Information and Privacy
Commissioner/Ontario

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

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-040003-1

A Provincial Government Program

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FILE NO. HI-040003-1

INVESTIGATOR: Nancy Ferguson

SUMMARY OF INFORMATION GIVING RISE TO REVIEW:

A government program allowing individuals to apply for reimbursement of certain health expenses mistakenly mailed documentation relating to one applicant to another applicant. The documentation was in the form of a "report" describing the health services for which reimbursement was being sought. The government program was faced with how to fulfill its obligations under the *Personal Health Information Protection Act* (the *Act*) including the notification of the affected applicants under section 12(2). The matter was reported to the Information and Privacy Commissioner/Ontario (the IPC).

RESULTS OF REVIEW:

The mailing error was identified when the applicant, who received information in error, reported the matter to their Member of Provincial Parliament (MPP). The MPP then contacted the government officials responsible for the program, who undertook an investigation to determine how the error had occurred and to take steps to address it.

It was discovered that the error occurred when a processing clerk, preparing a mailing destined for one applicant, picked up a "report" that related to another applicant at the printer. Two processing clerks were sharing the same printer and were preparing the same type of mailings for applicants in the program.

When the error was reported to the program, staff immediately contacted the individual who had received the other applicant's information in error. The individual was asked to describe exactly what information had been received and was requested to return the documentation. The individual agreed to do this and confirmed that no copies of the documentation would be retained. The next day, the applicant whose personal health information was inadvertently disclosed was contacted and told what information had been disclosed, how it had occurred and what steps were taken to retrieve the documentation. Information was also provided about the steps that would be taken going forward to avoid a similar situation, including the investigation of the incident.

The investigation of this matter by officials administering the program identified two main causes of the incident: the programming of the printers being used by the clerks and, the failure of the clerks to fully verify the contents of the envelopes before mailing.

As a result of the investigation, steps were taken to correct the programming of printers to help avoid "inter-mixing" errors when staff prepare mailings for applicants.

Based on the lessons learned from this incident, the program undertook a general review of policies, procedures and tools for maintaining the confidentiality of personal health information and dealing with privacy breaches. A document addressing these issues was prepared with the plan of incorporating it into the organization's overall policy manual for all staff.

Further, a full staff meeting was held to review the circumstances and remind staff of their responsibilities and accountabilities as they relate to mailings. Training was provided to the clerks involved in the incident and all processing clerks to explain how to minimize potential errors in mailing. This training was also implemented as part of the orientation for new clerks. In addition, daily spot-check inspections by managers within the department were commenced to ensure that care was being taken in this aspect of their operations. A one page document entitled "Procedures to Ensure Confidentiality when Returning Documents/Mail" was distributed to staff and posted in strategic locations near printers and in the mailroom.

In addition, arrangements were made for a future training session for all staff relating to the application of the *Act* and ensuring confidentiality, to build on training that staff had been provided with earlier in the year.

Finally, with the assistance of the IPC, a notice was developed with a view to placing it on all future mailings to applicants. The notice provides applicants with information about what to do if they receive another applicant's information in error. It is hoped that providing this direction to applicants is a useful step toward ensuring that any loss is identified and contained quickly.

On the basis of all of the above, it was determined that further review of this matter was not warranted and the file has been closed.

Original signed by: April 25, 2005

Ann Cavoukian, Ph. D.
Commissioner