NORTHWEST TERRITORIES
INFORMATION AND PRIVACY COMMISSIONER

Review Recommendation 13-115
12-179-4
January 3, 2013

THE REQUEST FOR REVIEW

The Complainant in this case was the recipient of a faxed copy of some sensitive personal health information of a third party stranger. He was aware of news reports about misdirected medical faxes and felt that the breach was significant enough that it should be brought to my attention.

On June 8th, 2012, the Complainant received an email to his personal email address from "YPCC_Xerox@gov.nt.ca". The subject matter was noted to be "Scan from a Xerox WorkCentre". The body of the email stated:

> Please open the attached document. It was scanned and sent to you using a Xerox WorkCentre.

It indicated, further, that there were "6 images" included in the scan. The attachments, when opened, included what appears to be a prescription for an identifiable third party, as well as a reference to the same individual's medical test results and proposed therapy.

Within minutes, the Complainant received a second fax from the same source. The attachment in this case consisted of a one page "fax cover sheet" from Yellowknife Health and Social Services Authority. The message on the cover sheet was as follows:

> Please destroy last email that was sent. From YPCC.

THE PUBLIC BODY'S EXPLANATION

I requested the public body to provide me with an explanation of how this error happened. The response on behalf of the Yellowknife Primary Care Clinic (YPCC) was provided by Yellowknife Health and Social Services Authority (YHSSA).

The Authority explained that the Complainant is a client of YHSSA and the YPCC. The only way that the clinic can contact the Complainant is by email, as he does not have a land line or a cell phone. He does, however, have an internet connection and had asked the clinic to send an email to his personal email address if/when they needed to contact him, just indicating that they needed to speak to him. To do this, YPCC used a "fax to email" system to send the email. When he received such emails, the Complainant would then use his internet connection to "phone" the clinic. This was not an established practice for patients in the clinic and was done only to accommodate the Complainant in his particular circumstances. The error which resulted in the misdirected fax, they say, occurred as a result of a human/technical error. No details were provided.

YHSSA emphasizes that the use of "fax to email" is not something that they use on a regular basis in any of their offices, either for communicating with patients or to transmit client information. This process was being used in this case only to accommodate the Complainant. Further, as a result of this complaint, YHSSA has directed staff not to communicate using the "fax to email" function at all until such time as a policy or protocol is in place. Unfortunately for this particular patient, that means that his health care providers will be unable to contact him except by conventional mail.

The public body also provided me with a copy of their 'Guidelines for Fax Transmissions' which was put into place in July, 2010 as a result of earlier incidents of misdirected faxes, as well as their newest policy, in place only since early December of 2012, which updates and improves on the previous policy. Neither of these policies deal with "fax to email" situations.

THE COMPLAINANT'S RESPONSE

The Complainant's response to the submissions of YHSSA was clearly one of frustration. He did not feel that the public body explained how the error happened or what they were doing to address the problem. As a consumer, he questioned whether his own personal health information was secure within the offices of YPCC if they could not even identify specifically how the error occurred. This particular individual happens to be particularly sensitive about how his personal health information is used and disclosed and he has previously raised concerns about procedures and practices surrounding privacy at the clinic.

He was particularly frustrated that YHSSA had decided to prohibit YPCC from communicating with him by the only expedient method available to him, and expressed the opinion that this amounted to discrimination against him because of his personal circumstances.

DISCUSSION

Whenever human beings are involved in doing just about anything, there is a real possibility of error. No organization can guarantee perfection from it's human employees. I accept that the personal health information of the third party in this case was sent to the Complainant as a result of human error. Furthermore, the error was recognized immediately and the public body did what it could to recall the misdirected information.

That said, the incident raises concerns for me. Firstly, it surprises me that in today's world, where fewer and fewer people have "land lines" in their homes, and there are so many ways to communicate with one another, there are no policies in place with respect to how these other means of communication are/should be used. It seems to me that the arrangement in place between the YPCC and the Complainant prior to the misdirected fax incident was a good one that suited everyone's needs. I also agree wholeheartedly, however, that there need to be some clear policies and procedures in place with respect to such communications, particularly where email is involved. In my opinion, no details of personal health information should ever be exchanged or communicated by means of email unless it is in encrypted form. That said, however, an email message to a patient from the clinic asking them to contact the office is not inappropriate, provided that the patient consents to this form of communication and the communication does not include any medical details. Provided there are rules and procedures in place, those rules and procedures are closely followed and monitored, and no actual health information is exchanged, there is no reason why alternatives to the telephone cannot be employed to communicate with patients.

I am also concerned that the public body, in this case YHSSA, could not provide any real explanation as to how the third party's information ended up being sent to the Complainant, other than that it was a result of "human error". If YPCC was using the "fax to email"

function solely for communication with the Complainant, and not for communicating with any other person, how is it possible to scan and fax a third party's sensitive health records to the Complainant in error? If you cannot pinpoint exactly what happened or how it happened, you cannot fix the problems or address the issues that lead to the mistake in an effort to prevent the same error from occurring again. We learn from mistakes and the public body should be able to identify exactly how the mistake was made, and what needs to be done to prevent it from happening again. Simply shutting down that avenue of communication is not necessarily the answer, particularly, as noted above, where the public is moving more and more toward the use of electronic means of communication.

CONCLUSIONS AND RECOMMENDATIONS

In conclusion, I recommend that the Yellowknife Health and Social Services Authority take immediate steps to develop and implement policies for communicating with patients by non-conventional means, including email, fax to email, text messaging and other electronic means, keeping in mind the additional risk to privacy that is entailed in the use of such methods of communication, and with a view to having such policies and procedures in place within three months.

Elaine Keenan Bengts
Information and Privacy Commissioner