ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2016-01

January 12, 2016

COVENANT HEALTH

Case File Number H6013

Office URL: www.oipc.ab.ca

Summary: The Applicant requested changes be made to her health information. The Custodian refused to make changes. The Adjudicator confirmed the Custodian's decision to refuse to make changes. The Adjudicator found that the Custodian failed to respond to the Applicant fully when refusing to make corrections. The Adjudicator ordered the Custodian to provide the Applicant with a new response that sets out full reasons for refusing to correct the records, as well as providing the Applicant with a new opportunity to choose among the options in section 14(1) of the Act.

Statutes Cited: AB: *Health Information Act* R.S.A. 2000, c. H-5, ss.13,14, 15, 80.

Authorities Cited: AB: Orders H2005-006, H2005-007

I. BACKGROUND

[para 1] The Applicant phoned the police and asked them to attend her residence. She reported to them that she was being abused and harassed by another resident in the building. The police, after speaking to neighbours, contacted the Addictions and Mental Health Clinic (Crisis Unit). A record was created at the Crisis Unit (Crisis Record). Notes about the telephone conversation between a clinic worker and the police were placed on the record. The clinic worker noted there was a potential that the Applicant was medically comprised, which may have been affecting the Applicant's presentation. It

appears, from the notes, the police agreed to contact Emergency Medical Services (EMS) to attend to the Applicant and assess her further. EMS did attend and determined the Applicant was to be transported to the emergency department of the Misericordia Hospital to treat her dangerously high blood pressure.

[para 2] Records indicate that the Applicant was admitted to the Emergency Department of the Misericordia Hospital approximately an half hour after midnight on January 17, 2013. At noon that day, she was admitted to the Misericordia Hospital under a Form 1 Certificate pursuant to provisions of Section 2 of the *Mental Health Act.* She remained in the Emergency Department until nearly 7 p.m. that evening. Approximately six weeks later, the Applicant requested access to her health records that had been created in the Emergency Department of the Misericordia Hospital.

[para 3] Upon receipt and review of the records, in July, 2013 the Applicant made a request for correction or amendment of her health information. Covenant Health refused to correct or amend stating the following in their letter to the Applicant sent in September, 2013:

> We have consulted the physicians responsible for your care and they have indicated that the information you wish to be corrected or amended consists of their professional opinion or observations, therefore Covenant Health is refusing your request under section 13(6) of the *Health Information Act* which allows a custodian to refuse to make a correction or amendment that has been requested in respect to a professional opinion or observation made by a health service provider about the applicant.

[para 4] To this letter, the writer appended section 13(1)(6)(a) of the HIA which reads:

> *13(1) An individual who believes there is an error or omission in e individual' health information may in writing request the custodian that has the information in its custody or under its control to correct or amend the information.*
> …
> *(6) A custodian may refuse to make a correction or amendment that has been requested in respect of*
> *(a) a professional opinion or observation made by a health services provider about the applicant* [*, or*] not included in the letter

[para 5] In its submissions to this inquiry in May 2015, the Custodian raised section 13(1)(6)(b) as an additional justification for a refusal to correct or amend. That section reads:

> *(b) a record that was not originally created by that custodian*

[para 6] Upon review of the records and submissions, the Adjudicator requested a conference with the parties to discuss options regarding the inquiry, the scope of the inquiry and whether further issues were to be added to the inquiry.

[para 7] The Custodian responded by objecting to such a conference as "neither an established practice during OIPC inquiries, nor would it appear to be necessary or

appropriate in the current written inquiry." The Custodian also stated that "This inquiry cannot inquire into any potential concerns unrelated to the correction request".

II. RECORDS AT ISSUE

[para 8] The Applicant, in her submissions, included 14 pages of records. She requested corrections on most of the pages.

III. ISSUES

[para 9] Did the Custodian properly refuse to correct or amend the Applicant's health information, as authorized by section 13 of the HIA?

IV. DISCUSSION OF ISSUES

[para 10] The Applicant received 52 pages of records from the Custodian in response to her request for health information. In submissions to this Inquiry, the Applicant attached 14 pages of those records. The Applicant asked that certain information in the following 4 documents be corrected:

1. AMH EMHC Crisis document (Crisis document – 2 pages)
2. Admission Certificate (Form 1 – 1 page)
3. Consultation Request (1 page)
4. History (5 pages)

[para 11] The Applicant also requested that certain information be included in the Nurse's Record and the Patient Care Record.

[para 12] I understand the Applicant's submissions recount her version of the events during her time at the emergency department. The Applicant expresses her dismay at the treatment and care she received. The submissions also ask questions regarding her treatment and care. To be clear, I do not have the authority under the Act to direct that the Custodian respond to those questions, nor do I have the authority to answer those questions.

[para 13] This Inquiry deals with a correction request. Before there is a requirement to correct health information in records held by Covenant Health, a number of criteria must be met and steps must be taken.

[para 14] Firstly, the information must be the Applicant's health information and be in the custody of the Custodian. Covenant Health, in its submissions has agreed that, in all cases, the documents contain the Applicant's health information and that all documents are in its custody. Save for the Crisis document, it agrees that the information was collected by, or compiled by Covenant Health personnel in conjunction with the provision of health services to the Applicant.

[para 15] The relevant parts of section 13 of the HIA read:

> ***13(1)*** *An individual who believes there is an error or omission in the individual's health information may in writing request the custodian that has the information in its custody or under its control to correct or amend the information.*
>
> …

[para 16] The next step is to determine whether the Custodian should correct or refuse to correct information contained in the records.

[para 17] The next relevant section is 13(6) which reads as follows:

> **(6)** *A custodian may refuse to make a correction or amendment that has been requested in respect of*
>
> *(a) a professional opinion or observation made by a health services provider about the applicant, or*
>
> *(b) a record that was not originally created by that custodian.*

[para 18] I will follow the process as outlined by Commissioner Work in Order H2005-007:

> [para 49] I will use a two step process to address the issues in the case before me. First, I will consider whether any of the information at issue consists of a professional opinion or observation under section 13(6)(a) of HIA. If the information is a professional opinion or observation, that information is not subject to correction or amendment, as a custodian can refuse to make a correction or amendment under section 13(6)(a) of HIA regardless of whether there is an error or omission. (my emphasis) The burden of proof under section 13(6)(a) of HIA is to show that the information consists of a professional opinion or observation.
>
> [para 50] Second, with respect to the information that is not professional opinion or observation, I will consider whether there are errors or omissions under section 13(1) of HIA. If the information contains an error or omission of fact that information may be subject to correction or amendment. Therefore, a custodian must justify a decision to refuse to make a correction or amendment under section 13(1) of HIA. The burden of proof under section 13(1) of HIA is to show that the information contains an error or omission. A custodian must properly exercise discretion when refusing to make a correction or amendment to health information.

C. Application of Section 13(6)(a) (Professional Opinion or Observation)

[para 51] As stated, my first step will be to consider whether any of the information at issue consists of professional opinion or observation under section 13(6)(a) of HIA. A custodian is allowed to refuse to correct or amend information that is a professional opinion or observation under section 13(6)(a) of HIA.

[para 52] I have previously interpreted section 13(6)(a) of HIA in Orders H2004-004 and H2005-006, so there is no need to repeat those discussions here. I have said that the following three requirements must be met for section 13(6)(a) of HIA to apply (Orders H2004-004 (para 17), H2005-006 (para 44)):

- There must be either a professional opinion or observation,
- The professional opinion or observation must be a health services providers', and
- The professional opinion or observation must be about the applicant.

[para 53] The Act is silent regarding which party has the burden of proof to show that the information consists of professional opinions or observations under section 13(6)(a) of HIA. In Orders H2004-004 and H2005-006, I said that a custodian has the burden of proof under section 13(6)(a) of HIA, as the party who refuses to correct an applicant's information is in the best position to speak to the reasons for refusing (paras 21 and 46 respectively). I adopt that reasoning here and find that the Custodian has the burden of proof under section 13(6)(a) of the Act.

Professional Opinion or Observation

[para 54] I have previously said that "professional" means of or relating to or belonging to a profession and "opinion" means a belief or assessment based on grounds short of proof, a view held as probable. "Observation" means a comment based on something one has seen, heard, or noticed, and the action or process of closely observing or monitoring (Orders H2004-004 (para 19), H2005-006 (para 47)). Opinions and observations are subjective in nature.

[para 19] I will deal with the 4 documents separately.

1. Form 1 (Admission Certificate)

[para 20] The Admission Certificate indicates that a personal examination of the Applicant took place at 12:00. There is an indication, on the form, that in the opinion of the doctor signing the certificate (Dr. C), the patient being admitted is suffering from a mental disorder, is likely to cause harm to the patient or others or to suffer substantial mental or physical deterioration or serious physical impairment, and is unsuitable for admission other than as a formal patient. The form further indicates that the opinion is based on facts observed by the doctor upon examination. The facts that are related on the form are that the patient is paranoid and believes that gang members have followed her and are recruiting members to abuse her. The Certificate is signed by Dr. C at 12:05.

[para 21] Looking at the handwritten notations added to this document by the Applicant in her submissions, I understand her to be seeking the following corrections:

- Dr. C should not be listed as the person who examined her.
- On the document, Dr. C lists a fact that he indicates was observed by him. As the Applicant asserts that since Dr. C did not examine her, this observation was not made by him.

- On the document, Dr. C lists as one of the facts communicated to him by others is that the Applicant had displayed certain behaviours for the past 5 years. As the Applicant has lived in Edmonton for only 3 years, she asserts that this is incorrect information about her.

[para 22] The Custodian has refused to correct information in the Form 1 document which is referred to as the Admission Certificate. The Custodian has submitted an affidavit of the Coordinator, Information and Privacy, at Covenant Health. In his affidavit, the Coordinator deposes

> 12. I am advised by counsel for Covenant Health, [AC], and do believe that the *Mental Health Act*, R.S.A. 2000, c. M-13 and the *Mental Health Act Forms Regulation*, A.T. 136/2004, provide for a specific form for the formal certification of mental health patients. This is the form of certificate signed by Dr. [C] in relation to the Applicant (the "Admission Certificate").
>
> 13. From my review of the Admission Certificate, I believe that Dr. [C] would have reviewed information available from collateral sources, and from information provided by the Applicant. I believe that this information, combined with a mental status examination, led to a diagnostic formulation, which Dr. [C] determined necessitated certification under the *Mental Health Act*.
> …
>
> 19. On or about August 26, 2013, I received a response from Dr. [C] regarding thee (*sic*) Correction Request indicating that Dr. [C] did not agree that the correction request should be granted. Dr. [C]'s response indicated the following:
>
> > "The information provided within these documents were the result of a comprehensive assessment, at the appropriate request of the emergency room physician. The assessment included, as is standard in psychiatric consultations, information available from collateral sources, and from information provided by the individual being assessed. This, combined with a mental status examination, led to a diagnostic formulation, which necessitated certification under the Mental Health Act of Alberta, and a recommendation for further assessment and psychiatric consultation at an inpatient facility. The information contained within the above documents are qualitatively reflective of the circumstances presented at the time in question."
>
> 20. On or about August 26, 2013, I also spoke with Dr. [C] who confirmed that he examined the Applicant during the Hospital Visit, and who again confirmed that the records accurately reflect the information he observed and the opinions he formed at the time.

[para 23] On this record, it appears that there are both professional opinions and observations by Dr. C that the Custodian refuses to correct under section 13(6) and health information about the Applicant that the Custodian also refuses to correct. The statement that Dr. C examined her is health information about the Applicant. The rest of the information on the document is Dr. C's observations and opinions about the Applicant.

[para 24] One of the facts the Applicant believes the record is in error is Dr. C did not examine the Applicant as the doctor states he did in the Admission Certificate. The Custodian argues:

> Not only do the Records confirm that this occurred, and the Applicant acknowledges various conversations or encounters with Dr. C, Covenant Health confirmed with Dr. C that this examination took place [Affidavit of [SW] at para.20].

[para 25] The Applicant, in her submissions, relates two brief incidents of conversation or encounters with Dr. C. The first, she says, occurred immediately she stopped the student intern's questions of her when he asked her about pregnancies. The Applicant was offended by the questioning of her (a 73 year old woman) about pregnancies, particularly when it was her understanding that she was being admitted for exhibiting extremely high blood pressure. She relates that at that time, Dr. C. informed her that he was admitting her to a Psych Ward and told her "if I left the hospital he'd send the cops after me…I asked to see a lawyer or another Police Officer and he totally ignored me." The second encounter or conversation she relates occurred later that afternoon after the Admission Certificate was signed. Neither of these encounters is recorded in any document before me. I also cannot find any other record of Dr. C.'s examination of the Applicant in the documents before me, save the Admission Certificate.

[para 26] I examined the records provided to me to determine when Dr. C.'s examination of the Applicant took place.

[para 27] The document labelled HISTORY was dictated by the student intern, D.L. The contents of that document indicate that at the time of dictation, the Applicant had already been admitted under a Form 1 (Admission Certification). This document was edited and electronically signed by Dr. C. the next day. There is also a document labelled "Admission Note". This form indicates that it is to be completed by the admitting student intern. There is no indication of the author of this form. The form does indicate that the Mode of Admission is "Form 1". I infer from this that the admission has already taken place when the "Admission Note" form was completed.

[para 28] I also look to the nurses' record for evidence that an examination by Dr. C. has taken place. I found no such evidence. I note that the record indicates that at 08:30 a psychiatric medical student is "in to see pt.". At 09:30 there is a notation that "no orders rec'd from psych". Further, at 10:20 "waiting for results of psych interview" is noted. The next notation is 12:20 "pt. now certified by psych Form I." The last note regarding any psychiatric care is at 15:35 where it is noted "Psych resident quare (*sic*) Pt. wanting to speak with him."

[para 29] While the Custodian submits that there are records that confirm the examination, I can find only one document (the Admission Certificate (Form 1)) in the records submitted to me that indicates that Dr. C. examined the Applicant personally some time between 12:00 and 12:05. This is the very document that the Applicant wishes corrected.

[para 30] In order H2005-007, Commissioner Work indicates that "the Applicant has the burden of proof to show that there is an error or omission under section 13(1) of HIA

in this case, because the Applicant is in the best position to show where there is an error or omission in her own health information."

[para 31] Initially, there was no direct evidence from Dr. C. This was troubling to me. It would have been of great assistance to both me and the Applicant to have Dr. C. provide direct evidence of his examination of the Applicant. Given the comments made by another health care provider in the Crisis record to the Police Officer that there was a potential that the Applicant was medically compromised so as to affect her presentation and given that the Applicant was suffering from dangerously high blood pressure, it may be that the Applicant's recollection of the events was also compromised.

[para 32] I requested that the Custodian provide me with direct evidence from Dr. C. I received an affidavit from Dr. C. In it he deposes:

> 4. In order to consider the completion of an admission certificate, I first met with the student intern, Mr. L, who initially examined the Applicant as a result of the consultation request from an emergency room physician. As is standard in psychiatric consultations, the information gathered by Mr. L included information available from the Applicant herself, as well as from collateral sources (such as records from responders, the emergency room records and information from a member of the Applicant's family). In our meeting on or about January 17, 2013, Mr. L described all of this information to me in detail.
> 5. I then met with the Applicant in person and conducted a mental status examination of her with Mr. L present. I conducted this examination of the Applicant at the Misericordia Community Hospital on or about January 17, 2013. In conducting this examination, I asked the Applicant questions and performed assessments that in my professional opinion were relevant and appropriate in order to assess the Applicant's mental status. Given the nature of the examination, it is my belief that it may not be apparent to a lay person that a mental status examination is being conducted. Nevertheless, in my professional opinion, the questioning and assessing activities that I engaged in with the Applicant on or about January 17, 2013, constitute a mental status examination. (my emphasis)

[para 33] It would appear that Dr. C does not take any issue with what the Applicant is suggesting in her narrative. Rather, he explains, in his professional opinion, what he was doing and saying to her constitutes an examination.

[para 34] I appreciate that the Applicant has said she does not see how, given the nature of the interaction between herself and Dr. C, it could be said that a medical mental-status examination was being carried out. Nonetheless, she does concede that an interaction between herself and this doctor took place. Even accepting the nature of the exchange was as she recounts it, it is not within my jurisdiction to comment whether it was appropriate for the doctor to use this interaction as part of the basis for his decision about the Applicant's mental state, nor to challenge his conclusions. While I understand the Applicant feels strongly aggrieved by the decision that was made to admit her under a certificate in the circumstances, the doctor made his decision on the basis of these circumstances, including information that was provided from other sources, and recorded his professional opinions about this matter. There is therefore no correction that I can order to be made on this record.

2. AMH - EMHC Crisis document (Crisis document – 2 pages)

[para 35] The Custodian, in submissions to this Inquiry, indicated that upon review of this record, it determined that it was not created by Covenant Health personnel. Under section 13(6)(b), it refused to correct that document.

[para 36] In its original letter to the Applicant denying her correction request, the Custodian did not mention this section of the Act. Upon review of submissions, I requested that the Custodian and the Applicant meet with me informally to discuss this document and the scope of this Inquiry. The Custodian refused.

[para 37] In its letter responding to my request, the Custodian states the following:

> The response letter provided to the Applicant…notified the Applicant that Covenant Health was relying on s.13(6) of the HIA to refuse the correction request. This letter does not specify which subsection of s.13(6) is relied upon, although it does paraphrase that one (my emphasis) reason is that the records contain professional opinions or observations.
>
> Covenant Health did in error omit the text for s.13(6)(b) in its appendix to its correspondence.

[para 38] The response letter does not indicate that this is one reason. It indicates it is the reason for refusing her request. It reads as follows:

> …therefore Covenant Health is refusing your request under section 13(6) of the Health Information Act which allows a custodian to refuse to make a correction or amendment that has been requested in respect to a profession opinion or observation made by a health services provider about the applicant.

The letter attaches section 13(1) and 13(6)(a) of the HIA only.

[para 39] Section 13(5) reads:

> *(5) If the custodian refuses to make the correction or amendment, the custodian must within the 30-day period or any extended period referred to in subsection (2) give written notice to the applicant that the custodian refuses to make the correction or amendment and of the reasons for the refusal.*

[para 40] This record is clearly not a record that was created by Covenant Health personnel. However, this should have been clearly communicated to the Applicant in September, 2013, not in Inquiry submissions in 2015.

[para 41] I find that the Custodian failed in its duty to the Applicant to give the reasons for its refusal to correct this record.

3. Consultation Request (1 page)

[para 42] The Applicant, in her submissions, indicates that Dr. W. did not attend to her and was therefore not the Attending Physician. She requested that this record be corrected.

[para 43] This record, in its first stand-alone hand-written line, reads "See Chart." That chart would be the Emergency Record. The Emergency Record lists Dr. W. as the emergency physician and clearly has Dr.W.'s notes on the face of the record. It is clear that Dr. W. spoke to the Applicant and then determined that a consult with Psychiatry was required.

[para 44] The Custodian, in submissions, states that the "Applicant misdescribes Dr.W.'s gender and thus may be confused in her belief that she was not examined by Dr.W." I agree with these submissions and find that other records provided to me show that Dr.W. did indeed examine the Applicant.

[para 45] The notes in both the Emergency record and the consultation request are the opinion and observation of Dr. W. As stated by Commissioner Work in order H2005-007:

> [para 48] Opinions and observations are subjective in nature. Opinions, even those based on the same set of facts, can differ. Dr. X may see a patient and form the opinion that the patient has the flu. Dr. Y may see the same patient and form the opinion that the patient has a cold. HIA does not compel custodians to resolve these differences of opinion by forcing physicians to change their opinions under the guise of correction. For example, in Order H2004-004, I said the physician's notations of "paranoid" and "personality disorder" were professional opinions and the physician's notation of "unable to get along with people" was a professional opinion or observation that the physician could refuse to correct (para 24).

[para 46] Previous orders of this office indicate that once it has been established that the health information in question is an opinion or observation of a health service provider about the Applicant, the burden of proof shifts to the Applicant to show that there has been an error or omission in that person's own information. In Order H2005-006, Commissioner Work states:

> [para 75] In Order H2004-004 under HIA, I previously said that an "error" is a mistake, or something wrong or incorrect; an "omission" is something that is missing, left out or overlooked (para 10). "Correct" means to set right, amend, or substitute the right thing for the wrong thing (Order H2004-004, para 11).
>
> [para 76] In Order 97-002, the former Commissioner said "fact" means a "thing that is known to have occurred, to exist, or to be true; an item of verified information" (para 42). That interpretation is adopted in a number of Orders issued from my Office. In Order 97-002, the former Commissioner said a fact is information that could be determined objectively (para 43).

[para 47] The Custodian, in submissions, asserts that "it is not sufficient for the Applicant to merely allege that the information is wrong or missing without establishing

the correct or complete facts or the true version of events. The Applicant must provide sufficient evidence to prove that a factual piece of information recorded in the records is in error.

[para 48] The Applicant has not raised any objections or concerns regarding Dr. W's notes on the Emergency Record. The Applicant, in submissions indicates that Dr. W's opinion about her is not correct. As indicated above, professional opinions are, by their nature, subjective. They do not have to be correct. The Custodian correctly refused to correct this record.

4. History (5 pages)

[para 49] From the Applicant's submissions and her handwritten notation on this document, I infer that she wishes that the Physician responsible be identified on the top of each page of this record. I note that page 4 indicates that the record was dictated by a student intern. The last page indicates that the record was edited by Dr. C. the day after dictation and electronically signed by Dr. C. at that time. I find that there is no correction to be made on this record.

2. Other Documents (Nurse's Record, Neurological Vital Signs and Patient Care Record)(3 pages)

[para 50] From the Applicant's submissions, I infer that she wishes additional information on these records. She lists various incidents that she states were not included in the records. I take it from this that she believes that there are omissions in her health information.

[para 51] One of these incidents is, as she states it: "how there was no HBP readings taken in that room, until late in the PM." I see from the Nurses Record that the Applicant was taken into the room that she refers to at approximately 12:05 p.m. and remained there until 6:45 p.m. On page 4 of her submissions, the Applicant indicates that at approximately 2 p.m. she had heart palpitations and the nurse took blood pressure readings at that time. The Neurological Vital Signs record shows that blood pressure readings were taken at 5:00 a.m, 7:00 a.m., 7:37 a.m. 10:15 a.m., 2 p.m. and 4:45 p.m. The 2 p.m. readings were elevated along with a high pulse rate and respiration rate. This is also recorded in the Patient Care Record next to the 1400 time.

[para 52] I cannot see that there is any correction to be made with respect to this incident as the fact that the Applicant's blood pressure reading at 2 p.m. was recorded in two different records.

[para 53] The Applicant also wishes certain of her reactions to events to be listed. For example, she wants the question that she asked the nurse "Why are you doing this to me?" to be recorded. The Act does not allow for the Applicant to add information unless it is corrected health information. I cannot see that there is any correction to be made.

Conclusion

[para 54] I have found above that the Custodian failed in its duty under section 13(5) of the Act when it failed to provide the Applicant with the actual reason it had decided not to correct the 'Crisis document' – a record that was key in terms of the decisions that were ultimately made about her.

[para 55] Section 14(1)(b) states:

> *14(1) Where a custodian refuses to make a correction or amendment under section 13, the custodian must tell the applicant that the applicant may elect to*
> …
> *(b) submit a statement of disagreement setting out in 500 words or less the requested correction or amendment and the applicant's reasons for disagreeing with the decision of the custodian.*

[para 56] The failure by the Custodian to provide the proper reasons in its initial response meant that the Applicant did not have an opportunity to properly consider her options with respect to that record. Her choice to request an Inquiry rather than requesting that a statement of disagreement be appended to her health records was therefore not a fully informed choice.

[para 57] There seems a reasonable possibility that the Applicant would have chosen to make another correction request to the other body that created that particular record, before deciding whether to request the Inquiry. In any event, there is no way to know whether, had she been fully informed, she would have decided to request the Inquiry with respect to any or all of the records, and therefore to forego her opportunity to provide a statement of disagreement with respect to any or all of them.

[para 58] On this account, will I order the Public Body to provide the Applicant with a new response which sets out its actual reasons for refusing to correct all the records, which will give the Applicant a new opportunity to make her choice as to which step she wishes to take. I urge the Applicant to have regard to my findings above in making her decision as to how to proceed.

V. ORDER

[para 59] I find that the Custodian correctly refused to correct health information of the Applicant.

[para 60] I find that the Custodian failed in its duty to the Applicant to respond openly, accurately and completely. I order the Custodian to provide the Applicant with a new response that sets out its actual reasons for refusing to correct all the records, as well as

providing her with a new opportunity to choose among the options in section 14(1) of the Act.

[para 61] I make this Order under section 80 of the Act.

[para 62] I further order the head of the Custodian to notify me and the Applicant, in writing, within 50 days of being given a copy of this order, that it has complied with this order.

_____

Neena Ahluwalia Q.C.
Adjudicator