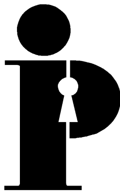

Information and Privacy
Commissioner/Ontario
Commissaire à l'information
et à la protection de la vie privée/Ontario

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050004-1

A Public Laboratory

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Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050004-1

INVESTIGATOR: Nancy Ferguson

SUMMARY OF INFORMATION GIVING RISE TO THIS REVIEW:

A public laboratory was informed that the patient test reports it sent out using a commercial courier were missing. The van being used to transport the reports was broken into and the reports could not be located. The lab was faced with how to fulfill its obligations under the *Personal Health Information Protection Act* (the *Act*) including the notification of affected patients. The break-in was reported to the police and the Information and Privacy Commissioner/Ontario (the IPC).

RESULTS OF REVIEW:

An internal investigation was undertaken by the lab to examine the circumstances surrounding the loss. It was determined that the break-in had occurred when the van was left unattended for a two hour period between 12 and 2 am while the driver made another delivery in a different vehicle. The test reports had been picked up the previous day and the driver had planned to deliver them the next day. The police were called in and investigated the matter, including searching the area for the missing reports that night. The police conducted a second search of the area the next day at the request of the lab but were unable to locate the test reports. The police released the theft information to the public the day after it occurred, however, the status of the reports remains as "missing."

Among the missing test reports were reports that originated from four other public labs across the province. The reports were destined for various health care providers in the region. The courier van had a set list of destinations that were visited every day to deliver test reports and pick up any new test requisitions and specimens.

Determining the list of patients who had reports on the courier van was difficult because individual labs do not have a daily summary of the list of reports leaving their site. The only

record maintained is a copy of the test report itself indicating the "date reported." The affected patients were identified by contacting each of the labs and determining which reports were likely on the van, then contacting each delivery site on the vans delivery route to clarify what test reports were expected and never received.

The test reports were inside sealed envelopes on the courier van. The patient information contained in the reports varied depending on the nature of the testing, but generally included the patient's name, date of birth, Ontario Health Insurance Plan number, test result and any related information that was provided when the test was ordered.

Once the list of affected patients was compiled, the lab worked closely with the IPC to develop a notification program to fit the circumstances of the loss pursuant to its obligation under section 12(2) of the *Act*.

The notification program included contacting each doctor who had an affected patient through an initial phone call and a follow-up letter requesting their assistance. Doctors were asked to notify their affected patient(s) about the incident at their next appointment with the patient and to provide each patient with a document entitled "Notification of Affected Patient." This document set out the details of when and how the patient's test report had gone missing, and assured the patient that a duplicate copy of the test report was now with their physician. The patient was advised that, as a result of the incident, procedures would be reviewed and changes implemented to help ensure the security of patient records. Contact information was provided for patients wishing to speak to someone directly who could answer further questions about the incident.

Physicians were also asked to write a note to their own files for each "affected" patient once they carried out notification so follow-up could be undertaken by the lab to confirm that all patients had been contacted. The lab apologized to the physicians for any inconvenience caused as a result of the loss and thanked them for helping to carry out notification in a way that was hoped would reduce anxiety for their patients. The notification of patients directly during an office visit was also designed to avoid the potential for inadvertent secondary disclosure which could occur if notification was provided by letter or by making phone calls to the patients' homes. This was considered important in this particular case, given the sensitive nature of some of the testing that was documented in the test reports.

As a result of the incident, a review of all courier contracts was undertaken to make sure provisions are in place to ensure the security of patient records. The courier route involved in this incident was revised to make certain the van would not be left unattended while carrying patient records, and would deliver reports the same day as they were picked up as opposed to holding them overnight. In light of the challenges encountered in determining what test reports were part of the loss, an internal working group was formed that will develop options and study the feasibility of a system to track each report sent by courier.

The internal working group will also study the possibility of masking the names of patients on requisition forms, test reports and other testing materials. In some cases involving laboratory testing of a more sensitive nature such as HIV testing, the testing is requisitioned and reported anonymously because the health care provider substitutes the patient's name with a numerical

code known only to the health care provider. The lab reported that the decision about whether or not to code the requisition form to protect the name of the patient is up to the doctor, the patient and the clinic. In the case of this loss, some test reports were "anonymous" while others were not.

The lab contacted each physician and was able to confirm that every affected patient had been notified.

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

Original signed by: June 30, 2005
Ann Cavoukian, Ph. D.
Commissioner