Office of the
Saskatchewan Information
and Privacy Commissioner

INVESTIGATION REPORT 032-2022

Saskatchewan Health Authority

July 4, 2022

Summary: The Town of Gravelbourg (Town) received a misdirected fax from the Saskatchewan Health Authority (SHA). The Town notified my office and the SHA of the breach of privacy. The Commissioner initiated an investigation and found that the breach was the result of human error when an SHA physician googled the fax number for Gravelbourg Labs and used the fax number of the Town instead. The fax was sent using an electronic medical record system. The Commissioner also found that the SHA did not sufficiently notify the affected patient and did not set out a plan for prevention in terms of stopping the systemic issue of misdirected faxes involving the SHA. He recommended the SHA change the contents of its notifications to patients and proactively report all misdirected fax breaches to his office. He also recommended the SHA prioritize eliminating the use of traditional fax machines immediately and prioritize finding a solution for misdirected faxes going astray through electronic systems and advise him of the initial steps within 30 days of his Investigation Report being issued.

I BACKGROUND

[1] On December 14, 2021, the Town of Gravelbourg (Town) contacted my office to advise that it received a fax containing personal health information from the Saskatchewan Health Authority (SHA).

[2] Also on December 14, 2021, my office contacted the SHA to see if it was aware of the incident. The SHA advised my office that the Town had notified it of the misdirected fax on December 8, 2021.

[3] On February 11, 2022, my office notified the SHA that it would be undertaking an investigation pursuant to section 52(d) of *The Health Information Protection Act* (HIPA).

My office requested the SHA investigate the matter and provide my office with a completed *Privacy Breach Investigation Questionnaire*. On April 1, 2022, the SHA provided my office with:

- the completed *Privacy Breach Investigation Questionnaire*
- a copy of the SHA's draft of its *Clinical Documentation and Communication Standards* for fax communications that is still being worked on
- a copy of a policy for the former Saskatoon Health Region titled, *Policy, Number 7311-75-011: Facsimile (Fax)* which was last revised in December 2014
- a copy of a policy for the former Prince Albert Parkland Health Region Administration titled, *Privacy: Faxing of Personal Information* which was last revised in February 2009
- a copy of the notification letter sent to the affected individual in this matter

II DISCUSSION OF THE ISSUES

1. Do I have jurisdiction?

[4] HIPA is engaged when three elements are present: (1) personal health information, (2) a trustee, and (3) the personal health information is in the custody or control of the trustee.

[5] First, personal health information is defined by section 2(m) of HIPA, which provides:

> **2** In this Act:
> ...
> (m) **"personal health information"** means, with respect to an individual, whether living or deceased:
>
> (i) information with respect to the physical or mental health of the individual;
>
> (ii) information with respect to any health service provided to the individual.
>
> (iii) information with respect to the donation by the individual of any body part or any bodily substance of the individual or information derived from the testing or examination of a body part or bodily substance of the individual;
>
> (iv) information that is collected:

(A) in the course of providing health services to the individual; or

(B) incidentally to the provision of health services to the individual; or

(v) registration information;

[6] From a review of the misdirected fax, it is titled, *Community General Requisition*. It contains in part:

- Patient's full name
- Patient's telephone number and address
- Patient's date of birth
- Patient's personal health number
- The type of lab test being requested
- The specific examination being requested
- The area on the patient's body where pain is being experienced
- Whether the patient was pregnant or not

[7] This information qualifies as the personal health information of the individual pursuant to sections 2(m)(i) and (ii) of HIPA. As such, the first element is present.

[8] Second, the SHA is a "trustee" pursuant to section 2(t)(ii) of HIPA, which provides:

> **2** In this Act:
> ...
> (t) **"trustee"** means any of the following that have custody or control of personal health information:
> ...
> (ii) the provincial health authority or a health care organization;

[9] Therefore, the second element is present.

[10] Lastly, I must determine if the SHA had custody or control over the personal health information at issue. "Custody" is physical possession with a measure of control. Control need only be considered if there is no custody by a trustee.

[11] The misdirected fax originated from Prairie North Health Centre in Lloydminster, Saskatchewan. Prairie North Health Centre is a primary health care centre run by the SHA.

The fax was sent by a physician at Prairie North Health Centre. Therefore, I find that the SHA had custody over the personal health information when the fax was sent. As such the third element is present.

[12] Based on the above, I find that HIPA is engaged, and I have jurisdiction to investigate this matter.

2. Did a privacy breach occur?

[13] A privacy breach occurs when personal health information is collected, used and/or disclosed in a way that is not authorized by HIPA.

[14] The term "disclosure" means the sharing of personal health information with a separate entity that is not a division or a branch of the trustee organization. Before disclosing personal health information, a trustee should ensure it has authority to do so under HIPA.

[15] In this case, the SHA incorrectly sent a fax containing a patient's personal health information to the Town instead of the intended recipient – Gravelbourg Lab Staff. This would constitute an unauthorized disclosure. Therefore, I find that a breach of the patient's privacy has occurred.

3. Did the SHA respond appropriately to the privacy breach?

[16] In circumstances where a trustee proactively reports a privacy breach to my office, the focus becomes one of determining whether the trustee appropriately handled the privacy breach. In order to be satisfied, my office would need to be confident that the SHA took the privacy breach seriously and appropriately addressed it. My office recommends four best practice steps be taken when a trustee discovers a breach of privacy has occurred. These are:

1. Contain the breach
2. Notify affected individuals and/or appropriate organizations

3. Investigate the breach
4. Prevent future breaches

(*Privacy Breach Guidelines for Trustees*, updated September 2021 at pp. 2-7)

[17] I will consider the appropriateness of the SHA's handling of the matter against these four best practice steps.

Contain the breach

[18] Upon learning that a privacy breach has occurred, a trustee should immediately take steps to contain the breach. Depending on the nature of the breach, this can include:

- Stopping the unauthorized practice
- Recovering the records
- Shutting down the system that has been breached
- Revoking access to personal health information
- Correcting weaknesses in physical security

(*Privacy Breach Guidelines for Trustees,* updated September 2021 at p.3)

[19] Effective and prompt containment reduces the magnitude of a breach and the risks involved with personal health information being inappropriately disclosed.

[20] According to the SHA's *Privacy Breach Questionnaire*, the Town mailed the misdirected fax back to the SHA and it was received on December 13, 2021. As such, it appears the breach has been sufficiently contained.

Notify affected individuals and/or appropriate organizations

[21] Notifying an individual that their personal health information was inappropriately accessed is important for several reasons. Not only do individuals have a right to know, but they also need to know to protect themselves from any potential harm that may result from the inappropriate access. Unless there is a compelling reason not to, trustees should always notify affected individuals. An effective notification should include:

- A description of what happened (a general description of what happened)
- A detailed description of the personal health information involved (e.g., name, medical record, etc.)
- A description of the types of harm that may possibly come to them because of the privacy breach
- Steps taken and planned to mitigate the harm and to prevent future breaches
- If necessary, advice on actions the individual can take to further mitigate the risk of harm and protect themselves (e.g., how to change a health services number)
- Contact information of an individual within the organization who can answer questions and provide information
- A notice that individuals have a right to complain to the IPC
- Recognition of the impacts of the breach on affected individuals and an apology

(*Privacy Breach Guidelines for Trustees,* updated September 2021 at p.4)

[22] In addition to notifying individuals, trustees may want to notify other organizations, for example, my office, law enforcement or other regulatory bodies that oversee professions.

[23] According to the SHA's *Privacy Breach Questionnaire*, it provided notification of the privacy breach to the affected individual on February 9, 2022. The SHA provided my office with a copy of the letter.

[24] Upon review of the notification letter, it appears to inform the individual that their "lab request and medical imaging request were in error faxed to the Town of Gravelbourg when

it should have gone to the Gravelbourg Lab". The letter included an apology and indicated that the SHA has reviewed its processes with staff. The letter also provides the affected individual the contact information for my office if they are not satisfied.

[25] Although notification to the affected individual has been provided, it does not provide a detailed description of the personal health information involved or a description of the types of harm that may occur because of the privacy breach. I would suggest that the SHA ensure it is including this type of information in its notification letters as a standard practice as it not only assists affected patients, but it ensures the SHA is considering the risks and impacts of misdirected faxes. I would also suggest that the SHA proactively report all misdirected fax breaches to my office. It often does but did not do so in this case.

[26] As a result of the above, I find that the notification provided by the SHA to the affected patient was not sufficient.

Investigate the breach

[27] Once the breach has been contained and appropriate notification has occurred, the trustee should conduct an internal investigation. The investigation should address the incident on a systemic basis and should include a root cause analysis. At the conclusion of its investigation, the trustee should have a solid grasp on what occurred which helps inform how to prevent future breaches at step 4.

[28] According to the SHA's *Privacy Breach Questionnaire*, the SHA commenced an investigation on December 8, 2021, following the telephone call from the Town advising it of the misdirected fax. The SHA privacy officer contacted the Prairie North Health Centre and spoke with the physician that sent the fax. According to the physician, they googled "Gravelbourg health care" and the Town website came up and on its first page is all the health care services with the Town's fax number at the bottom of the page. The physician assumed it was the Gravelbourg Lab and used that fax number. The fax was sent using the electronic medical record (EMR) system at Prairie North Health Centre. The SHA

concluded that the root cause of the breach was human error. The physician did not double check the fax number before sending.

[29] My office has been contacted by the Town on more than one occasion indicating it is receiving misdirected faxes from the SHA, so this was not a 'one-off' event. It will continue to notify my office if it receives misdirected faxes containing personal health information and my office will continue to investigate when it does. The issue of patient privacy being breached because of personal health information being faxed to the wrong locations in the province is a systemic issue that I address further in the next section of this Investigation Report.

[30] In conclusion, I find that the SHA sufficiently investigated this specific breach. However, I would like to see the SHA stop addressing each misdirected fax breach as an isolated event and begin looking at the systemic causes of these breaches and find solutions to prevent them. If human error is the cause of most of these types of breaches, that must be addressed.

Plan for prevention

[31] Prevention is perhaps one of the most important steps. A privacy breach cannot be undone but a trustee can learn from one and improve its practices. To avoid future breaches, a trustee should formulate a prevention plan. Some changes that are needed may have revealed themselves during the investigation phase. For example, deficient policies or procedures, a weakness in the system, a lack of accountability measures or a lack of training.

[32] According to the SHA's *Privacy Breach Questionnaire*, changes are being worked on with the new *Clinical Documentation and Communication Standard* that is currently in draft form. A copy of the draft was provided to my office. I note the draft states:

1. Personal health information may be faxed if there is not a more efficient manner in which to send the information.

> **Note: Always consider if a more secure, reliable or timely form of communication can be utilized instead of fax.**

[33] While I appreciate the additional note to consider more secure, reliable and timely options, it does not appear the SHA plans to cease the practice of faxing personal health information. My office has been dealing with several privacy breaches that involve misdirected faxes. It is easy to minimize the impact of one fax that has gone astray and to continue to report it as 'human error' but when one considers the volume of faxes going astray, it has become a systemic issue. I will now provide a brief history of reports my office has issued involving misdirected faxes containing personal health information.

[34] In 2010, my office issued the *Report on Systemic Issues with Faxing Personal Health Information*. The report involved 60 misdirected faxes from 31 trustees. The report was mainly focused on the use of traditional fax machines. A primary factor that led to the 60 misdirected faxes was a medical clinic's ownership dissolving and the medical clinic's fax number being reassigned to a private business 17 months later. The private business began to receive faxes intended for physicians who had worked at the medical clinic from pharmacies, other physicians, regional health authorities and other health care organizations across Saskatchewan. In the meantime, physicians who had practiced medicine together at the clinic had formed a new clinic and were assigned a new fax number. The physicians had made efforts to advertise the change in fax number at the new clinic, including informing the Canadian Medical Association, College of Physicians and Surgeons of Saskatchewan, and the Saskatchewan Medical Association. At the conclusion of that report, former Commissioner, Gary Dickson Q.C. expressed his concerns with the how trustees handled the breaches:

> Overall, I am underwhelmed by the response of the trustees to these privacy breaches. Most trustees have not adequately investigated the breach. More importantly, their current fax policies and procedures do not address the issues that caused these breaches, and therefore, are not likely to prevent a recurrence in the future…
>
> Regardless of the quantity of personal health information that has been disclosed without authorization, it is the sensitivity of the information that matters most. It is my view that personal health information is highly sensitive and deserves the highest threshold of protection…

> I am also concerned with the preoccupation of providers with convenience that has eclipsed the need to respect the privacy of patients.

[35] My office made a number of recommendations in that report including that trustees establish and strengthen written policies and procedures. It is disappointing that nearly 12 years later, my office is still dealing with trustees 'drafting' work standards, policies, and procedures while the issue remains a systemic one.

[36] In 2014, my office issued Investigation Report H-2014-001 that involved 10 trustees, 20 separate files and approximately 1000 affected patients. With a couple of exceptions, this investigation report focused on faxing features associated with electronic systems such as the EMRs at medical clinics and the provincial electronic health record (eHR) as developed by eHealth Saskatchewan. Misdirected faxes were resulting for several different reasons including unverified fax numbers loaded on the Radiology Information System (RIS) and automated features of EMRs, including the 'auto-suggest' feature for searching physicians' names. Several recommendations were made including disabling the "auto-suggest" feature in electronic systems, develop comprehensive and specific faxing policies and procedures, devise strategies to audit and update fax contact information regularly, and the Minister of Health considering an update to sections 18 and 18.1 of HIPA on an expedited basis. Specifically, updating section 18(2) of HIPA which appeared to be meant to require some sort of agreement between a trustee and an Information Management Service Provider which had still not been proclaimed 10 years after the Act was enacted in 2003. I note it is now almost 19 years since HIPA was enacted and section 18(2) of HIPA has still not been proclaimed.

[37] In 2017, I issued Investigation Report 223-2017. In 2018, I issued Investigation Report 005-2018 and Investigation Report 043-2018. All three investigation reports involved the SHA. These investigations involved privacy breaches resulting from the use of traditional fax machines. A private business, Kelly's Computer Works, was receiving faxes containing personal health information from the SHA intended for a physician. Kelly's Computer Works estimated it had been receiving one fax intended for that physician once every two weeks to a month for a period of 18 months to two years. The physician's fax number was

identical to that of the fax number of Kelly's Computer Works except for one digit. Therefore, these faxing errors were a result of manually inputting the incorrect fax number into a traditional fax machine. During these three investigations, the SHA had informed my office that it was working towards eliminating the faxing of personal health information. In my Investigation Report 043-2018, I had recommended that the SHA establish project timelines to eliminate the faxing of personal health information and to provide those timelines to my office within six months of the issuance of that Report. Although the SHA indicated it would comply with my recommendation, the SHA never did provide my office with such timelines.

[38] Between 2017 and 2021, my office issued 10 additional investigation reports where medical reports (such as consult reports or lab reports) were misdirected as a result of three physicians that had similar names being confused with one another. These misdirected faxes were a result of dictation and transcription errors or selecting of the incorrect physician within electronic systems such as the Laboratory Information System (LIS). The similarity in names, and not fax numbers, contributed to these privacy breaches. Several recommendations were made including that the SHA continue its efforts to error-proof the dictation and transcription process and develop a strategy to minimize mixing up of physician names in dictated and transcribed reports (see my office's Investigation Reports 151-2017, 208-2017, 233-2017, 235-2017; 152-2017, 219-2017; 305-2017; 041-2018, 203-2018; 014-2018, 016-2018; 083-2018, 084-2018; 137-2018; 291-2018; 308-2019; and 103-2020.

[39] In 2022, I will have issued five investigation reports so far involving misdirected faxes with more in the queue. Investigation Report 082-2021, 118-2021 involved a report containing a patient's personal health information being faxed to the wrong physician. The fax was sent using an electronic system. On February 2, 2022, I issued Investigation Report 045-2021 et al. This report dealt with multiple misdirected faxes which were reported to my office by physicians and a non-profit organization. Some of the misdirected faxes were sent using both traditional fax machines and electronic systems. Overall, 23 misdirected faxes were reported. 19 of the 23 faxes were sent through electronic systems. I found that overwhelmingly, the root cause of the privacy breaches was human error. At the conclusion

of the investigation report, I made several recommendations. Some of those recommendations and the SHA's responses were as follows:

- work towards eliminating the use of traditional fax machines.

  SHA response: *The SHA is committed to reducing our faxing footprint and has taken strides through COVID to automate critical workflows wherever possible. We will continue to work with eHS to prioritize and request funding for related initiatives where needed.*

- I recommend that the responsible trustee for each investigation file complies with the recommendations below within the deadline specified or if there is no deadline stated, provide my office with quarterly updates until all are addressed.

  SHA response: *The SHA will provide OIPC with notification once a task [has] been completed or if it is determined to not be operational.*

- provide my office with the Work Standard it created to prevent misdirected faxes within 30 days of the issuance of the Investigation Report.

  SHA response: *Attached is the draft clinical standards document regarding faxing personal health information…*

[40] At the time of issuing this Investigation Report, the SHA had not provided any updates indicating it had completed a task or determined a recommendation was not operational.

[41] On March 14, 2022, I issued Investigation Report 072-2021, 110-2021, 125-2021, 020-2022, 021-2022, 022-2022. A medical imaging report containing a patient's personal health information was sent to the wrong physician. The medical imaging report was sent via fax machine to the wrong physician twice and it was difficult to determine where the fax originated from. I concluded Dr. Tshipita Kabongo was likely responsible for sending the fax. However, Dr. Kabongo did not cooperate with my office's investigation. I recommended the Minister of Justice consider a prosecution in that case pursuant to section 64(1) of HIPA.

[42] Given the systemic nature of misdirected faxes, I recommend the SHA prioritize eliminating the use of traditional fax machines. Considering it responded to my Investigation Report 043-2018, indicating it would comply with my recommendation to

eliminate faxing of personal health information in 2018, it is overdue. I also recommend it prioritize a solution for misdirected faxes going astray through electronic systems such as EMRs.

[43] Due to the systemic nature of misdirected faxes involving the SHA, I find that the SHA has not sufficiently set out a plan for prevention in terms of stopping the systemic issue of misdirected faxes involving the SHA.

III FINDINGS

[44] I find that the notification provided by the SHA to the affected patient was not sufficient.

[45] I find that the SHA has not sufficiently set out a plan for prevention in terms of stopping the systemic issue of misdirected faxes involving the SHA.

IV RECOMMENDATIONS

[46] I recommend the SHA include in all its notifications to affected patients, a detailed description of the personal health information involved in a privacy breach and a description of the types of harm that may occur as a result of the breach.

[47] I recommend the SHA proactively report all misdirected fax breaches to my office.

[48] I recommend the SHA prioritize eliminating the use of traditional fax machines immediately.

[49] I recommend the SHA prioritize finding a solution for misdirected faxes going astray through electronic systems and advise my office of its initial steps for exploring this issue within 30 days of this Investigation Report.

Dated at Regina, in the Province of Saskatchewan, this 4th day of July, 2022.

Ronald J. Kruzeniski, Q.C.
Saskatchewan Information and Privacy Commissioner