evidence Act* as grounds to protect the requested information from disclosure, in light of the class action lawsuit that was commenced in May 2019 against the Province on behalf of residents of the facility, alleging negligence, Charter violations and breach of fiduciary duty.

57. Section 43.1 of the *Evidence Act* states:

> **Investigative report**
> 43.1 An investigative report that is prepared for the dominant purpose of being submitted to a solicitor for advice with respect to, or use in, contemplated or pending litigation, or any part of an investigative report in which an opinion is expressed, regardless of the purpose for which that report was prepared, is privileged from disclosure and production in civil proceedings.

58. I fail to see how this provision could apply to any of the information at issue in this case. As indicated above, the quality of care and safety of patients committee did not prepare a written report at the conclusion of its review into the circumstances of this patient's death. Even if the committee had done so, the dominant purpose of such a report would have been to report to Vitalité's board of directors on the facts and resulting recommendations as a result of the quality review process. In short, there was no report, and even if there were, it would not have been prepared for the dominant purpose of litigation.

59. Further, I note that the class action lawsuit filed against the Province was filed in May 2019 and the event at issue in this complaint occurred prior to that time.

60. For these reasons, I do not find that s. 43.1 of the *Evidence Act* applies to the records at issue in this case.

61. Vitalité also raised the applicability of s. 43.3(2) of the *Evidence Act*. This provision speaks to the compellability of evidence in court proceedings relating to information and documents generated by hospital committees. To better understand the purpose and interpretation of s. 43.3(2), the text of ss. 43.3(1), (2), and (3) are reproduced below:

> **Hospital committee**
> 43.3 (1) In this section
> …
> "legal proceeding" means a proceeding in any court, including a proceeding for the imposition of punishment by fine, penalty or imprisonment to enforce an Act of the Legislature or a regulation made under that Act;
> "regional health authority" means a regional health authority as defined in the *Regional Health Authorities Act*;
> "witness" includes a person who, in connection with, or in the course of, a legal proceeding, is called upon to provide information, to answer, orally or in writing, a question or to produce a document, whether under oath or not.

43.3(2) A witness, whether a party to a legal proceeding or not, is excused from

(a) providing any information as to any proceeding before a committee established by a regional health authority to conduct any study, research or program for the purpose of medical education or improvement in medical or hospital care or practice,

(b) producing any document made by or for a regional health authority or a committee established by the regional health authority, prepared for the purpose of being used in the course of, or arising out of, any study, research or program the dominant purpose of which is medical education or improvement in medical or hospital care or practice, and

(c) disclosing any written or verbal opinion that

(i) is provided to a regional health authority or to a committee referred to in this subsection when it is investigating an occurrence, and

(ii) is an opinion as to the standard of the medical or hospital care or practice that was provided by any person in the circumstances under investigation.

43.3(3) Subsection (2) does not apply to

(a) records maintained by regional health authorities as required by the *Hospital Act* or the *Regional Health Authorities Act* or the regulations under those Acts, or

(b) medical records maintained by attending physicians pertaining to a patient.

62. Section 43.3 of the *Evidence Act* bars certain kinds of information from being presented as evidence in legal proceedings that are before the courts. While a complaint made to this Office under the *Right to Information and Protection of Privacy Act* can be considered a legal proceeding, it is not a matter that is before the courts and thus the above provisions do not apply either to restrict this Office's authority to require the production of records under s. 70 nor as grounds to refuse access to information under the *Act*.

63. I do not find that the claimed provisions of the *Evidence Act* apply to the information at issue in this case, and as a result, do not have any impact on my findings or the recommendations that follow.

V RECOMMENDATION

64. Based on the above findings, I recommend under s. 73(1)(a)(i)(A) of the *Right to Information and Protection of Privacy Act* that Vitalité disclose to the Applicant the following information:

(a) the email that was sent the day after the patient's death and accompanying attachment, with redactions to the fourth and fifth bullet points to protect the personal information of the patient's family members under s. 21(1) (unreasonable invasion of privacy); and

(b) the table of recommendations that lists the recommendations issued as a result of the quality review process in this case, along with the responsible Vitalité official, the time lines, and the current status of implementation for each recommendation for the three-month period that includes the patient's death, with redactions to protect information related to other quality reviews under s. 16(1.1) (not relevant to the request).

65. Under s. 73(1)(a)(ii)(A) of the *Right to Information and Protection of Privacy Act*, I confirm Vitalité's decision to refuse access to the remainder of the relevant information for the reasons set out above.

66. As set out in s. 74 of the *Right to Information and Protection of Privacy Act*, the head of the public body must give written notice of its decision with respect to these recommendations to the Applicant and this Office within 20 business days of receipt of this Report of Findings.

67. Under the authority of s. 64.1(1)(h) of the *Right to Information and Protection of Privacy Act*, I also recommend that Vitalité review its process with respect to documenting the work conducted by its quality of care and safety of patient committee, including the report that is required to be issued to Vitalité's board of directors at the conclusion of the quality review process as per s. 2(3)(b) of the *Health Quality and Patient Safety Act*.

68. As this recommendation is made under my general powers and duties under s. 64.1(1)(h) rather than s. 73 of the *Right to Information and Protection of Privacy Act*, the timelines for responding to these recommendations under s. 74 do not apply, nor do they trigger the appeal rights under s. 75 of the *Act*. Nevertheless, I ask that Vitalité notify this Office of its decision with respect to the recommendations above within 20 business days of receipt of this report.

This Report issued in Fredericton, New Brunswick this 12th day of March 2020.

original signed by

Charles Murray
Acting Ombud for the Province of New Brunswick