STANDING COMMITTEE ON INTERGOVERNMENTAL AFFAIRS AND INFRASTRUCTURE

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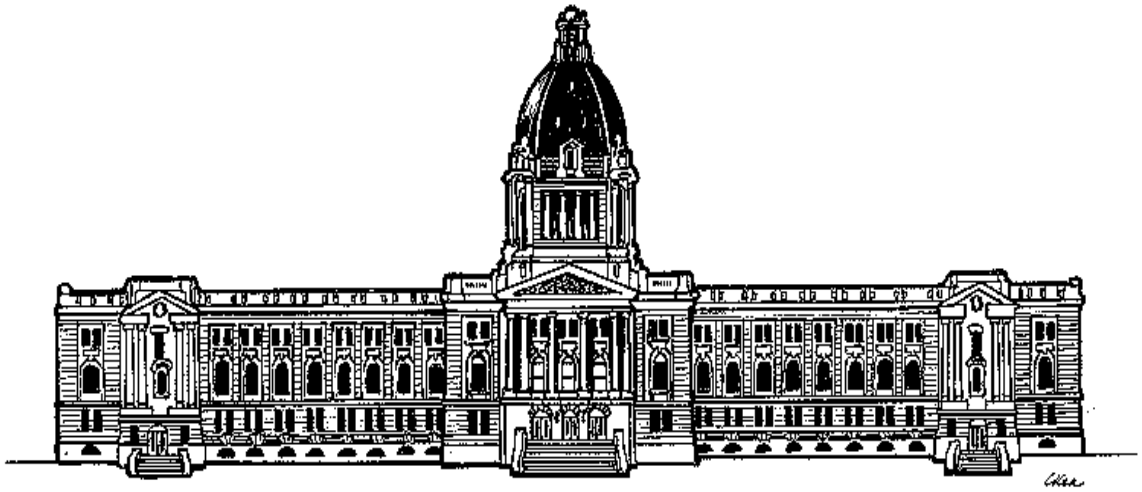

Legislative Assembly of Saskatchewan

Twenty-fifth Legislature

STANDING COMMITTEE ON INTERGOVERNMENTAL AFFAIRS AND INFRASTRUCTURE
2007

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[The committee met at 13:30.]

Bill No. 20 — The Gunshot and Stab Wounds Mandatory Reporting Act

The Chair: — Well good afternoon. We'll reconvene the Standing Committee of Intergovernmental Affairs and Infrastructure. Today we have chitting in for Mr. Iwanchuk . . . Ms. Crofford is chitting in for Mr. Iwanchuk. And I see that we're all here and that this first set of witnesses before our committee is the Saskatchewan Union of Nurses. I will ask their spokesperson to introduce herself and her guests.

Ms. Romanow: — My name is Marg Romanow. I'm the benefits officer on staff with the Saskatchewan Union of Nurses.

Ms. Nezima: — I'm Linda Nezima. I'm the director of operations with the Saskatchewan Union of Nurses.

Ms. Gerlach: — And my name is Loretta Gerlach, and I'm a employment relations officer with the Saskatchewan Union of Nurses.

The Chair: — Thank you very much. I remind you, you have a maximum of 20 minutes for your presentation, and after that we'll have a period of question and answers. So we'll have your presentation now, please.

Ms. Romanow: — Thank you. This is the SUN's [Saskatchewan Union of Nurses] submission to the Standing Committee on Intergovernmental Affairs regarding Bill No. 20. The government has proposed legislation, Bill 20, which would require health care workers to report to police the names of patients who've either been shot or stabbed. SUN does not support this legislation, and we ask that this legislation not be enacted.

We believe that the requirement of the legislation unnecessarily involve health care workers in police work. We do not believe that the negative impact to health care settings is justified by the intent of this legislation.

We believe that many other initiatives can be taken by government to reduce crime without interfering in the delivery of health care. Bill 20 would require nurses to report information to police without patient consent. We believe that this is a violation of nurses' professional responsibilities to maintain patient confidentiality. These professional responsibilities are outlined in The Registered Nurses Act, another piece of legislation in Saskatchewan.

We believe that releasing information without the patient's consent is also breaching the rights of the patient. Consent in the health care system is an integral component in these settings. There does not appear to be sufficient and valid reasons supporting the creation of this law to void the consent requirement for the release of patient information. The patient's right to privacy regarding their personal information is outlined in The Health Information Protection Act. Furthermore this may also be considered as a violation of a section of the charter of human rights.

If this legislation is implemented, health care facilities will be required to produce policies to implement the provisions of the Act. The policies will support the legislation in the requirement to report to police. The employer can then invoke discipline upon a health care worker who fails to follow the policy. We anticipate that the nurse would face discipline by the employer for failing to comply with Bill 20. Yet if the nurse complies with Bill 20, the professional nursing organization could also discipline the nurse for not protecting the public by reporting patient information without patient consent, which as we said is a violation of The Health Information Protection Act. The passage of Bill 20 would place nurses in this untenable situation. From SUN's perspective there is no professional nursing rationale to justify breaching patient confidentiality in this case.

A quote from the Saskatchewan Registered Nurses' Association correspondence in 2005, written by the Saskatchewan Registered Nurses' Association, was referencing the nurses Act and it states:

> While respecting all legislation, including the OH&S Act, a registered nurse is called upon to be a patient advocate, [to] use her professional judgment, and bring his/her concerns to his/her employer or the appropriate authority.

The Registered Nurses Act requires that nurses are foremost a patient advocate. Nurses have the training and ability to exercise their professional judgment as to the necessity to contact the police if and when the nurse assesses that it is necessary to do so. As nurses, our priority is to be a patient advocate and to protect the rights of the public as patients. The reporting inherent in this legislation does not encompass sufficient rationale to require that nurses share this confidential information, and we believe there is no justification by doing so to supersede patients' rights.

Reporting to police would unnecessarily violate patient privacy. The nurse would have no assurance that the security of the information that is being provided will be maintained. The nurse remains responsible for the security of the patient's information. The nurse is accountable to releasing confidential information to only secure systems. This legislation could lead to unrestricted or unprotected exchanges of private information between health care workers and police when there are insufficient provisions in place to secure this information.

The legislation requires that the patient name, the name of the facility, and to quote, "any other prescribed information," be reported. We are gravely concerned that the term any other prescribed information will mean all medical information relating to the patient. This would equate to a significant breach of confidentiality unnecessarily.

As health care workers, we are aware there are instances where nurses do report patient information when it involves child or sexual abuse. We understand the critical importance of reporting these heinous situations, and that this reporting is justifiable. We fail to understand the necessity of breaching patient confidentiality for an earlier commencement of a police investigation. Our responsibility in health care is providing optimum patient care and not law enforcement. If this

legislation is passed, will other aspects of privacy be jeopardized by future, further legislation based on similar rationale?

We believe that insufficient rationale has been established to warrant this legislation. No other province in Canada has a similar law. We are aware that Ontario requires only the reporting of gunshot wounds and not stab wounds. We do not consider that any evidence has been made available to support that this Bill will reduce crime.

Some believe that the release of this information would jeopardize the trust and the professional rapport and relationship between health care workers and their patients. We also submit that this legislation could deter patients from seeking health care services. Victims of crime would see health care providers as extensions of police rather than people concerned primarily with the health of the patient. In situations involving attempted suicide, the involvement of the police would not be conducive to the psychological well-being of the patient. Despite this fact there are no exemptions to the latitude of this proposed legislation.

The reporting of these incidents required by this legislation would initiate police investigation. We are concerned that a police investigation conducted while the patient is in a health care facility would disrupt health care services. Following a report, can the police in any number and at any time enter the facilities and interrogate the patient and/or the nurse? This unknown is quite disconcerting. A nurse's priority is patient care, and those services should be the priority of any health care facility.

Police investigations should not be interfering in the health care processes. Police investigations should be conducted, as they always have been, outside of health care. If patients are to be interrogated in their hospital beds, could this be considered as a further breach of patient's rights according to sections 8 and 9 of the Charter of Rights, in that these patients are being detained without proper cause and no option to refuse?

Another factor to consider in this legislation is the safety of health care workers. We believe that this legislation will jeopardize the safety of health care workers. The call to police may involve a negative reaction from the patient. The patient who is allegedly suspected of gang violations will hold the health care worker directly responsible for police involvement. The health care worker maintains constant contact with that patient and therefore will bear the brunt of any retaliation. The commencement of a police investigation within the health care facilities may create further animosity between health care workers and the patient and may involve family or acquaintances distraught with the police involvement.

SUN is aware that some nurses may personally welcome this legislation because it will dictate that police will be called or shall be called. Some nurses have struggled with their decision when and if to contact police. The police association has also mentioned this situation to support the need for this legislation.

We believe that nurses should not be faced with this dilemma of whether or not to report to police. Policies of the health care facility should have clearly established that there are legislative requirements to maintain the privacy of patient personal information, and those patients have the right to retain consent to the release of personal information.

If these legislative requirements have not been adequately communicated to health care workers, new legislation is not the means to do so. Health care facilities should ensure that all health care workers are aware of the legislative requirements within their workplaces at this time.

The requirements for privacy dictated by the professional nursing entities — both The Registered Nurses Act and The Registered Psychiatric Nurses Act and the privacy legislation, The Health Information Protection Act — supersede any temptation experienced by nurses to call police based on their personal opinions regarding moral issues or a sense of community obligations to report crime. Health care workers must abide by their respective nursing Acts and The Health Information Protection Act while at work. To not abide by these Acts is not an option.

We believe that any considerations that this legislation could potentially positively impact the safety of health care is misdirected. Safety in health care facilities is the responsibility of facility administration as dictated by occupational health and safety legislation. Concerns regarding safety in health care are to be appropriately addressed by the occupational health and safety legislation and not this proposed legislation. If nurses or any other health care worker believe they are in danger, there should be policies in place to address these situations. Health care workers have exercised their professional judgment in seeking appropriate assistance when necessary and in accordance with the policies of their facility.

The legislation at this time only refers to the verbal reporting. We anticipate that at some point the occurrence of the verbal report will be documented. We expect that the first health care worker to contact the patient may be the individual required to execute the report. That health care worker's name will now be in a document to provide proof that the report to the police was made. We believe that this situation will significantly increase the chances that the health care worker will be called to testify in future court proceedings. In establishing the probable cause of the incident, that nurse may be required to provide evidence of the circumstances regarding the report. This is an unnecessary risk to impose on health care workers who already work in stressful environments.

It is well known that health care facilities are understaffed and that health care workers face tremendous workloads. Administration staff of health care facilities are also facing exorbitant demands. Employees of health care facilities need not be faced with the processes involved with this type of legislation. Policy development, staff education, communication regarding the implementation of this legislation would be time consuming and impose additional stressors on a system that has many other priorities to address.

Furthermore, the required time for additional documentation, the actual reporting, and the interferences by the police investigation are additional burdens to health care workers. Health care workers have many other, more critical priorities.

SUN was not consulted in the drafting of this legislation. Most of the situations which would require the enactment of this legislation will involve nurses. We are disappointed that we were not asked to consider the impact of this legislation. As a result we do not know what facility means in the legislation. Does it mean all health care entities in the province including home care, public health, long-term care facilities, ambulance attendants, paramedics, medical clinics, first responders?

The legislation suggests that the facility will be responsible for reporting to the police. What individual in the facility will that be? Will the responsibility lie entirely with the chief executive officer of the region? Will the responsibility remain with the administrative staff of the health region? We suspect that the responsibility to report will be the first health care worker to contact the patient and identify that the injury involves either a gunshot or stab wound.

The legislation does not mention the consequences of failure to report. Is it anticipated that employers should discipline health care workers for failure to comply? If a nurse evaluates her workload and deems in her professional judgment that her patient care is a priority and the report to the police is not a priority, will the nurse be disciplined? We believe that SUN members experience excessive stress in the workplace at present and do not need to be concerned regarding the potential of any discipline as a result of this legislation.

SUN's opposition to this legislation in no way is intended to obstruct justice or support crime. We believe that this legislation does not focus on the root cause of crime, which should be the priority of the government. In opposing this legislation, nurses are not preventing police from doing their work. Police have investigated crimes and have functioned without this legislation in the past.

We do not see the rationale, that by imposing on health care workers to report only certain types of crime, that gang violence will be diminished. Only two types of attacks are covered by this legislation. We do not believe that any of the potential merits of this legislation in its limited coverage will offset the negative effects that it will have on health care work. We encourage the government instead to look at programs and services that would address the root causes of crime and gang violence in this province.

This legislation is apparently intended to reduce crime and/or gang violence by having the police start an investigation sooner. We question the success of this endeavour, because is it realistic to believe that the patient, for instance the suspected victim of gang violence, will be compliant in sharing information with the police when they arrive in the health care facility? We submit that police will be involved unnecessarily with no positive outcome in their investigative efforts from the liberties provided to them by this new legislation.

In conclusion, SUN requests that this legislation not be enacted. We submit that the rationale for this legislation is not sufficient to interfere with the rights of privacy for patients under The Health Information Protection Act and the professional responsibilities required of nurses under The Registered Nurses Act or The Registered Psychiatric Nurses Act, and the delivery of health care services in Saskatchewan. We thank you for your time.

The Chair: — Thank you very much. The first set of questions will go to the opposition members. Mr. Morgan.

Mr. Morgan: — Thank you very much for your presentation. We appreciate the time and effort that goes into preparing a detailed brief such as this.

As legislators, we have to go through a difficult process of trying to weigh the needs of a timely, well-focused police investigation versus the rights of doctor-patient privilege and the privacy rights of patients.

And we're very mindful of the fact that, as difficult as it is for us, we only go through the process once. And whatever legislation this government chooses to pass, we know that the nurses and doctors have to live with it for a long time. So we want to be very cautious and very careful in the deliberations in here, everything that's come forward, so that hopefully we can strike a balance that will probably not please everybody but can at least be seen to provide something workable and give our police a tool that will further the ends of justice. And we realize that there is a concern expressed by the Privacy Commissioner about function creep, where the medical profession would be moving into a judicial function, and we appreciate that that's a valid point.

What I would sort of like to ask you is a hypothetical situation. You had indicated in your presentation that there was some professional discretion that you would use when you would choose or when a nurse would use to call a police officer. And I'm wondering when, if you give us an example of that.

And one of the examples that was put forward yesterday was that of an unconscious patient that arrives at the hospital, doesn't regain consciousness for several days or doesn't regain consciousness at all and ultimately expires. At what point do we give some information to the police, or do we start a police investigation? Do we assume that because somebody's unconsciousness when they went in, that they would want the police called, or do we make the assumption that they would not want to?

Most people that are victims of crime would probably want to involve the police . . . [inaudible] . . . so I'm sort of wondering, you know, how you'd, sort of what the default position might be. So anyway if you want to give some comments sort of to as the practicalities of how it is and I'll let you . . .

Ms. Romanow: — Well for the example of someone coming in to the health care facility unconscious, that does happen, and in those cases, that maybe their family is unable to be contacted for several days if they have no identification on them. And I guess the point that we question is that, why are different patients treated differently? Our role in nursing is to treat everyone the same. So whether they come in unconscious because of a stab wound or unconscious because of an overdose, why should that be treated differently?

We're responsible for the patient's rights, and that patient should have the right to consent. And if they're unconscious, then obviously they can't give that right and that there may be a

delay in contacting family. But the person that's coming in with a certain type of wound should be treated no different from our perspective than any other person who comes in, in that same situation.

Mr. Morgan: — You had indicated that you would contact the police in the case of a sexual assault. And I don't want to rank order or get into a discussion of what's a more serious crime — a sexual assault or a person that's been shot. But what would be the rationale to say, we're calling the police because it's a sexual assault but we won't for somebody that's been shot. You know, I'm trying to sort of understand why we would extend the rights or the privacy rights to one type of victim but not to another.

Ms. Romanow: — And perhaps I should have been more clear, but it's a sexual assault of a child.

Mr. Morgan: — So a sexual assault of an adult, a person over 18 you would not so . . .

Ms. Romanow: — No. And there are many other situations where patients come into the hospital that perhaps one might feel compelled that perhaps someone should be notified, but we don't. We never have. We have to abide by our obligations to maintain the privacy of that patient. And there's other pieces of legislation that require that and they were put in place for a good reason.

Mr. Morgan: — You have indicated, your sort of closing remarks are that you would not want the legislation enacted. If the legislature chooses to go ahead with it, is there a compromise or a different form of this legislation that your group would have a greater level of comfort with?

Ms. Romanow: — Because this legislation is very minimal at this point in time, it raised more concerns and questions that I don't think we could be comfortable with. I mentioned a few of them. What does facility mean?

Mr. Morgan: — What does a stab wound mean?

Ms. Romanow: — What does a stab wound mean? You know, then and we're only reporting certain crimes, and where would this end? If we enact this, we worry that the patients' rights will continue to erode as maybe beatings are included or other . . . Like where will the patients' right to maintain their privacy be left?

The Chair: — Mr. Yates.

Mr. Yates: — Thank you, Mr. Chair. I do very much appreciate the work that's gone in and the effort that's gone towards making your presentation. I do however have a couple of questions. You had indicated in your presentation that legislation prohibited you from disclosing this information. I'm going to quote now directly from The Health Information Protection Act, section 27(4)(a).

Ms. Romanow: — What section?

Mr. Yates: — Section 27(4)(a). It says:

> A trustee may disclose personal health information in the custody or control of the trustee without the consent of the subject individual in the following cases:
>
> where the trustee believes, on a reasonable grounds, that the disclosure will avoid or minimize a danger to the health or safety of any person;

And there are other criteria. But in this particular case, if you believe that by disclosing that information to the police or to any other individuals — it may be social workers or others — to assist somebody that may be in danger or even in potential danger, you clearly have the authority to disclose information. And health care professionals do disclose information. As an example, it's mandatory to report of sexually transmitted diseases.

So if we have a situation where an individual comes into the hospital and has been the victim of a violent attack with a knife or shot, how do we know that there aren't other potential victims still in the home, there aren't children involved back at a potential residence? It's very difficult to know. And there is a potential that others, if you have somebody out there that's attacked an individual with a knife or shot somebody, that there may be other victims, and this is the one victim that was able to reach hospital. So by in fact informing the police, you're living up to what The Health Information Protection Act would expect.

Now I do know that we take very seriously, as well as you, the protection of and the privacy of health information, but I'd like to have your viewpoint on how you sort of square those two things, which clearly there is an anticipation here in the HIPA [The Health Information Protection Act] regulations and HIPA Act that in fact we would disclose that information for the protection of others.

Ms. Romanow: — And I think the key is the reasonable grounds. This legislation doesn't establish reasonable grounds. Any stab wound, any gunshot wound and not beatings. So I think trustees now, under The Health Information Protection Act, based on reasonable grounds . . . And nurses will call police when they in their professional judgment deem that there is an unsafe situation. They do that now when they have exercised their judgment.

The Chair: — Mr. Trew.

Ms. Gerlach: — Could I just add something? And I'm not sure that's quite the applicability of that section. So to your example where you talked about there might be other people in the home who are, you know, in danger. There might be serial sexual assaults taking place in society, and there might be serial beatings taking place. There might be abusive people who are circuiting in social settings all the time who abuse, you know, engage in common assaults on a regular basis. We don't enact that legislation at that level for that.

In addition, the trustee — if you go back to the definition — isn't the individual front-line health care provider. It's the region — right? — and so those assessments, when they are made, are made with careful professional distinctions and consulted with administration before that sort of thing happens.

And so I just wouldn't want us to mistake in the sort of purpose of when that part of HIPA is currently used in accordance with the direction from the Privacy Commissioner.

The Chair: — Mr. Trew.

Mr. Trew: — Thank you, Mr. Chairman. I know Mr. Yates would like to get in again, but we're sharing the questions on the government side. Thank you for the presentation, Ms. Romanow, and for your supporters.

I urge that you on behalf of SUN look at the testimony that was . . . and presenters from yesterday as well. Get a copy of *Hansard*. Because these issues were not necessarily dealt with to your satisfaction, but they were addressed yesterday. We attempted that.

And I can only ask you one question, and then I have to pass the baton. I do want to make the observation before I go to my question. I think committee members generally accepted the premise that silence is a tool of the perpetrator. And silence, if we are silent every time there is some violence done to someone else, our silence enables further violence. That resonated, I think it's safe to say, with most of us committee members.

I want to deal with the mandatory reporting versus discretionary reporting, and I'm asking for your views on this premise. My belief is that a mandatory report, given the best set of guidelines we can come up with — that's part of the job of the committee, part of the job of the Department of Justice, part of the job of us seeking advice — but if we can come up with a mandatory reporting, it takes the onus off of the RN [registered nurse] or off of any health professional. Then there's no purpose for retribution because the health care professional — whoever it is that's mandated — is simply following the law straight up; it's not that they have an option. If we give an option and it's a discretionary report, then all of a sudden, shame on that health professional for reporting, you know; I think that they did the wrong thing, if I'm involved, and I might take exception.

And it's particularly worse I think in a smaller community. Having grown up in a small community, you know, you know everybody. And you know, we knew all of the health care professionals, not necessarily as health care professionals but we knew them in the community. So I'm curious on your comments around mandatory reporting versus discretionary reporting. Thank you.

Ms. Romanow: — In terms of discretionary reporting we believe now if policies are clearly identified to health care workers that there isn't a discretionary option. The Health Information Protection Act clearly identifies that. And as well, registered nurses and registered psychiatric nurses are to maintain patient confidentiality.

We still believe, as we mentioned in our submission, that once a nurse's name is on a report, that patient knows who reported it to the police. Whether it was mandatory or not, they know. And they may not be rational to think it through and determine that it was the law and that that employee didn't have a choice. The fact is they know who did it, who reported it.

And the nurse-patient trust ratio has to be significant to make the health care services be optimal. We have a fiduciary responsibility to our patient and we have a hard enough time doing that in this system, and that we do not believe our responsibility is to do police work.

The Chair: — Ms. Crofford.

Ms. Crofford: — Thank you very much. I, actually when I chitted into this committee, didn't know I'd be involved in such a provocative discussion but it's very interesting. The sense I'm getting is that there's both deep-seated legal and cultural values that the nursing profession holds that are coming into, I guess, conflict here.

One of the things that's always difficult is to balance, if I could put on the table, the notion of public health with individual rights and responsibilities. And I think we're dealing with a bit of a public health issue here where a whole community becomes sick because of an activity that's taking place.

Now my question is, in places where they report gunshot wounds — I think in Ontario — have you had any feedback from your medical colleagues there on really how that's all worked out?

Ms. Romanow: — I did contact Ontario. And the Ontario nurses' union, the Registered Nurses' Association of Ontario, and the college of nursing in Ontario all did not support that legislation. However, it was passed anyway. I do not know any of the statistics since it was implemented.

Ms. Crofford: — Yes. I think that would be very interesting to know really because we can all think what might happen but I wonder what has really happened. I don't know either.

Ms. Romanow: — And you know Ontario is just gunshots. It's not stab wounds.

Ms. Crofford: — Yes.

Ms. Romanow: — And you will be hearing from the registered nurses' association but their focus is the rights of the public to safe . . . protect the rights of the public. And in those terms that's the right for the patients to consent before the information is released.

Ms. Crofford: — . . . I guess my question.

The Chair: — Mr. Huyghebaert.

Mr. Huyghebaert: — Well thanks, Mr. Chair, and thank you . . . [inaudible] . . . One of the things that I'm trying to get my own head around is the difference, I guess, between if somebody comes in with a gunshot or stab wound — and, by the way, I agree; this Bill does not include blunt instrument trauma, for an example, and where it could go. And you mentioned the term facility. And there's a few other issues within the Bill that you've identified that we have looked it.

But if somebody comes in with a trauma, a gunshot — we'll use gunshot — where is it in your code of ethics that you feel that you would be violating patient rights by just phoning the police and saying, we have somebody in here with a gunshot wound?

Is that violating patient confidentiality and privacy of the individual just by making a phone call? You're not telling them anything except that you have somebody in there that has a gunshot wound.

Ms. Romanow: — I believe by the fact that we're calling the police and saying John Doe has a gunshot wound, that's his personal information. His name and his quote "diagnosis" is his personal information and we're releasing that without his consent.

Mr. Huyghebaert: — Just to follow on that. I didn't know that you'd have to give his name by just phoning up and saying, we have an individual that came in with a bloodshot wound. At that point in time your primary focus is on the health care of the individual and we understand that. But you may not even know his or her name at that point in time.

So somebody to call the police and say we have a victim of gunshot wound, and I guess that's where I'm coming from, where the line is drawn between the privacy and the confidentiality between health care provider and the victim. And that's why I'm having this little bit of a trouble in my own mind and saying, how is that violating it if you just phone up out of the blue and say we have a patient or a victim come in with a gunshot wound? There's no name. There's no nothing. That's up to the police to find out when they arrive.

Ms. Romanow: — And if that person came in without any ID [identification] and the police were called, I mean, it will soon become apparent that the patient will be identified by the police. And again it will be without that person's consent. And the legislation at this point in time does require the name. So, I mean, if we know the name, we're going to have to give it and the facility and then any other prescribed information. I don't know what that means, and that causes concern.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you . . .

Ms. Gerlach: — Can we follow up on that answer just one moment? If that were the intent of the legislation, to simply call, I think that even opens the door more for some Charter violations that cause me some concern. So if a nurse were to call the police — and think of a small rural facility, so the RCMP [Royal Canadian Mounted Police] were to come — and say, we have a patient here with a gunshot wound, then what? Are the police allowed to enter the facility? Are they allowed free reign within the facility? Are they allowed to access patients' charts to determine which patient it was that diagnosed with said wound? That would be even more intrusive, I think.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much. In the course of the consultations with individuals across the province, the National Emergency Nurses Affiliation Incorporated, which represents emergency nurses including in the province of Saskatchewan, have taken a contrary position. In fact they commend the government for taking the responsible acts and implementing this legislation. And they polled their members and drew their conclusion from contact with their members.

And I'm just wondering. When you've taken the position that SUN has taken, was it taken in consultation with the membership of SUN, or was it derived from long-standing policies of the organization? Or just how was the position formulated? And why the, I guess, the contrary position from the emergency nurses?

Ms. Romanow: —Yes. And I'm aware of the emergency nurses association survey, and I'm aware of how many people completed the survey. And in talking with the emergency nurses, that's why on page 3 I mention those last two paragraphs, that some nurses welcome this legislation because they were in a dilemma at the moment whether or not to report. And our position is that policy should have clearly identified within health care's existing facilities the legislation that is in place now — in other words, The Health Information Protection Act that requires them to maintain confidentiality.

And though nurses have moral temptations to report, they don't. They don't report if there are other circumstances where they wonder if there was violence involved because there is legislation to protect the right of patients. And health care entities will not be doing police work. Investigations will be done outside of health care facilities.

The Chair: — Mr. Morgan.

Mr. Morgan: — You had expressed concern about the regulations, that the regulations could be used to enlarge the Act or change the type of injuries or redefine things. When we heard the presentations yesterday, I think most of the people — I don't want to speak for everybody — had similar concerns about the regulations being able to vary the scope of the Act incredibly.

I think if the legislature chooses to enact this or this type of legislation, one of the things that we would want to recommend is that we eliminate or reduce the type of things that would be in the regulations so that it's abundantly clear on the face of it and not subject to being changed by an order in council.

I share your concerns with regard to what is a facility, how that might be expanded. For the Act to have any practical application, if you included that just to mean hospitals, what happens to somebody that's brought in by air ambulance? You're not including the staff in the air ambulance, the air ambulance itself, everything else so you're imposing the obligation on the facility which would be a hospital.

So the police, in a Regina hospital, you know, are called because somebody's presented with a gunshot wound. Well they're not, wouldn't even be entitled to the information. The person was brought in from two or three hours outside or flown in from somewhere else. So in that case, we've made the Act so that it's meaningless, you know, and then to try and do something through the regulations makes it difficult. So anyway we share your concerns with that aspect of it and we, you know, we want to wrestle with those things.

The question I have though deals with your concern for safety of the nurses afterwards, and I share that concern. And if this goes ahead, I'm wondering what kind of safeguards would be there.

The way the legislation would be expected to work or, you know, the obligation is on the facility to notify the police just as soon as is practical after the person would arrive there. So you know, once the person is stabilized, dealt with, whatever, you know, the police would be brought in. And then, you know, the expectation would be that a police officer would attend, would want to be told where the patient is and would want to interview the patient.

Being a health care practitioner, I would think you would not want to talk to the police yourselves, nor would I think you would be obliged to under this Act. Your obligation is only as is defined in the Act; you call the police and say we have somebody here with that, with that. But I'm wondering what kind of safeguards might be the appropriate . . . Would it be, you know, deleting the name of the individuals, the health care workers', from whatever report was made, and the report is supposed to be merely nothing more than a phone call saying we have somebody here with a gunshot wound?

So I'm wondering, you know, what kind of safety or what safeguards would give a higher level of comfort to the nursing people, because it's not a risk that I think is one I would want to put in place.

Ms. Romanow: — And we've raised the question of safety of health care workers, that if the patient does not appreciate the fact that their personal information was released without their consent and there is some retaliation against health care staff, we're concerned about that. And we've talked to the police, and they said that they will have the next available car there, and that's a nice gesture. But again, we believe that the investigation can wait until the patient can either consent or has left the health care facility.

We are not assured that there would be proper staff in place to enhance security. Many health care facilities have no security personnel whatsoever. And even those that do, would there be additional staff to address these types of situations? We're not convinced that would be in place.

Ms. Gerlach: — I guess there's also a subsequent concern to that, and it goes back to our lack of understanding about the interpretation of the legislation because if in fact what you had said — which had never been something we discussed with any of our consultations — that it was just a phone call, then I am at a complete loss, as someone with a master's in policing strategies, about how that would be implemented. How then would that aid the police in any way or form, unless it's going to enable the courts to issue a warrant to allow the police to have access to all patients' medical records?

If in fact this legislation simply obligates a medical or a health care professional to call and say there's someone in the General Hospital with a stab wound and that's all that's required, what then would happen? How would this in any way or form aid the police? Would they again have free will to be able to wander about the facility, to have access to a multitude of patients' diagnoses? How would they then proceed to gain any further information, and especially if it was a victim who is also an offender?

The Chair: — Mr. Trew.

Mr. Trew: — Thanks, Mr. Chair. I have one really, really quick . . . it's not really a question but a point of clarification, and then I want to go into my question. The point of clarification is, Loretta, I hear you talking about police officers and would they have the right to enter a hospital. Don't police have a . . . Like, a hospital is a public building right now. I appreciate they can't go into the O.R.[operating room] and, you know, obstetrics while the baby's being delivered under a normal course of events. But aren't they as free to roam a hospital as I, for instance, am?

Ms. Gerlach: — Right. You are free to semi-roam a hospital depending on the time of day. But you wouldn't be accessing any individual patient's room. You wouldn't have access to a patient's file, a patient's diagnoses or even, for that matter, who a patient is in any given unit on a facility.

Mr. Trew: — Thank you. The concern is around HIPA, The Health Information Protection Act . . .

Ms. Gerlach: — Absolutely.

Mr. Trew: — Not so much the policeman walking up and down the corridor or . . .

Ms. Gerlach: — Right. Absolutely. Sorry . . .

Mr. Trew: — No. That's fair enough because that's where I wanted to go. The Health Information Protection Act was passed by the legislature, presumably in consultation with professional organizations that would have something to say about it. I'm not saying that the consultation was as effective as any of us would wish it to be; that's not where I'm going. But the intent of the Act was what legislators wanted it to be, primarily government side but we had our go at it here.

What this is proposing to do, as I understand it from hearing from the Minister of Justice yesterday, is you'd name John Doe is at the Regina General Hospital, emergency department, suffering from a gunshot or a stab wound and that's it. This is not whether John Doe has some disease or not, whether he's, you know . . . any of his health — just the immediate. There's a gunshot or a stab wound because that's all that the police would be interested in. I don't believe that there's a need for the health record to go beyond that. If that's the case, are you a little bit more comforted?

And I'll close with the comment that it's my belief that many people in the general public today think that if I present myself into the General Hospital with a gunshot wound, that the police would be called. Many people think that that's the law today and would be shocked to know that it may not be in fact the case. So that's kind of a broad-ranging question, but I'd appreciate hearing your response.

Ms. Romanow: — I guess what we are saying is there is a law today, and it's HIPA. And it was put there for good reason. And this is violating HIPA. And if there was sufficient rationale to say that HIPA must be trumped, like child abuse is . . . child sexual abuse trumps HIPA, that circumstance, and we looked at that. Will it reduce crime? Will it reduce gang violence? Will the investigation starting earlier reduce crime? And we concluded no.

The investigations will still continue as they have with police work and that we have many more priorities in health care than police work. And that if this is to be targeted at gang violence, it's our understanding in talking with police that most gang members will not talk to the police anyway. So to violate everybody's patient's rights to say that perhaps it would reduce gang violence, again we don't see the justification in this legislation.

The Chair: — Ms. Draude, you'll get the last question.

Ms. Draude: — Thank you for your presentation. Can you give me an idea how many times in the last year or number of years a scenario like this would have presented itself to one of the members where they would have had to phone the police?

Ms. Romanow: — I'm sorry; I wouldn't have the numbers. But certainly in inner city hospitals, I am sure there are a number. But there are also a number of other crimes that occur that this wouldn't assist with either.

Ms. Gerlach: — Yes, I mean it's as simple . . . And that would be, I guess, a good question for us to be asking the proponents of this legislation because, I mean, there's no question in our mind — and we've spent a lot of time talking to members and researching this — that this will lead to a violation of section 15 of the Charter of Rights and Freedoms, and so this state can violate section 15 of the Charter of Rights and Freedoms. The Supreme Court has ruled on two premises: that there is a pressing and substantial social problem and that their response is justifiable in a democratic society. And I guess at this point I'm having a lot of difficulty being able to answer that I think this is a justifiable response.

I'd be the first person to recognize that gang violence has grown substantively in urban centres in Saskatchewan over the last six years, however. And so does that make a substantial problem? Perhaps. But I'm not sure that that justifies the vagueness of this legislation and what could be a very broad applicability to roll back key privacy rights that have repeatedly been enforced by both our Privacy Commissioner in this province as well as the Supreme Court of Canada.

The Chair: — Thank you. That concludes the time. I'm sorry that concludes the time. Okay. Mr. Huyghebaert.

Mr. Huyghebaert: — I'd just like to thank SUN for their presentation and the answers that you've given us. There's a lot of questions out there yet with respect to this Bill, and we would from our side really like to thank you for your presentation and your comments.

Ms. Gerlach: — Thank you for your time.

The Chair: — We would like to say thank you to you for coming in and letting us share in your position. Thank you very much. The next witnesses before the committee will be the Saskatchewan Federation of Police Officers and if we can have them take the witness chair as soon as possible.

Good afternoon and thank you for appearing before our committee. We'll ask your spokesman to introduce himself and then the rest of the guests at the table.

Mr. Bray: — Well good afternoon, Mr. Chairperson, and committee members. I'd like to thank you very much for the opportunity to have us here. A lot of familiar faces around the table. I think at one point or another I've spoken to most of you, but I will introduce myself and who's here with me today.

My name is Evan Bray. I'm the vice-president of the Saskatchewan Federation of Police Officers. I also sit on our national Canadian Police Association board as the Saskatchewan rep. I'm also on the executive of the Regina Police Association, and I'm a corporal with the Regina Police Service who just happens to be working today.

I've got with me a couple of members that . . . one is a current member. To my right is Darren Wilcox. He's the vice-president of the Regina Police Association and also a sergeant, a street sergeant working in patrol with the Regina Police Service. And to my left is Bernie Eiswirth. He's the executive officer of the Saskatchewan Federation of Police Officers and a retired member of the Regina Police Service who ended his career in polygraph, so he's here today to determine if there's any lying going on in the room which I'm sure there won't be.

The Chair: — Thank you very much. I just want to remind you, you have 20 minutes for your presentation which will be followed by a 30-minute question period and answer period.

A Member: — Three minutes?

The Chair: — Twenty minutes, twenty minutes for your presentation; 30 minutes for questions and answers.

Mr. Bray: — No problem. I was going to . . . I thought maybe I'd have to speak as quickly as Clive Weighill did last night because he's a fast talker, I know.

Well I would just like to again thank you very much for this opportunity. I do have some things written down. I am going to refer to my notes. But my presentation is going to be very, very informal, very interactive. I know that there's some questions that you're going to have as well.

The Saskatchewan Federation of Police Officers represents over 1,000 police personnel that are members of our organization from police associations in Regina, Saskatoon, Prince Albert, Moose Jaw, Estevan, and Weyburn, and two senior officer associations in Saskatoon and one in Regina, and represents both police officers and civilian police personnel as well.

I would like to take this opportunity on behalf of the Sask Fed to commend the government and the opposition for coming together to get this important legislation to become law. We know that you've heard from the chiefs of police, Chief Clive Weighill, who used to be Deputy Chief Weighill in Regina, so we're very well acquainted with him. He spoke to you yesterday I believe on the Bill. I saw his presentation. And so we're not going to repeat everything that he said because very much everything that he said is what we say as well. And we don't agree with the chiefs that often, so you might want to write that down. But we are sitting here today saying that our position is that of the chiefs'. We agree with what they say.

We know that you've got some questions, so I'm going to touch

on a couple of issues. I had the opportunity to sit in on the presentation that was just given to you by the Saskatchewan Union of Nurses. I've got some comments on some things that were said there, and then certainly welcome any questions.

The first area that I want to talk about is the privacy issue. Municipal police officers in Saskatchewan are governed by the Saskatchewan police Act, 1990, and any violation of privacy is investigated and members face discipline that could result in the police officer losing their job. This is a reality that we deal with every day.

When police officers are hired, we take an oath of secrecy and confidentiality, and privacy is drilled into officers from day one. So our reporting systems are safe. They're secure, and we know what confidentiality is. Without sounding corny, privacy, confidentiality, security is our life. It's like saying danger is my middle name, but that's the reality. That is the case. We deal with issues every day that are safe and secure and not for public consumption.

So whether I've pulled someone over and given them a traffic ticket, whether I attended to your neighbour's house for a domestic dispute, whether I go to the hospital to investigate a gunshot wound, or whether I'm called to a barking dog — that's a confidential matter, not something that I would share with any member of the public and not something that I would even share within certain confines of our police department.

Confidentiality is not something new to us and so privacy is what we build our careers on. That is what we build our job on. That is the basic pillar of so much of what we do. This is not something new to us. So the privacy issue I know is something that was raised by the nurses saying that, you know, they're violating privacy, their patient's privacy when they notify the police and have us attend.

The preservation of life and property. The preservation of life is a police officer's number one priority, which is no different than health care. Their number one priority is to make sure that people are safe, fix them if they're not feeling well, make sure that they are able to remain healthy, and make sure that they survive if it's an attack or if something has happened to them that is so malicious that their life is in danger. That's no different than what we do. Whether that's at an accident scene, whether it's at a house, or whether it's at the hospital, it's no different than what we do, and we will not let an investigation get in the way of . . . We'll not endanger someone's health. We would never do that. I never have, never will, and nor will any police officer.

I'm going off some notes that I made off the presentation that I heard from the Saskatchewan Union of Nurses, and I just want to talk about a couple of things. One of the early things that was discussed was the report of a suicide, a suicide attempt. I don't think it's shocking for you to hear that as a matter of course for us, if someone attempts suicide with the use of a firearm, we go through an application process for a prohibition of firearms. That's something that we do because we say that it's in the public's interest that this person perhaps not possess or be around firearms. That's something that we would do.

So I know there was a concern raised that a suicide isn't necessarily something that police need to attend to or need to be reported and made aware of. I would argue just the opposite of that. That is, we attend to suicides unfortunately on a daily basis, something that obviously is kept confidential. But we always keeps the public's safety in mind, and so that there is a real issue there as well.

The safety issue of health care workers when they're reporting these issues. You know, I think that we need to look at the practical terms of how this would happen. This isn't a case where the health care worker in front of the victim is going to be calling the police so that they know that that particular nurse, doctor, social worker, whatever the case may be, has reported it. This is a case where someone comes in, whether they walk in on their own or they're brought in on a gurney from EMS [emergency medical services] with a stab wound, with a gunshot, the health care worker somehow will notify us, whether it's a phone call when they get back to the nurses' station, whatever the case may be. But it's not something that we're asking them to announce loud and proud and put themselves in harm's way or by identifying to the victim that they are doing this. And I know that that was a concern that was raised by them. The reality is that this is actually happening quite a bit right now. Not all the time — I won't even say more often than not — but it is happening quite a bit.

And I know reference was made to that section that is in HIPA right now, which I believe is section 27(4)(a), which the legislation there says that they may contact or disclose to the police if it's in the public interest. And perhaps this legislation wouldn't even be necessary if that was changed to shall — if the word may was changed to shall. I mean that's a minor change that would make a fairly big difference. But they are expected to report suspected child abuse and domestic abuse and should report anything that is criminal in nature.

The reality is, I mean, I'm what I would call a street cop. I work on the street which means I'm at the hospital probably almost daily working with the ground level, front-line health care workers — the nurses and the doctors that work in ER [emergency room]. We've got a great relationship, very good relationship with those professionals. We work hand in hand with them all the time. They want to help us; we want to help them. It's kind of that professional courtesy.

We're in the same business. We want the same things. And we want the same things for our community when we're not wearing these uniforms, which is safety for our community, safety for our families, and to ensure that we make sure that justice is served, to make sure that we don't have people out there stabbing and shooting people and it's able to go unreported. I don't think we live in a community where we want that to happen. So, you know, I think that you have to know that a lot of the front-line health care workers are very, very much supportive.

Now I'm not indicating that the representatives that you just heard aren't giving you accurate testimony of what their rank and file want. But I am saying that the practicality of how it's working right now, we are receiving phone calls from nurses saying, we got someone in bed 8B; you're going to want to come check this out. And it's not necessarily a stab wound. It's a baseball bat to the noggin. And you know what? That's

something police officers should be called to. We should be called to that; we should be able to investigate that. So I think that's very important.

Focus on the root cause of crime was another topic that was raised. It's tough to do that when you're not doing it in a timely manner. We need to be able to investigate. The reporting of a stabbing, the reporting of a shooting isn't just to be able to go and catch the person that did that. It's to gather intelligence. We have units that work full-time in intelligence, in gang-related crimes, and they're constantly gathering intelligence — finding out who's related to who, who's involved with what.

And these investigations, with someone walking into the hospital with a stab in their arm, can turn into so much more than just laying a charge for someone who did that stabbing. It really can. And it provides, the investigation provides public safety. A lot of times it prevents other people from being victimized from similar crimes specifically from that person or by other people associated to them as well.

One other quote that I heard that kind of made me smile is, most gang members won't talk to police anyway. If I had a gang member sitting right there and asked him in front of all of you if he or she would like to talk to me, they're going to say no. If I said that in a hospital bed with a nurse and doctor there, they said no. But I'll tell you right now, most gang members do talk to police. They always do. We have gang members who call police on a regular basis, in the way of informants. This is a very, very common thing.

I worked in a serious habitual offender unit dealing with . . . focused mainly on car thieves. They love to talk to police. They do. We actually build relationships — albeit a bit of a weird and warped one, not the same sort of relationship that we all think of in the traditional way. But we do build relationships with these people and we get to know them, just the same as I can see Kim and have dealt with him before and I might be able to talk to him and address him by his first name. It's no different than someone who stole 50 cars last weekend. When he sees me, he's going to say . . . [inaudible interjection] . . . Yes, well, it's a little different.

A Member: — I can only do two.

Mr. Bray: — But they will. They'll call you by name, and we build relationships with them.

So gang members definitely do talk to police. Now they may not want to when they're laying in that hospital bed, but if we can get in there and get that investigation started, we will be able to get information. And getting that investigation started, the verbal communication is only part of what we would do. There's all kinds of other evidence gathering that we would conduct that would go along with that.

Programs and services, programs and services are great because they educate the up-and-comers and hopefully prevent future crimes from happening. But programs and services don't help the person that's laying there bleeding. And that's where we can come in.

So privacy, the only other thing I want to say kind of on this topic is, right now we're kind of focused in on a situation where a certain group of people are being compelled to report crime that they might not normally have been obliged to report. But privacy is an issue, like I said, that we deal with daily. And just because it may not be a nurse, it might be a neighbour saying, I'm hearing screaming and yelling from next door. We get that every day — someone driving by and says, I just saw a guy laying on the sidewalk on the corner of 5th and Cameron and he didn't look too good. He was bleeding, and he was laying in the snow. We get those calls all the time.

That's how we do our job. We do our job based on people calling us and telling us what happened. Unfortunately we have to; we are forced to be reactionary. There's all kind of proactive thing we can do, crime prevention things we can do. We work on those strategies. Those are in place, and those are working in many different areas. But we investigate and conclude and charge based on people reporting to us. That is how we do our job.

And I think that it's very incumbent on us as a society to want people to be held accountable for their actions if they've done something as serious as stabbing or shooting. That is quite the escalation in crime. That's not a slap to the back of the head like my dad used to give me when I was out of line. That's something that is a lot higher than that. And that's something that we need to be able to investigate and we need to be able to prevent from happening again. And we need to send a strong message and say that this shouldn't happen and we're not going to tolerate from happening.

So those are a few comments around privacy. I've touched quite a bit on health care providers. I had some notes written, but I amended those a little bit after I heard the presentation.

But it is our experience that the doctors and nurses that we deal with want to co-operate. They do feel handcuffed by HIPA. There's no question about that. They, I don't think, totally understand what they can and can't do. I don't know that all of the nurses in Regina understand section 27(4)(a) which says they may disclose to police. I don't know that they do. And maybe we can do a better job of educating them to that, and like I've already said, maybe changing the word may to shall might make a difference.

And one of the last things I want to touch on is investigations. This is obviously a big part of our job. Once police are aware of an injury that is caused by a criminal act, an investigation is initiated. And of course we secure a scene; we gather evidence. We interview people as much as we can at the scene or people that may have been witness to it as well. If a stab wound is reported and through investigation it's found out to be an accident, which could very easily happen, then I know that there might be a concern, well then that person's name would be in a police report or would unnecessarily be disclosed and didn't need to be.

Well the reality is . . . And I'll give you a what if. And I know what they say about ifs and buts . . . [inaudible] . . . were candies and nuts, every day would be Christmas. I know. But anyway what they say . . . If I were to get a call to go to the hospital and someone had a stab wound in their hand, and when I got there we talked to the fellow and he says, I was separating

steaks that were frozen together for the barbeque and I stabbed my hand. Okay. Did that happen to you, Don?

Mr. Morgan: — No.

Mr. Bray: — Well I'm sorry, but you're giving me a look like it did.

Mr. Morgan: — It was the example that came up twice yesterday.

Mr. Bray: — Oh okay.

Mr. Morgan: — I used it. I had driven my spouse to the hospital after she had done it.

Mr. Bray: — Right.

Mr. Morgan: — And then one of the technicians had actually showed us the scars where he had done it, so I think it's a frequent type of homeowner stabbing . . .

Mr. Bray: — Right. Sure.

Mr. Morgan: — . . . And would be, under this Act, reportable. So it was discussed as being . . .

Mr. Bray: — Right. It would be reportable. And I would get there and I would talk to the guy and I would find out what I'm being told happened. And through I guess the small investigation that would happen there, if I say, yes I'd say that's pretty accurate, that's what happened, I wouldn't even be putting a report in on that. I wouldn't. I would be clearing that call saying it was accidental, whatever, and I would be leaving the hospital and I would not be doing the paperwork. I would be going on to the next call.

So we deal with those all the time. I mean we get a call, someone saying I think the . . . something's happening next door. Someone's getting beaten up; I hear a lot of screaming and yelling. And we get there and there's a slumber party happening and there's, you know, 12 teenage boys or 13, 14 boys in the bedroom having a pillow fight. That was an actual call that I went to where, I mean, the neighbour honestly thought something like World War II was happening in the house and there wasn't. Well I didn't put a report in. I didn't ask everybody their name in that house. I cleared it, unfounded, and I carried on to the next call.

So I mean that's the reality of what could happen. And that is a possibility, but we'll deal with those. And I'll tell you, at the end of the day, that's kind of refreshing to get a call to go to a stabbing and find out — I mean if there's such a thing as a refreshing stabbing — but to be able to go and say, you know, it was only some . . . you know, someone made a mistake and whatever. But being able to carry on and not having to go through the investigation, better safe than sorry.

So I guess to conclude, I mean I think that we're looking at our community and our province and we're saying, what type of community do we want to live in? Do we want to live in a community where it's acceptable for people to be shot, stabbed, go to the hospital, not want to report it because they're intimidated? Or do we live in a community where we want to ensure that our public remains safe, that criminals are put behind bars, and that we can continue to educate and promote safety for all members of our community no matter what area of the city or what area of the municipality that they live in?

So we definitely encourage the members of the legislature to enact this Bill into law. We would strongly suggest that the Bill be amended to include any injury caused by a criminal act. This legislation is important. We believe it could go even further to help with the safety of the public and the police. Thank you.

The Chair: — Thank you. Mr. Morgan.

Mr. Morgan: — The Bill, as it's presently drafted, contemplates regulations and has got some definitions that were somewhat problematic. One is the definition of facility. And it talks about facility being, you know, it would be a hospital unless otherwise prescribed by the regulations. If we were to either amend the Act or make recommendations regarding the regulations, what would be workable for police officers by way of a definition of facility so that . . . Because right now, the way the Act is drafted, the obligation is on the facility to report. So would that include in your view — should it include — an ambulance or an EMT [emergency medical technician] if they transported for a distance, or an emergency medical clinic or doctor's office? And I don't know whether this is something that you've given any thought to.

Mr. Bray: — Well I can give an answer to that, and Darren or Bernie might have some thoughts on it as well. But I mean, I think facility is . . . And I mean, I guess a lot has to be built into definitions. But it's representative of the organization, so whether the facility is the hospital, whether the facility is EMS . . . I mean, EMS and the hospital tend to be kind of the same thing. I don't know where EMS would transport someone other than a hospital if they had been the victim of something like a stab wound or a gunshot. So, I mean, the two kind of go hand in hand.

And right now we do have again a very, very good working relationship with EMS. We work hand in hand with them. They are partners in community safety with us right now so we get a lot of information from them as well in the way of, you know, we're transporting someone to hospital and you guys might want to come and check this out. So I don't know if that's provided an answer to you but, I mean, I think facility is taking . . . it's depersonalizing it so it's not saying that the onus is on the nurse. The onus is on the paramedic. The onus is on the facility, which could be the health region, to report it to us. And I mean, that way it kind of takes the onus off of that.

Bernie, do you want to . . . Yes, I mean, time is kind of of the essence in these sorts of things, and an investigation like this, I mean, we want to find out as soon as possible. We've had it happen before where someone has showed up at the hospital with a laceration on their arm, and an investigation has led to a house full of people still fighting or a house full of people that also have lacerations on their arm or the suspect — who's still in the house — passed out or whatever the case may be. Finding out in a timely manner is very helpful to us. So I guess whatever the facility is, it's helpful to find out quickly.

Mr. Morgan: — This Act varies from the Ontario Act. The Ontario Act includes gunshots only. This one's broadened to include stab wounds.

There's two issues that arise out of that. One is that there is no statutory definition of stab wound, and according to Dr. Kendel yesterday there is no specific medical definition of the term stab wound. So I'm worried about the quandary we put health care professionals in by trying to decide what is a puncture wound or a laceration or whatever else. And then Chief Weighill presented last night, and he said that by limiting the Act to only gunshots and stab wounds, we probably catch less than half of the victims of violent crime. That the vast majority of people that would be victims of violent crime would be there as a result of blunt instrument trauma or . . . and oftentimes wouldn't break the skin or even a beating with fists or by hand.

So I don't know whether you would want to see a different definition other than stab wound or your comments regarding the limits to stab wound? Or whether you would like to see it, injuries related to potential or possible criminal . . . sort of your comments whether that you share Chief Weighill's concerns.

Mr. Bray: — Yes. I think that Chief Weighill makes a good point and that's why I brought up in my closing comments that we think that there is room for this to be expanded. I'll tell you there's . . . I've been to so many cases where someone's had a two-by-four across the forehead. And that's not a normal injury. That's not something that you can pass off by saying, I fell down the stairs. Now there's going to be some injuries that that may be the case for, but I think blunt trauma injuries definitely fall into this.

You know, the reality is about . . . and I'll talk about Saskatchewan because our police officers face more and more firearms. Unfortunately guns are . . . It's kind of one of those things — what happened in the States however many years ago is becoming a trend up here. That's true. But the reality is most people in our rougher areas are carrying a knife. So knives are very common amongst, unfortunately, amongst gang members and amongst people that travel in circles where they're highly likely to be victimized by this.

But the other thing is, I mean, I've gone to murder scenes with table legs. I've gone to, you know, I mean, terrible violent attacks with baseball bats. That's not a surprise I'm sure to anybody in this room. So to suggest that they should be treated, you know, less seriously than say something like a stab wound to the arm or a gunshot, I don't think . . . well I know we're not in a position to say that. So Chief Weighill's comments I think are accurate. They're valid, and they are definitely something that we would support.

And you know, I know that there's a concern too been raised about, you know, putting the hospital staff in a situation where they need to assess that, like almost turning them into investigators as to whether or not this is something that the police need to be involved with or not. I don't think that's that hard to determine. I mean there's going to be cases where that happens. But I think of domestic cases where we get calls on quite a regular basis now — usually from social workers within the hospital — where a woman shows up with some bruises on her arm or on her leg and the social worker's saying, you know, I'm not buying the story that I'm being given right now and I think you should look into this further. In many cases there is more behind that. And if there isn't, then I guess no harm done. We've checked into it and there was nothing there. But in the cases where there is something to it, which is a vast majority of them, I think it's important that we are called.

Darren, do you want to bring that up or . . .

Mr. Wilcox: — Well just in regards to gang activity — and we're seeing a lot more of that unfortunately in the urban centres — many times when there's a gang attack there's retribution. And if the first attack isn't reported we have no way of preventing the retribution or the retaliation. And a lot of the times what we can see is the retaliation is often two- or ten-fold. And then we may even see innocent victims being harmed.

So in regards to that, I think if we're made aware — and in particularly with the gang activity — we can do some prevention here and we can have our intelligent units out there saying that an individual from such-and-such a gang has been stabbed, has been beat up, has been shot. We know that probably that gang now is going to seek retribution on the gang that inflicted the injury on that member.

Mr. Morgan: — . . . I'm trying to get a sense of what might happen or how the Act would be used. Presumably you would get a call from the hospital saying that there is somebody that's presented with injuries that would be consistent with either a gunshot or a stab wound. And clearly you're getting the call because they haven't consented to being called. You're not being called on behalf of the patient.

So I guess I wouldn't mind if you'd sort of walk through what you might do. I presume you would go to the hospital and want to meet with the patient. But I'm trying to just . . . How many officers might go? How long would you be there? Who else might you want to talk to? What, you know . . . Would you be looking for information from the nurses? And I presume they're not going to give you any. But I'm sort of wondering what the process might be when you get that call saying that we have somebody here that has refused to tell us to call the police and we're . . . pursuant to section whatever, we're doing that now.

Mr. Bray: — Okay. The call from the hospital gets us in the door and we take it from there. And I can think of literally hundreds of examples from my own personal career where we've gotten the call, we go to the hospital. I don't . . . I have never once sat down a nurse and done a question-and-answer on what they've found because I'll do my own investigation. I will take pictures. I will observe the injuries myself and speak with the victim.

Now if the victim is not able to speak, if the victim is unconscious, then, I mean, I don't expect that I'm going to get much more from the nurse than what I'm going to get from visually walking in the room and seeing that. And again, if that person is in room number one, the trauma room, and is being worked by doctors and nurses and it's that typical ER scene, I'm not walking in there. I won't. I mean I'll maybe get the person's name, and I will wait until things have either calmed down or whatever the case may be.

If that person showed up in a cab, I'm going to find out where that cab came from. If that person showed up in an ambulance, I'm going to find out where they were picked up from. And we may send investigators to the scene, follow a blood trail. We've done that many times in both summer and winter. We'll do anything like that. But as far as the investigation goes, we'll go.

Now many times that person, that victim . . . You know, if you think about it from their point of view, which may be kind of tough to do, but if you get stabbed, my first reaction isn't going to be to call the police. My first reaction is going to be actually to get to the hospital. And when I get to the hospital, I might very well want to talk to police.

So when I get there, one of the very first things that I'm going to do is get them to sign — if they're willing to report and talk to me — to sign a medical release form. We have those with us. That's part of our kit that we carry with us in the police cars every day. They sign the medical release form and then we have access. We can access for court purposes any of their medical documents without having to go to the nurses. That's all done through the records department and produced for court as documents. So we do that.

But, I mean, I would make any of my observations there. If the person has a broken knee and they're sent to X-ray and they come back and while they're sitting there, I'll always say to the doctor, is it okay if I go in and have a chat with them? I've never once had a doctor say, no, you can't. Never once. Because I'm not asking at a time when the doctor needs to be in there doing his or her job. I'm going to ask at a time that I know is fine, and I'll go in and talk to them.

Now if they say to me, I'm not talking to you — which happens sometimes — I'm still going to find out their information, still going to get their name, find out their injury, try and find out where they came from. If there's a house party going on, I might go talk to people at the house and find out what happened there.

But if at the end of the day they don't want to talk to me and I can't determine who did that to them, there's not much more I can do. Whether the legislation is in place for the nursing staff to call us or not, I can only do so much. And so we're going to investigate it as much as we can, but we may not be able to find a charge. But we will be able to find out that person X was hit in the knee with probably a baseball bat or some sort of a blunt object, and person X belongs to this street gang, and this street gang is in a fight with this street gang, and so on and so forth.

We gather intelligence all the time. That intelligence is constantly shared within our police department, within the different sections and plays a huge role in how we do our job. So finding out who did it and charging the person obviously is optimal, but just because that doesn't happen doesn't mean that it wasn't important that we be called.

And when I say gang and gang, I'm not trying to say NDP [New Democratic Party] and Sask Party. I wasn't doing that. I'm just, you know, generalizing. You're a different type of . . .

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, Mr. Chair. I'd just like to start by thanking you for the presentation, and I'd like to go to an issue that's been raised by others regarding the ability of individual citizens to raise a complaint about a breach of privacy and that police in Saskatchewan don't fall under the Privacy Commissioner or an independent body, in the view of some, that would investigate a complaint.

Now what I'd like is some understanding of how a citizen could do that and to know whether or not that I or any citizen could go to the police complaints investigator with a complaint of a violation of privacy and have that independent body investigate a complaint about privacy outside the force itself or the police department itself.

Mr. Bray: — Okay, I will. That's a good question, and I have a good answer. As I said before, we're governed by the Saskatchewan police Act which is, I mean that's I guess the bible to which we do our job. And within that we have some very strict guidelines around what we can and can't do and privacy issues are obviously one of them.

I've been involved myself, personally, with a new process that has just been built in regards and around public complaints against police and against police officers. And I think that it's safe to say that in 2007, it's as easy as it's ever been to complain about the police. And I'm not saying that's a bad thing because I think that we need to work and live in a society where, if people don't feel comfortable with what's happened, they need to be able to go and to lay a complaint.

So we do have a new provincial complaint system in place. And without walking you through all of that, I mean any police service, any RCMP, it's in the phone book where these complaints can be laid, can be lodged. And the reality is that the consequences of a breach of confidentiality could result in a police officer losing their job. That's something that we take very serious.

And so I know that there was some concerns raised yesterday in Saskatoon by the Privacy Commissioner, I believe, around the fact that we don't necessarily, municipal police officers don't fall under that jurisdiction. Well the fact that we fall under The Police Act is no different. Make no mistake about it, we have strict consequences if we breach confidentiality. So it's very easy to follow through on something if police have breached that. We've taken an oath that we won't, and there's consequences that can be as severe as police officers losing their job if that happens. That's something we deal with daily, something we don't take lightly, and something that we know is just kind of a part of our job.

The Chair: — Mr. Trew.

Mr. Trew: — Thank you, Mr. Chair. Mr. Bray, I'm enjoying your presentation. I don't even take offence to the gang reference of Sask Party and New Democrats. I'm not sure I like being referred to as not dissimilar from the car thief that steals 50 vehicles, so I did interrupt there and say there is a little difference. No, we're having some light moments in a very serious discussion, a very serious topic, and I'm glad we're able to do that because it makes things a little easier.

Release of medical information, you used an example where if somebody had a broken knee, you would get the X-ray, and it triggered a thought. I'm wondering what medical information do you have access to? I mean presumably all you need to know is that somebody broke their kneecap with an automobile or with a baseball bat, you know, that's what you're really after. But do you have broader access in terms of the health information? Or is it just that particular injury?

Mr. Bray: — Yes, it is just that injury. It doesn't go back into past injuries or other health information. It pertains to the crime. So let's use an example of a domestic situation where a female has shown up at the hospital and said she got in a fight with her husband and, you know, her arm was sore and hurting. And so we get notified or we find out somehow. Maybe she's called us and said, I'm going to the hospital, and so we show up there. I'll talk to that victim and find out, you know, if she's willing to give me a statement, tell me what happened. And let's say she says yes, absolutely; I'm tired of this. Enough's enough.

She'll give me a statement, and I'll say I would also like you to sign this medical release form. And what this is saying is that we're not going to go back into your health history. We're not going to try and find out anything about your health other than what the injury is to you today as a result of what happened, because this is going to be produced in court as evidence if you agree to this. She says yes, no problem. Then she goes off to X-ray and we find out that her arm was broken.

So then when it goes to court, I get a prosecutor's request saying please get us the medical information because, as you've said on the file, you have a release of information. So our records department gets in touch with the health region, and they get that sort of stuff but only pertaining to the injury that day so that we can produce it in evidence to say yes, there was an injury; it was a broken arm. And here's the notes that the doctor made at the time.

So the patient does have the ability to give us that. And we don't use that for any, you know, sort of a purpose to go back into health histories or anything like that. It's only dealing with what we're dealing with there.

Mr. Trew: — A quick follow-up. If somebody were to be disingenuous, could you, could you go back to the Department of Health records and ask for more? Is there a prohibition or . . .

Mr. Bray: — Yes, I don't think we can. Darren, I don't know if you know, or Bernie. But yes, I think it's only if they've signed and agreed. And then it's only the injury that pertains specific to that day.

Mr. Trew: — Yes. Okay, thanks. Thanks for allowing that brief follow-up.

Mr. Bray: — Yes. And I guess just to throw one other thing in there, like Bernie just mentioned, I mean, if for some reason that there was a need to be able to try and find that information, then we would need to go, like, through the courts in the way of getting a warrant, like getting an actual search warrant to be able to go into the health records. And to do that, we'd have to be able to prove to a judge that there's a need, an evidentiary need for us to get that information. So it wouldn't be easy to do, and I don't really think of a case that we would do that in.

Mr. Trew: — Good. Thank you.

The Chair: — Ms. Crofford.

Ms. Crofford: — Yes. My question is the same one around the question that I asked of the nurses earlier. And that's, they do have the gunshot provisions in Ontario, and is there an indication that it's leading to some of the outcomes it was hoped for? Is it helping to prevent anything? Is it helping to deal with anything? Or is it just much more activity on behalf of nothing in particular? And I'd like your view of that.

Mr. Bray: — Well I can give you my view, but I can't give you actual numbers. And that's something that we can probably get. As I mentioned off the start, I sit on the Canadian Police Association. I have counterparts that work, you know, in Ontario with the PAO [Police Association of Ontario], with the Ontario Provincial Police, and I think that's probably something that I might be able to dig up. And I can do some checking into that.

But the basis of kind of our talk here today is that, my opinion would be and our opinion would be, that yes, that would help. It would. I mean, Darren touched on the payback, the retribution. Someone goes into the hospital with a beating of some sort, a stab wound, a gunshot. There will be payback if it's gang related. There will be unless we intervene. But we'll do the investigation, hopefully arrest and charge the person that's done it. And in many cases that is the payback that they've been looking for, that person is now in jail.

But not only that, I mean, I can think of many times where just because officer A is at the hospital, officer B and C are told by officer A, this person came from a house party at this address. They're going to go there, and I would suggest that you're going to prevent other injuries from happening or that drunk person that did this from going out and doing it to a cab driver on the way home or doing it to a pizza delivery guy, which happens nightly, unfortunately in our city, that sort of thing. So I think that it's the stitch in time mentality, and I think it does make a difference, absolutely.

The Chair: — Thank you. Mr. Allchurch.

Mr. Allchurch: — Thank you, Mr. Chair. Thank you, Mr. Bray, for your presentation today. In the submissions made yesterday and also today by both the Saskatchewan Union of Nurses and also the SMA [Saskatchewan Medical Association], in regards to their submissions, when we ask questions about did they have any consultation before this Bill was written, and there was very little or no consultation between both of them in regards to the Bill.

We know that there's been lots of consultation between you as a police force and the government in regarding this Bill. Was there any consultation taken place between the police and the union of nurses and the SMA and those professionals before this Bill was brought into play?

Mr. Eiswirth: — Yes. As far as I know, no. As far as this Bill goes, we had talked to the chiefs of police about it, and they

were the ones who actually pushed for it, our organization did. But if you're asking did we consult with SUN or someone else, that's as far as I know, no that didn't happen. You know, and I really can't even answer why it didn't happen, you know. It's kind of like, I don't know how much we were consulted or the chiefs of police were consulted when HIPA came in, although it did have some effect on our organizations.

Mr. Allchurch: — Okay thank you. The reason for my question is because from yesterday and even today, what we see is kind of a battle between the police force who want this Bill and I think the public as a whole want it to a point. But yet the other part of this Bill regarding the medical profession, there was little or no consultation between the government and them in regarding this Bill. And as you can see, it puts a lot of pressure on the medical profession, whether it's a union of nurses or medical professional or whatever. So trying to put the Bill through without the other side having some input is going to cause and has . . . is going to cause a lot of problems. I guess I'm wondering why this happened and why wasn't something changed so that they were allowed to put forth their issues.

Mr. Bray: — Just a couple of things, I think that we're . . . I don't know exactly how this process works and where we're at in the process. But I mean, I guess what you're doing right now is hearing from the interested parties. This was a chance for SUN to give their presentation. As far as the position that it puts nurses in, maybe I'm not in a position to comment on that.

But I tend to think that the reason that we've got a policy in Regina for example on domestic violence is that it takes the pressure off the victim. Because when I go to the house and there's an allegation of an assault and there's evidence of an assault, I'm going to lay a charge whether that victim wants me to or not because we know how domestic violence works. We take it seriously. We're going to lay the charge. And that takes the pressure right off the victim because then the victim doesn't really . . . The victim in some cases say, no I don't want to charge him. And we do, because at the end of the day we think there's a need for that. We know how the cycle of violence works.

I think that this takes the pressure off the health care professionals because if I'm a nurse and I'm looking at a guy with a gunshot wound and I got HIPA on one shoulder and my citizenship on the other, and I'm thinking, you know, I'm not supposed to disclose this information although I may — section 27(4)(a) — I may but I'm not supposed to and I don't know whether I should or I shouldn't, but if there's legislation saying I do, then I do. And maybe that is you go to the head nurse who doesn't even deal with the patient, and she calls the police service and says we've got a gunshot wound victim in here, and we would like the police officer down here, and that's how it happens; I don't know how that happens.

But I think, I think that it takes the pressure off them. There's no dilemma. They don't have to worry about whether they should or shouldn't. Is this serious enough that I should? Is this person capable of making a complaint by themselves? It's there and they do it. That's just my feeling on it. But I think it's one that as police officers and working in the services in Saskatchewan, we all share.

Ms. Draude: — Thank you, Mr. Chair, and thank you for your presentation. I'm wondering if there's another group of people through the privacy legislation that aren't allowed to talk to the police about issues like gunshots and stab wounds.

Mr. Bray: — I don't know. Bernie, do you know of anybody? I don't think so. I mean health care professionals would be . . . I mean, other than like a lawyer, maybe something along those lines . . . Don, quit smirking. No, I mean someone like a lawyer where there's some sort of, you know, confidentiality. But those aren't going to be, those aren't usually going to be time sensitive things, right? In those cases the person has . . . You know, if it's a stab victim or a gunshot victim, I mean, their first stop isn't going to be to their lawyer's office. So I think that's why this is focusing so intently on health care workers because they are the first ones that are going to be dealing with these. But as far as some sort of legislation or privacy that prevents conversation with police, off the top of my head, in relation to this topic, I can't really think of any.

Ms. Draude: — I have follow-up questions. Social workers don't have any problem reporting what they may consider to be abuse to police?

Mr. Bray: — No. They do on a regular basis. And the reality is we have integrated units. We have our family services unit, for example, in Regina. And I know there's a similar one in Saskatoon, works on child abuse, sexual exploitation, all of those types of very sensitive issues. And the partnerships there are not two police officers. They are a police officer and a social worker, and they're partnerships. And they have access to information.

Now there's certain information that the police would deal with because it's sensitive and not necessarily something that the health care or the social worker would be able to get, and vice versa. But at the end of the day, there's enough sharing of information that the well-being of the victim is protected and the police officer looks after dealing with the person who's responsible for causing this and hopefully preventing it from happening again.

The Chair: — Thank you. I'm going to invoke the prerogative of the Chair to ask a couple of questions. Did I not hear correctly, in your presentation you said that you have recognized that there has been an increase in crime, in gang-related crimes in the city of Regina or perhaps in the province?

Mr. Bray: — Yes. I've been a police officer for 12 years. And I mean I can't give you the stats, but I'm sure that they're there. Is that what Clive mentioned? Chief Weighill, I think, was going to try and get some stats on that. But there has definitely been an escalation not only in the amount of crime but the severity of crime that's happening that's gang related. Absolutely.

The Chair: — At the same time have you noted an increase of knife-related involvement in these crimes?

Mr. Bray: —Well yes. I mean, Darren just brought up firearms. I mean, firearms is unfortunately becoming more and more prevalent. When we sit in those detailing sessions before we

head out on the street — just like they used to do in *Hill Street Blues* — they tell us, you know, what's been happening and what's going on.

I mean, we're hearing about people that are supposed to be carrying sawed-off shotguns and handguns on their person and in their vehicles and behind their sofa and under their mattress. We're hearing about that kind of thing all the time, so it is definitely becoming more and more common. But what I'm saying is that the gang member that may or may not be carrying a gun pretty much is guaranteed to be carrying a knife, and in Saskatchewan I would suggest that the stab wound issue is probably bigger at this point than the gunshot wound issue. That's something that we deal with more often. The stab wound may not be a knife. It may be a broken beer bottle, might be the screw on a table leg. We've seen any of those situations happen, but it's definitely there.

The Chair: — We'll quantify a period of time, say over the last year, the cases that you've been involved in. Has there been more knife-related incidents as opposed to gunshot wounds or are they about the same or has there been any change in that or . . .

Mr. Bray: — I would say knife, more knife. Yes, I mean, unfortunately the firearm issues are becoming larger all the time, and then they tend to be a little more newsworthy. You tend to hear about those more often, but stab wounds is, I want to say daily — but definitely a weekly thing unfortunately in the city of Regina. I would suggest most of our municipalities, especially Saskatoon, Prince Albert would be the same.

The Chair: — To quantify it, would you say that there is twice as many stab wounds as gunshot wounds or how would we measure this?

Mr. Bray: — I don't know. Yes, I mean, it's probably a better way to handle it to see if I could get some stats, and I think that's something that would be possible to pull together. I can talk to our crime analyst in Regina, and those stats may be specific to municipalities so I would have to pull them from, you know, the different municipalities, but something I could work on. We've got a meeting tomorrow actually of the Saskatchewan Federation of Police Officers. Representatives from each city will be there. That's an easy task for me to try and compile those stats for you.

The Chair: — I would appreciate that. The committee members would appreciate it also. Any further questions by anybody? Seeing the time has elapsed, I don't think I'd accept them anyway, but thank you very much for coming in and making your points known here. Thank you very much. Mr. Trew.

Mr. Trew: — I just wanted, on behalf I think all of the committee members, to say thank you for the presentation and the work that you do. And I do want to note that the committee Chair used up more than his allotted quota of questions for the entire hearing with our system of one-off back and forth. So anyway we say that with a smile. But thank you very much for your presentation.

The Chair: — The next group will be witnessing before the committee will be the Saskatchewan Registered Nurses' Association, and we will commence with them at exactly 3:30.

[The committee recessed for a period of time.]

The Chair: — If we can have order, please, we'll reconvene the committee meeting. Thank you very much. If we can have the members take their seats, please. The next witnesses before the committee is the Saskatchewan Registered Nurses' Association. We'll ask the spokesperson to introduce herself and the guests at the witness table.

Ms. Brunskill: — Hello. I'm Donna Brunskill, and I'm the executive director of the Saskatchewan Registered Nurses' Association.

Ms. McKay: — Good afternoon. Shirley McKay, director of regulatory services at the SRNA [Saskatchewan Registered Nurses' Association] and also a registered nurse.

The Chair: — Thank you. I'll remind you, you have a maximum 20 minutes for your presentation and then we'll follow that with 30 minutes of question and answer period. We'll have your presentation now. Thank you.

Ms. Brunskill: — The Intergovernmental Affairs and Infrastructure Committee is to be commended for convening a public hearing regarding Bill 20, The Gunshot and Stab Wounds Mandatory Reporting Act. On behalf of the almost 9,000 registered nurses of Saskatchewan, I'm pleased to provide a professional regulatory voice that is spoken in the public's interest.

We are indeed living in challenging times in this post-9/11 era wherein fear, violence, and socio-economic factors are increasingly leading to fragmentation, and challenging our social unity and what our society stands for. Issues of inequity, poverty, violence, and weak social fabric are frequently seen as root causes of anti-social behaviour.

The Saskatchewan Registered Nurses' Association believes that we must work hard together to create healthier communities. The SRNA does not support this proposed legislation as a key tool. While the goal behind this legislative endeavour — creating safer communities — is laudable, it is our opinion that mandatory reporting for every hospital or health facility that treats an individual with a gunshot or stab wound serves as an extension of the police, rather than an extension of community health and well-being.

Ultimately it will be health professionals who will need to do the reporting if it is to be done in a timely manner. As health professionals and the regulatory body speaking on behalf of the largest health profession in this province, this will serve to undermine one of our core values as appended, which is to establish a trusting client relationship and to maintain confidentiality of health information. Further the SRNA supports an individual's right to autonomy and works with the principles of informed consent and the promotion of actions by the client themselves when and where possible.

To date the SRNA has not found any research that supports the mandatory reporting of gunshot and stab wounds has done

anything to curtail violence in the community and has not led to any safer communities that we are aware of. Registered nurses are committed to treating each client in a non-discriminatory manner with a trusting nurse-client relationship being a foundational building block to that relationship.

This proposed legislation is not a desirable response to the problem of gun and stab wound related violence. Such legislation has existed in many American states for years without any evidence of having any positive impact on the control of violence. It will produce little benefit and has significant potential to cause harm to the nurse-client relationship.

As has already been reported by the province's Privacy Commissioner, Judge Krever, who headed up the tainted blood scandal in 1980, when commenting on the confidentiality of health information stated:

> . . . the primary concern of physicians, hospitals, their employees and other health care providers must be the care of their patients . . . A free exchange of information between physicians and hospitals and the police should not be encouraged or permitted. Certainly physicians, hospital employees and other health-care workers should not be made part of the law enforcement machinery of the State.

And I've cited where that quote comes from.

Certainly registered nurses are key health professionals within the health system who must establish a trusting relationship with clients who access the system. The code of ethics for RNs already requires them to report to appropriate authorities when they believe that clients and/or other members of the public and/or care providers could be in danger. Registered nurses today contact the police if we believe there is a safety issue. Our code of ethics supports that.

The argument being made with the proposed Bill 20 is that police must be contacted to investigate the incident, determine the risk to the public, and intervene to prevent future violence. However, available statistics on violence involving guns call into question whether a police investigation is the most effective and efficient way to prevent further violence and to protect the public.

In 1997 in Canada, approximately 4 per cent of Canadian firearm-related deaths were accidental, 78 per cent were suicidal, and 15 per cent were homicidal. For firearm-related injuries requiring hospital admission between 1997 and 1998, 38 per cent were classified as accidental, 26 per cent as self-inflicted, and 26 per cent as inflicted by others.

Discernment by the health professional seems to be the most appropriate. Addressing the issues of education and safety training would be a far better strategy for preventing accidental firearm injuries and deaths than police notification. Furthermore, addressing disparities of social determinants of health such as poverty and mental health needs would be more useful for patients who attempt suicide with a firearm. These individuals require mental and social care, not a police investigation. Victims of accidental and self-inflicted gunshot wounds, which are the majority of the cases, pose little risk to the public at large.

Data needs to be standardized for the reporting of stabbings before meaningful research can be conducted as to what we need to do for action.

RNs anecdotally identify concerns about being at risk for violence when caring for spousal abuse victims. Everyone has a right to a safe workplace and policies are needed to address safety in the workplace. Mandatory reporting to the police is not the answer. Domestic violence has always had a risk at intervention and yet we're not considering this, nor am I asserting that we should, within this legislation. I am merely making the point that this appears to be a selective and not equitable approach to violence targeted at a particular population, i.e., gangs.

What we need to do is work together and go upstream and work at prevention and early intervention. If nurses and doctors feel threatened for their own safety in a health facility, their code of ethics enables them to report, as does HIPA, which is how we believe it should be. In fact research tells us that most homicides are impulsive acts involving people who know each other. They are not premeditated revenge killings by hardened criminals. The latter situation is very rare, and even if the concerns expressed are legitimate, it is our position that the proposed legislation is far too sweeping. Gathering data on the number, nature, and cost of gunshot wounds would be a key initial proactive strategy and would help policy-makers like yourselves formulate strategies for best intervention.

What about the broader concept of victims of violence such as spousal or elder abuse or neglect? Is this not of equal concern to our public policy-makers? A round table to discuss violence in poverty, with agreement on essential data to be collected across our country so that we can be aware of the magnitude of an issue, would be far more productive. Data like this could be collected without disclosing the identity of citizens with gunshot or stab wounds. Research could be conducted and beneficial results realized without compelling RNs to breach confidentiality, particularly to the police.

Rather, the SRNA stands by its position that nurses have a professional duty to maintain client confidentiality within a fair and just culture. Furthermore the professional competence of RNs qualifies them to determine where and when it is in the public interest to report gunshot and stab wounds and/or other acts of violence.

Empowering the client to report is, and should always be, a strategy of choice. The SRNA recommends a continuance of voluntary reporting by its members when the need for maintenance of confidentiality is outweighed by a reasonable concern for public safety. Mandatory legislation to deal with what may be very few incidents will not ultimately contribute to the greater public good.

The SRNA support of voluntary reporting is detailed in its code of ethics which states, at times nurses learn information which, if not revealed, will result in serious harm to the client or others. Nurses need to consult with the health care team and if appropriate report the information to the person or facility affected.

The code goes on to say:

> Nurses must not discriminate in the provision of nursing care based on a person's race, ethnicity, culture, spiritual beliefs, social or marital status, sex, sexual orientation, age, health status, lifestyle, mental or physical disability and/or ability to pay.

Furthermore, our national body, the Canadian Nurses Association, states they also believe that nurses have rights and that governments and employers must protect and support nurses while they are assisting those who require care. Nurses have the right to care for any person in need without fear of reprisal. To this effect CNA [Canadian Nurses Association] urges all governments to create environments where nurses can practise in an ethical environment, not a legalistic environment.

The SRNA is concerned that this proposed legislation might deter individuals with reportable injuries from seeking treatment because of their fear of being investigated by the police. Besides the potential threat to confidentiality and trust in the patient-provider relationships, the SRNA is particularly concerned that the RN is not perceived as a mere extension of the police force.

The proposed legislation requires mandatory disclosure as soon as it's reasonably practicable without interfering with the treatment of the patient or disrupting the regular activities of the hospital or facility. We all need to be aware that regardless of timing, mandatory reporting of a gunshot or stab wound to the police will further disrupt and interfere with the regular activity required of RNs.

The proposed mandatory disclosure identifies that RNs would provide the name of the individual being or has been treated for a gunshot wound or stab wound, name and location of the facility, and any other prescribed information. Regulations regarding disclosure to police officers could be worded too broadly and thus could lead to a registered nurse having to assist a police officer in investigating even minor criminal activity.

As previously highlighted, this policy's in direct conflict with SRNA's values, foundations, competencies, and codes of conduct. Accordingly, it's our position that there is significant need within our province for strong collaboration between public constituents — Sask Justice, Sask Health, educators, social workers, and health professionals — to address primary health care whose goal is social justice and not first line medical care. We need to return our key emphasis on primary health care that we began decades ago that was focused on building healthy communities, not medical practice models for rural communities.

The SRNA therefore respectfully requests that the legislation not be implemented but that rather we focus on priority issues in our communities such as poverty and violence, targeting our most vulnerable populations. We must have significant discourse with our citizens to create a comprehensive strategy to address youth crime and violence. It is time to again turn our minds to healthy communities and the real chronic diseases of poverty and violence, not simply wait lists that relate to illness.

We remain committed to the need for a focus on primary health care where there is intersectoral collaboration to work with communities to meet priority health needs, including the reduction and elimination of poverty and violence.

Finally, the SRNA remains committed to the need for a comprehensive electronic health record. The SRNA believes that providing police with access to information contained within the electronic health record has the potential to significantly erode public trust in the health system and may serve to have a significant negative impact that has not been considered with this legislation.

We remain concerned that a full impact assessment has not been conducted. The SRNA was not even consulted before this legislation was drafted. The SRNA has already provided Saskatchewan Health with our feedback on proposed amendments to The Health Information Protection Act — and I've appended that on appendix B — that would be presumed to increase police access to information, with similar arguments and concerns. We cannot support this. I'll be pleased to address your questions.

The Chair: — Thank you very, very much. Mr. Morgan.

Mr. Morgan: — Thank you for coming today. I'll repeat the comment that I made for the previous presenters. We know that anything that we do in this piece of legislation will encroach on a citizen's right of privacy. And as we try and strike a balance that will give police a tool to try and solve crime and reduce the possibility of further crime, we go through this exercise only once as we pass this legislation. We are all mindful of the fact that it's the doctors, nurses, and health care professionals that will have to live with the consequences of whatever we do on a long term if not permanent basis.

So we want to assure you that we're giving the process a lot of deliberation and want to come up with something that's workable and would certainly invite any comments that you might have with regard to alternatives that would give the police the tools that they feel they need, while at the same time promoting the relationships that we know that doctors and nurses have with their patients.

The question I have is, in your paper you talked about a voluntary reporting and how discretion might be exercised. When we heard from Dr. Doig of the SMA, her position was that without patient consent there should be no reporting whatsoever, which sort of . . . but you're talking about in the context of a voluntary reporting. And I'm wondering what circumstances you feel might be appropriate. And then my, you know, sort of the follow-up then no doubt is going to be if nurse A prepares to exercise that discretion one way, how do we know that the exercise would be exercised in a similar manner in another health unit or health region?

Ms. Brunskill: — My response would be just as it is already incumbent upon us as professionals to say for example mandatory reporting where one suspects child abuse, those kinds of things, exercising professional judgment is part of what we do and what we must do.

I hearken back to, albeit some time, but when I worked in a

small hospital, if I were the only registered nurse on nights and the situation I felt was becoming unsafe in the hospital because of someone that I was trying to treat in outpatients along with the physician, I would not hesitate to contact the police and say, things are getting scary here. I would continue to do that because we have a responsibility, not only to the individual client but to the clients that are in the unit and to our colleagues that we work with. And so as registered nurses I don't think we've ever hesitated to engage the police.

As well in the emergency department, if you come into a large city emergency department, police are coming and going, as are EMTs, all night long. And we have hospital security there. And I think it's incumbent upon the health regions to have solid policy in place for security measures, and they do. We usually call it code burgundy or code whatever. And if we think something's unsafe we have buttons that we can push to get the police there instantly — those kinds of things. And so every organization has a responsibility to have protective measures for the police. I'm sure here at the legislature there's protocols in place. And so I would not in any way want to diminish our wonderful working relationship with the police.

My point is that if you've got so many resources to try to invest and lever up on a policy to address youth violence, I think we'd get a lot further ahead working with street nurses and social workers and police coming together with community leaders and saying, okay, what can we do? Even the fact of . . . I heard the gentleman before; we don't know the statistics. We don't know the lay of the land out there. Let's first make sure we know what we're dealing with.

And I can just say that as a registered nurse our code of ethics requires, and we certainly do and will continue to educate our members that they have a responsibility to always act in the client's safety. And if that means contacting the police, our code of ethics is very explicit about that.

Mr. Morgan: — You made the point about prevention or not having the crime occur. I think all of us would certainly have the preference and would like to do other initiatives that would eliminate, reduce, minimize crime from occurring. Unfortunately emergency rooms and police officers are where we haven't been successful and we have to deal with that reality.

And I think by trying to develop a protocol does not in any way — nor should it — take away from the obligation of the Department of Justice, Department of Community Resources, to try and eliminate or do away with the root causes of crime. So I don't want to leave the thought of anything that's there to in any way sort of minimize the obligations and the needs that go there. So please don't think that.

You'd indicated you'd worked in emergency rooms. And I'm wondering, you would have heard Evan Bray's presentation and he talked about what his experience would be and what he would envision. Perhaps you could tell us whether that's an accurate representation or what your experience has been when police are notified because somebody has arrived there with either a serious shooting injury or stab wound or something like that. Is it as he says? Or you know, how disruptive is it having the police there? You know, what takes place or what has been your experience?

Ms. Brunskill: — Well my experience is quite . . . many, many years ago. And so I would not want to say that my experience is current. However I certainly have spent some time in emergency departments in several capacities. And my experience is that it's a very co-operative relationship and certainly the police don't in any way interfere with anything. And I think that very much the nursing staff always appreciate both the EMT paramedics and the police when, you know, often you can have clients that are disruptive or violent or whatever. But at the same time a lot of facilities as well have their own security staff that they call to deal with those kinds of situations.

So I don't see that anything is particularly disruptive. My fundamental concern is the erosion of the trusting relationship that the individual has with the health provider. And if they get to believe that your job is to report to the police when they come in with a gunshot wound or a stab wound: number one, might they not come in; number two, might they try to coerce you not to report that by threat or otherwise; or number three, might they try to . . . I mean, I live in a small town. It's not uncommon that people come knocking on my door to try to avoid having to go to the emergency department to say, will you look at my child's throat or will you do whatever.

And it would only be conjecture, but I mean one has seen in theatrics and wherever where criminals, to try to avoid police reporting, have accessed health professionals outside the regular system as well. So I mean that's all conjecture.

But my fundamental point is as a primary lever, policy lever, I still can't help but wonder if we don't need to look at the kinds of teams we need to be putting on the street versus in the emergency department.

The Chair: — Mr. Huyghebaert.

Mr. Huyghebaert: — Thank you, Mr. Chair. We've heard from the police that currently they get many, many calls from health care providers in the ER. So on one hand we're already doing what this Bill is talking about. But on the other hand, we say we don't want to do that. It's a difference between may and shall. So I think that's the disruptive word right now.

So my question is, is there some way . . . We're already living with HIPA. Is there some way of amending HIPA, rather than this Bill, that could satisfy the feelings of the SRNA?

Ms. Brunskill: — I can't say that I have found HIPA in and of itself to be problematic because the code of ethics of the registered nurse already enables and supports them to report to the police when they believe there is a public threat for the client and/or nurses or other health professionals. So from my perspective I've not seen that there's a particular problem with HIPA in that regard. We always tell a nurse that it's her professional duty, and if that conflicts with other things, we ask them to always act in the client's best interest.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, and thank you very much

for the presentation. As you can imagine, the balancing of the needs of the public and the public interest on an issue like this is difficult, and so the input is appreciated and valued.

Ms. Brunskill: — If I could make one comment, or can I?

An Hon. Member: — Sure.

Ms. Brunskill: — And it's historical. But it's something that certainly has always stuck with me when I talk about the need to be on the street and try to get in there and intervene or be sensitive to where things are at.

It's a few years since I've been a first responder, but as a first responder, I would come into Regina and ride ambulance. And what hit me was the one time when it suddenly dawned on me that every time I went to an incident or an accident scene, there were two fire trucks there. And then we'd get there in the ambulance, and we'd scoop up the patient or do whatever we needed to do. We'd be back in emerg, and it was then the police would come running in afterwards trying to get the story of what had happened at the scene.

And it finally led me to ask the question, well out on the street how many ambulance people are there relative to police, relative to firefighters? And I just encourage people to look at community resources as a whole because what I was advised at that time was that there were 8 to 10 ambulance paramedics, about 14 police, and about 60 firefighters. And so I keep looking at, is that the ratio of on a busy Friday night at 2 a.m. and is that not where we need to be looking, not in the emergency department.

Mr. Yates: — Thank you. This legislation contemplates going down a road and one of the things that is continually brought up, is there evidence in regards to some of these things? Now there isn't comprehensive evidence in many cases, but we do have a study in the United States that was done in a jurisdiction where they have mandatory reporting. And very clearly it is . . . In a scientific study done involving 2,123 inmates who all were incarcerated for gunshot-related injuries, 91 per cent of those reported to . . . went to a hospital after they were shot, even if the wound was minor in nature. And so the issue that continually gets raised about people not seeking medical help doesn't seem to be proven out in the one study that does exist, I guess.

Ms. Brunskill: — I would say though, to me, nine people that went elsewhere — that's not insignificant. If you said 91 per cent out of . . . 91 out of 100, nine people went somewhere else.

Mr. Yates: — Right. But do we know those nine wouldn't go regardless? That's I guess part of the . . . We don't have that evidence because those people never came forward. But to, I guess to go to the fact of assumptions, we do know in the one study that exists that 91 per cent did in fact report.

Now my question goes to this: if this legislation were to proceed in some manner or amendments were made to HIPA or . . . that resulted in the same impact, Dr. Kendel yesterday indicated that the College of Physicians and Surgeons would educate their members, support the legislation, and move forward. What would be the position of the SRNA? And I guess I ask that because as in some of your appendices it talks about, you know, disciplinary issues and that. I'd like to know what position the SRNA would be.

Ms. Brunskill: — Well certainly it would create a bit of a moral dilemma for our membership. What we do ask is that our members abide by the law. And so if it becomes the law, certainly I think that we would then have to look at complying with the law. I think that what we're doing here today is calling on you not to make it the law.

The Chair: — Mr. Trew.

Mr. Trew: — Thank you. Ms. Brunskill, thanks very much for your presentation. And I'm like Ms. Crawford; I'm finding this committee quite fascinating. It's a subject that we're all wrestling with. And really, as Mr. Morgan has said, we've got one sort of shot here to deal with it. Legislation of course could be changed any time in the future, but we're trying to get it as right as we can.

I appreciate your comments about the scarce resources that the community pays for. And I think where you're heading with that is we should be spending our resources where it'll do the most good.

I'll just make this comment. This committee has been tasked with looking at this legislation and making the best out of this legislation, not looking at whether the speed limit should be changed or, you know, some other . . . And there's probably a million very excellent questions out there, but that's not what we're tasked with dealing with.

I heard it said yesterday and I buy this personally — I'll share it openly — I buy that silence, our silence enables perpetrators of violence to do more violence, whether that's domestic violence or whether it's, you know, a gunshot or a stab or a blunt instrument, whatever. And on balance, my leaning is to say we should blow the whistle just on principle. So that's kind of my bias.

Now my question is going to be around compulsory reporting versus discretionary reporting. And I'm interested in your comments on this. If we're going to . . . if you accept that we're going to report or lean towards reporting, I believe or I've heard it said — and I'm leaning this way, I'm not firmly to this position but I'm leaning to — if it's compulsory reporting, then there can be no inference of blame that you, in this example, you chose to report me, you know, when I shot my spouse or knifed her or what have you. It's just you, by law, are required to report, straight up. So my problem, my beef is not with you. It's somewhere else.

Whereas if it's optional, whether you report it or not, maybe my beef is with you. So I'm curious about mandatory versus . . .

Ms. Brunskill: — For me I guess my frame of reference still over 50 per cent of the time is the distraught individual who's attempted suicide. And so it depends what you're conjecturing in your mind, that certainly if we ever believe someone's in danger or threat, then we've got a clear code of ethics. And perhaps it is time we could be doing more to make sure our nurses are aware of that, and that but at the same time, that it's

really important that you often can develop that trusting relationship to get that young person in a new gang, if you were using gangs as an example. They're often vulnerable. There's power and balances. If you can establish that trusting relationship, you can then sometimes . . . you can move and get further than when it's the law. So I guess I'm into . . . It may be that at some point one needs to go and regulate that.

But as one of the first tools, I think what I'm trying to say is that we've not sat down with the police and with a number of other groups to talk about youth violence yet, that it seems like the legislation's coming ahead of, you know, let's sit down and have a really good dialogue on gangs and what do we do to control them.

I was recently at a meeting in Saskatoon whereby an elder said, no wonder our kids are going in the gangs; it's the only family they know. And is it that they have affiliation needs? Is it that? Let's try to get to some of the root cause. And you need a multi-pronged approach, and we need to work with the police and look at what nurses would do if thus and so comes into emerg. I'm not opposed to that in any way, shape or form.

But sort of making things . . . The law takes it out of your hands. And when I think about the high mental health needs we have in this province and the fact that still the majority of our gunshot wounds are suicide attempts — certainly we're seeing increases everywhere — but I'm not aware of anywhere where the legislation has made a positive impact.

Mr. Trew: — A suicide attempt is always a plea for help. It would be my frame of reference . . . and I'm not sure that police is the appropriate intervention. But I'm not sure that it's not. What is appropriate is . . . or what is inappropriate is silence. We need to get that person some help, and it's often help that's not simply available in an emergency department.

So I really appreciate your comments on it, Donna. And I'm sure not trying to be argumentative. It's just this is a dilemma that we're stuck with. Thanks, Mr. Chair.

The Chair: — Ms. Crofford.

Ms. Crofford: — I think I'm getting more confused the longer we talk about this. First of all I want to acknowledge, I guess, the culture of your profession is that the most important thing is that a person gets the care and the help they need. And of course I think instinctively for a lot of people and the public that sort of wars against the public under the public health. Certainly for me it does.

Instinctively I would think this would be a good thing, but analytically then we step back. And I think one of the things that's a bit troubling . . . but I haven't been involved in the whole discussion; I'm a replacement for today. And I'm feeling a bit uncomfortable about the absence of data we seem to have. You've provided some today, but my question is around that. In Ontario they do have the gunshot provision, and have you spoken with your colleagues there to see how that's actually playing out in reality?

Ms. Brunskill: — I have not recently, but what my colleagues in Ontario have said is that whereas gunshot and stab wounds were of an infrequent occurrence several years ago, certainly it's almost a straight line up. The increase in violence is there. I'm not aware that the legislation has done anything to curtail that, but it's something that I certainly can ask about.

I did raise it at our national table, and what I just received was the comment about I think nurses throughout Canada from a professional regulatory body have not supported this legislation. Certainly the emergency nurses themselves, many of them think that this would be and could be a good idea, but they're thinking about it often from the immediate perspective of will this control or will this curtail it? And all of our research when we've done policy research into that, there's nothing to show to support it. So I'm not aware of anything out of Ontario yet.

Ms. Crofford: — I think that's what I'd be looking for. Just on the comment, having been the minister of Community Resources, one of the hugest frustrations . . . There is huge amounts of resources out there in the community, but partly due to privacy and other provisions and protocols perhaps not being worked out, there's a great difficulty to coordinate information to work in an assistive way to people.

I know the police have huge frustrations with that. And again that's sort of the bush we're beating around here — how much disclosure is fair to the individual but also is actually going to result in some help being brought to bear. And so maybe we have the wrong people around the table because there certainly are interagency and interhealth and police and government coordinating bodies. And so, you know, why are they spinning their wheels?

I think progress is being made on some fronts — housing, quality of housing, those kinds of things. But I think everyone in those systems including us, you, everyone has to examine deeply why even when we have these collaborative efforts, they aren't quite driving to outcome-oriented results. And again in this I'll be — for whatever contribution I make to the discussion — I'll be looking for the outcome potential at least. So thank you for your comments.

Ms. Brunskill: — Thank you, and we have had some good policy dialogues with your department of late and . . .

Ms. Crofford: — Yes. I'm not responsible now, but . . . Yes.

Ms. Brunskill: — Yes.

The Chair: — Ms. Draude.

Ms. Draude: — Thank you, and thank you for your presentation. A couple of years ago I had an opportunity to go to the Royal University and talk to a doctor around . . . talking about some drug issues, and he brought up the gang issue. He told me he'd been working in the hospital for 10 years, and at that time his worst fear was coming to work and finding out he had a stabbing. And he said now it's something I deal two to five times a week. And he said it's not . . . and it's changed so much in that short time. And I remember a number of decades ago when I worked in the hospital just as a aide, it wasn't something that we even thought about.

So one of our last presenters talked about the team approach

that the police and social workers have. And as elected people, we know that the professionals — the police and nurses and social workers — do have, you know, their ability. We have confidence in them. So to follow up on what Ms. Crofford said, there has to be a team approach.

So from your perspective and from the people that you represent, is there an ability to share your professionalism and confidence that can benefit everybody? Has there been any effort to do that, to work with the police and Social Services? Is that where we should be going?

Ms. Brunskill: — My response . . . And I don't want to take you on to another whole agenda. I think you'll find I'm the champion of primary health care. And I always say primary health care is just about trying to create healthy communities and using community-based approaches, where it's citizen engagement. And that we, as the professionals, sit in the outer circle with the community in the inner circle, and we try to hear what the needs are and then work with the community to try to address their priority needs be it addictions or violence or the need for daycare or the need for whatever it is. And it's about . . . I used to say when we called it SchoolPlus, we should have called it community plus.

And it is about crossing over all government departments and coming together. Public health is very important and sometimes, you know, we have to be able to look at it at a population base, sometimes at a community base, and sometimes at the individual level. And there are no quick fixes. But I think if we don't use . . . Nothing has ever worked except community development.

The Chair: — Any government members? Mr. Yates.

Mr. Yates: — Thank you. My question has to do with the role of educating nurses today and understanding HIPA. Throughout the presentations we've had many, many different interpretations as to what section 27(4)(a) as an example means in HIPA — the one that permits the sharing of information where there's an understanding that there may be the ability to help an individual.

Could you, from the SRNA's perspective, is there an education process or is there . . . What role would the SRNA play in ensuring that there is a consistent understanding as to the interpretation of HIPA and how it would be applied?

I sat on the legislative instruments committee, the committee of government that developed HIPA, and spent literally more time than I ever want to think about . . . that particular piece of legislation because of its detail and its application and moving down a road defining a very touchy and difficult subject, right.

And clearly my interpretation and my understanding of what we intended for that is much different than the representative of SUN had as an example, that this was a clause that gave permissibility for the sharing of that type of information where there was a need for the sharing of that type of information but allowed the health care professionals to in fact determine, based on the evidence that's there, right, whether or not this was crime-related, whether or not there was others potentially at risk and so on and so forth.

But over the last two days I've heard three or four very different interpretations of that particular section of HIPA. And some saying it should never be used; some saying it can't be used. Some saying that if they did use it, that the SRNA would punish them and so on and so forth.

And so my question goes to, you know, the interpretations of a clause like this. What role does the SRNA play in educating its members? And how can we get a more consistent interpretation of what I see is a very significant piece of legislation and a very significant clause?

Ms. Brunskill: — Thank you. I'll try to be brief. I guess I'm someone who always says, when you're a registered nurse, you have four levels of accountability: one with your employer, one with your professional regulatory body, the laws of the land, and then with the client themselves. So I think there's sort of the four factors at play. So the employer and certainly us, as the regulatory body, have a key role to play.

Certainly for people coming out of their basic nursing education program, that's something that we, when we look at approving programs or whatever, look to make sure that they're aware of the competencies, the code of ethics. And they know about confidentiality, the importance of confidentiality. I mean we certainly do deal with issues of confidentiality in receiving complaints about violations of it. And as a matter fact I think we've got one case right now that's awaiting the provincial Court of Appeal that has an issue dealing with confidentiality. So we do deal with those issues.

Working with our members all the time, we have questions that come, and we deal with them on a question basis. We certainly do publications in our news bulletin. That being said, that the employer has a lot of responsibility as well. I would like to say to you that all registered nurses know. I could only . . . That would be my wildest dream. I know that's not the case. And what I can use is one example. We introduced mandatory reporting of critical incidents a couple of years ago. We just did a survey of our members, and it was twenty-some-odd per cent were aware of that legislation. Seventy-five per cent didn't even . . . And we had been communicating about it in our news bulletin. And so it just requires massive ongoing communication about particular elements of legislation.

But in terms of the overall issue, like in HIPA, health information protection, those principles are so congruent with our code of ethics that I would expect registered nurses to be bang on. And that's one of the first things we did when HIPA was being considered; we evaluated it against our code of ethics. And it was very consistent. So the specific clause that you speak of, I would have to go and look that up because I would have to look at . . . But what I do know is that our legal analysis has said that our code of ethics fits very well with HIPA.

The Chair: — Mr. Allchurch will get the final question.

Mr. Allchurch: — Thank you, Mr. Chair. Thank you, Donna. Thank you for your presentation. I notice in your presentation it was clear that any presentation made from the medical side . . . It states that the SRNA was not even consulted before this legislation was drafted. That's similar to all the medical side of

the presentations we've seen.

In regards to the legislation, I think you'll agree that the main focus for this legislation is to deal with the gangs that we have in our province and also our country. You, as many of the other presenters — the SMA, the union of nurses, the SRNA, College of Physicians and Surgeons — have all stated that you today provide information on a regular basis to the law enforcement people, whether it be the city police, the RCMP, or whatever.

My question is, if you're already doing it now, with this legislation that's coming forth that we're dealing with right now, in your own words, what is different in this legislation from what you're already doing now?

Ms. Brunskill: — It takes away our discernment. Right now I can determine if someone comes in and, say, they had a mental health problem and had shot themselves or injured themselves, I can choose not to report that to the police. I can choose to access a social worker instead. And so that's what would be different, is right now there's the discernment of when do you need to report to the police and when do you not. And if we believe it's a public safety issue — Shirley's pulled out the specific — we say nurses are sometimes legally required to disclose confidential information and/or if you believe the public's at risk, then we're authorized by our code of ethics to disclose.

What would take away from now is right now I can exercise my judgment, and if I had a young person come in, say, that's been stabbed or whatever, I could work with that person and try to encourage them to report. I could get them counselling, get them linked with a social worker and may choose to use a longer plan to try to get them to somewhere and may work on trying to make a better life for that person than necessarily reporting it.

I don't know if that helps to give you a concrete example, but increasingly we're having RPNs [registered psychiatric nurse] and social workers in the emergency department so we can try to look at addressing their psychosocial needs. And I may choose to go that route if I believe that the public's not at risk or that there's not a risk in the department.

On the issue of somebody coming into the department with a gun or whatever, well I know how busy the police are from the former accident scenes. Like I said they normally come running in afterwards. So you know, one doesn't know what their response time will be and are there . . .

You know, if you're concerned about safety of an emergency department, let's look at policies. There's various ways to . . . What are all the issues and how do we explore them? We've not had that dialogue.

The Chair: — I'm afraid the time has expired. I want to thank you very much for coming in and being with us here and sharing your thoughts with us here today. Thank you very much.

Some Hon. Members: — Hear, hear!

The Chair: — The next item of business before the committee will be witnessing by the Saskatchewan Federation of Indian Nations, and that will commence at exactly 4:30.

[The committee recessed for a period of time.]

The Chair: — The next item of business before the committee is a witnessing from the Federation of Saskatchewan Indian Nations. I will ask you to introduce yourself for the record, please.

Mr. Warner: — Thank you, Mr. Chair. My name is Jack Warner, and I work for the Justice Secretariat of the Federation of Saskatchewan Indian Nations as an investigator. They've provided me with a bit of information and a text they would like read into the record if I may, Mr. Chair.

The Chair: — Certainly. Please.

Mr. Warner: — Well the Federation of Saskatchewan Indian Nations applauds any legislation that provides for safer communities for all people.

There are concerns about the manner in which the proposed legislation is drafted. The primary concern is in section 3(1) that deals with mandatory disclosure. And the document I have here goes through the section and various subsections. And in its present stated form, there is a risk of inequitable application of the legislation. This section must apply equally to all circumstances under which information is released.

The FSIN [Federation of Saskatchewan Indian Nations] is proposing the development of some type of a guideline which would assist the prescribed persons described in section 3 in assessing whether an incident should be reported. The practice of using such a guideline would also provide uniformity to the manner in which the legislation is applied and would not discriminate against any person. Additionally, it's the suggestion of the FSIN that subsection (1)(d) should be removed as it lends itself to subjective interpretation that may adversely affect individual privacy rights.

Secondly, as both prescribed person and facility are such integral components of the proposed legislation, it's felt that these terms should be defined in the interpretation section of the Act.

And thirdly, a mechanism to evaluate the legislation should be incorporated as it's the view that without considering the proposed amendments and defining the indicated terms, the legislation may lend itself to abuse by authorities through a liberal interpretation of it as it exists.

That's the text I've been given, Mr. Chair. I am prepared to answer questions. There may be those I may have to decline and defer to the vice-chief Justice Secretariat.

The Chair: — Thank you very much. Opposition members. Mr. Morgan.

Mr. Morgan: — The presenters that were there yesterday raised similar concerns to do with the issue about having any portion of the Act carved out and dealt with by way of regulation. So I'm somewhat pleased to see that you share that

concern.

In a general sense, if there was, if one is made clear, that your position would be if there was provisions in here that would preclude the health care providers from discriminating against a class of people or profiling or whatever, would that be the type of thing that would address the concerns of FSIN?

Mr. Warner: — Yes . . . [inaudible] . . . Mr. Morgan.

Mr. Morgan: — And maybe you want to share comments on . . . We had issues with the nature of the injury that was reportable, and we'd heard people saying, gunshots were readily identifiable. There was issues with the nature of what was a stab wound. Was it a laceration? Was it puncture wound? The doctor that we . . . One of the doctors we had yesterday said that there was no specific either statutory or textbook definition of a stab wound other than something that cuts the skin. It could be a laceration. It could be a puncture. It could be a number of things.

And would it be the position of FSIN that they would want that portion of the reference regulations removed and a more clear definition put in or is that something that's . . .

Mr. Warner: — I believe that would be the position of the federation, Mr. Morgan. Just the term stab wound itself is very confining, I suppose if you will. I suppose the intent of the legislation is to cover the broader spectrum of wounds caused by edged knives, edged weapons rather. Is that your question, sir?

Mr. Morgan: — Yes. Yes, I think that's all the questions I have. I know you came on short notice, but I certainly appreciate the position that's put forward and want to thank you for coming. I don't know whether anybody else on our side . . .

The Chair: — Government members? Anybody have any questions? Mr. Yates.

Mr. Yates: — Thank you very much. I had the opportunity over the summer to visit a number of northern communities and public meetings with the First Nations and the communities. In more than one community, the issues of violence among the young people was raised and the community was looking for any supports that we could give to assist in dealing with these young people in their communities. And an example, in the community of Sandy Bay, violence among youth is rampant, in the words that they used. And in the community of Sandy Bay, they don't have a hospital. They have a health care centre.

And so one of the issues that has been raised and that I have some concern about is whether or not, that if we proceed with this legislation, it should include health care centres as hospitals are only located in, particularly in the North, in a few communities, and that in fact this information then would assist the community and the police to deal with some of those youth that are involved in gang activity in their communities.

Mr. Warner: — I would think that, and would hope that the legislation would include such places as the health care centres rather than being restricted just to hospitals or medical facilities that we're commonly used to finding in the cities.

Mr. Yates: — Thank you very much.

The Chair: — Mr. Trew.

Mr. Trew: — Thanks. Thanks, Mr. Warner. That was a pretty concise presentation that you made, and I appreciate that. It allows us a little opportunity to ask some questions. And mine are around silence. I'm not sure if you were hearing . . . I asked the question of a previous witness, and it was along the same general line. I'm not a believer that we should ever be silent when there's an injustice or when there's violence. And if it's a gunshot or a stab wound, I think I'm coming to the position of favouring mandatory reporting. And I'm just curious what the view is around that.

Mr. Warner: — I think the position of the federation, sir, I think the position clearly is that they support it. They are anxious about the concerns that I did mention. And I think the underpinning concern with the federation is that clearly this is a legislation that's directed at or focused toward gang activity. But I think, in the vein of fairness, there's an expectation that it will be something that is applied universally. Although the focus may be the gangs, I think that the federation's position is, is that's fine, but it shouldn't be discriminatory in any fashion.

The Chair: — Opposition members, any further questions?

Mr. Morgan: — I would like to thank this witness and anybody else that's presented or participated for their work with us. It's going to be a significant challenge for our committee to work through. And no matter which side of the House people were elected from, I think the public has a fair right to expect that we'll put aside partisan differences and work towards the better good of the community at large. So thank you.

The Chair: — Mr. Trew.

Mr. Trew: — Yes, I actually still have a . . . [inaudible interjection] . . . No, that's fine. We were just going back and forth. And I have a follow-up sort of a question, Mr. Warner. You spoke of things being . . . everyone being treated equally, and it triggered a question in my mind. Is there any concerns around what is reported and what isn't?

You know, we've heard people, others express concern that maybe we should exclude knife injuries. We heard some say we should more clearly define what a stab wound injury is because the College of Physicians and Surgeons define a stab wound as any time you have a skin puncture, it's a stab wound. And nobody seems to have much heart to report every time there's any blood spilled, you know, because much of it is not what we're trying to capture in this legislation. So I'm curious if there's some view on what should be reported or not.

Mr. Warner: — Well I can probably speak to that more from my experience as a police officer. I spent 30 years with the RCMP, before being employed by the FSIN Justice Secretariat, the last 10 of which I invested homicides. And as I read through it and putting on my old hat, I looked at it and I thought that there was certainly a huge gap there in terms of the definition. Stab, in my mind from my past life, is a puncture wound.

And clearly a large majority of serious injuries created by edged

weapons and deaths result from slash or cuts inasmuch as stabs. So that did cross my mind as I read through it prior to coming here that the definition or even the title itself . . . a stab wound, I think, in my mind left something to be desired in terms of the spectrum that it covered. I'm sorry, does that answer your question?

Mr. Trew: — Well partially. Mr. Chair, partially it answers the question. It's been suggested to us that we need to make sure that there's some more work done on definition of what is reportable so that we're not reporting sunburns.

Mr. Warner: — Correct.

Mr. Trew: — And you're generally supportive of any effort to be a little clearer in the definition of what's reportable.

Mr. Warner: — Yes, absolutely. Very much so.

Mr. Trew: — Okay. That's the follow-up I have, so thank you very much.

Mr. Warner: — Thank you.

Mr. Trew: — I appreciate that, Mr. Chair.

The Chair: — Thank you. Seeing no further questions, I want to thank you very much for coming in and making the federation's position known to us. Thank you very much.

That concludes the witnesses for this afternoon. I'd just like to remind members, committee members, that we will reconvene the committee tomorrow morning at 9:30 a.m. For Yogi, I'm not sure what time that would be militarily for sure but . . . [inaudible interjection] . . . 9:30 a.m. Okay all right. Well just to be sure. We will probably, and my suggestion is . . . It'll be up to the committee, but my suggestion is that we'd likely start off tomorrow in an in camera session, so we can have the opportunity of free and open discussion between the members. So that's the case, and I'll bid you all a good evening, and the committee stands adjourned until 9:30 tomorrow.

[The committee adjourned at 16:48.]