INVESTIGATION REPORT
INVESTIGATION P94-003

RELEASE OF PERSONAL INFORMATION BY THE FORENSIC PSYCHIATRIC SERVICES COMMISSION OF THE MINISTRY OF HEALTH AND THE MINISTRY RESPONSIBLE FOR SENIORS

5 May 1994

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COMPLAINT:

On 29 March 1994, a complainant faxed a letter to the Office of the Information and Privacy Commissioner to complain that he had received information about his victim when he received his patient files from the Adult Forensic Psychiatric Out-Patient Services (the clinic) of the Forensic Psychiatric Services Commission (the Commission) of the Ministry of Health and the Ministry Responsible for Seniors (the Ministry). He complained that the Ministry released to him the name, address, and phone number of the victim of his sexual assault. He requested an investigation by the Information and Privacy Commissioner to determine if this release of third party information was in violation of the *Freedom of Information and Protection of Privacy Act* (the Act).

BACKGROUND:

Prior to filing a complaint with this Office, the complainant notified the Information and Privacy Branch of the Ministry of Health (earlier in March) about the same issue. When this Ministry received notification that this Office had also received a complaint, its staff decided to suspend action until contacted by this Office.

The complainant had also approached the print and electronic media and his case generated a great deal of interest. During a CBC-TV interview on 5 April 1994, the complainant said that it was wrong that he had received personal information about his victim and that he had contacted the Royal Canadian Mounted Police (RCMP) and suggested they inform his victim what had happened. The Ministry of Attorney General and the RCMP began a review of this case. (see page 5 below)

On 6 April 1994, during Question Period in the Legislative Assembly, the Opposition asked the Health Minister Paul Ramsey why this information was released and demanded his resignation.

The Minister explained that an internal review was underway and he would provide the House with more details when the review was complete. (see page 5 below)

The media then contacted this Office for comments. I stated that this Office was investigating the complaint and that the circumstances of this case were relatively unique.

It soon became clear that the locational information the complainant received about his victim was several years old and that her name was already known to him which at least minimizes somewhat the invasion of privacy that has occurred. Moreover, it was important to investigate this complaint to determine how this information was released and to review the Ministry's standard access to information and protection of privacy procedures.

INVESTIGATION BY THE COMMISSIONER'S OFFICE:

Upon receiving the complainant's complaint, staff from this Office contacted officials in the Ministry of Health. An initial interview revealed that the complainant had received the information following an informal request for routine access to his patient files from the Adult Forensic Psychiatric Out-Patient Services in Vancouver. Prior to release of the file, it was reviewed by his two health care professionals. It was their opinion that release of the information posed no harm to the complainant, nor to others. As this was an informal request, the files were not reviewed by an Information and Privacy Officer within the Ministry or the Forensic Psychiatric Services Commission.

Ministry documentation indicates that the test used prior to releasing the files was that set out in McInerney v. MacDonald, a decision of the Supreme Court of Canada handed down on 11 June 1992. The tests set out in this decision, combined with Ministry policies and procedures, were followed in evaluating whether or not the file should be released. The decision made was based on a reasoned process and a review of the entire file. The information in dispute was the name, address, and phone number of the victim, as they appeared on a police report dating to 1988. This information could reasonably be expected to have been known to the complainant at the time of his conviction, as the document might have been available to his defense counsel. This Office was informed by the complainant's probation officer that the address and phone number are, in fact, no longer current.

My staff and I visited the Forensic Psychiatric Institute in Port Coquitlam on

14 April 1994 to review their access to information and protection of privacy policies and procedures, particularly in respect to patient files. This on-site visit, which had been scheduled prior to the present incident, reviewed the data protection and security policies of this institution.

On 19 April 1994, I participated in a three-hour meeting with staff of Adult Forensic Psychiatric Out-Patient Services in Vancouver, where the complainant has been treated. I learned the following from a discussion of the complainant's case:

The Case of the complainant

The complainant was in the clinic's treatment program.

Probation Services had referred the complainant to the clinic as a condition of probation.

His file was closed in February 1994

The complainant then sought access to his own records in February 1994 through his social worker, who asked him to put his request in writing; the complainant was unwilling to do so. His two health care professionals perused the file in about an hour. The clinicians are primarily concerned about harm to anyone from the release of such a file. In their judgment, there was no evidence of the complainant being at risk of harm to anyone else or to himself.

Clinicians explained that it is common for certain offenders to deny the reality of their offences; they often blame external targets for anything that happens or has happened; the clinicians believe that this process of denial may lead to difficulty in the interpretation of their clinical information.

The social worker gave the complainant the entire file in a half hour meeting; there was not sufficient time to go over the file in detail. The next response was the complainant's claim, in writing, that his file was filled with inaccurate information.

Staff admitted to being surprised by the experience with the complainant's records and they are now very cautious about the release of third-party information. The process is at present very formalized and is especially cumbersome, because there is normally so much third-party information in such files that is used for therapeutic purposes.

Much of the information in the complainant's file is a public record; the full court record for example, was not banned from disclosure in this case.

The complainant's probation officer has spoken to the victim and her mother; the latter escalated from low concern to greater anxieties in response to the media attention to the complainant's charges.

General handling of patients' psychiatric files

Clinical reviews of records are time-consuming and costly, which must be a consideration for the clinic. It was suggested that training and record-keeping improvements could help here in preparing and reviewing files for disclosure.

Clinicians and patients are also concerned that disclosure of records be timely.

Crown counsel and police provide the clinic with various records on the basis of a blue referral form. Part E requests a list of information for each referral, including a summary or copy of the

police report of the offense; background information, e.g., the pre-sentence report, social history; a copy of previous medical reports and a court transcript.

Clinicians regard the various police reports as of critical importance for treatment, especially because of the barrier of denial in treatment. In the complainant's case, the victim's testimony in his file was the product of a police investigation. Confronting offenders with the reality of a victim's statements is essential for the treatment of certain offenders.

The clinic's patients may often know what is in their files because most of the records originate with probation, the crown's legal services, and direct interviews.

The clinic maintains what it calls "multidisciplinary clinical treatment files" on all patients. On a need-to-know basis, anyone involved in the treatment of a patient has access to the files.

Clerical staff type the various reports that are produced during assessment or treatment of individuals at the clinic. They only have access to the current audio tape of a particular session, not the entire file. The clinic requires its staff to sign an oath of confidentiality and trusts staff to maintain confidentiality.

I received a tour of the clinic's records room. Files are not in alphabetical order but are managed by numbers only; records are in a separate office, staffed by two health record personnel, off the main administrative office. This room has a separate locking system for which only two staff have keys.

All records are pulled daily for use by the therapists, signed out, and have to be returned at the end of the day; a separate large card [the charge-out] keeps track of which separate file records are out and who has them.

I was especially impressed that the health record technicians analyze each returned chart for errors, signature checks for medications, and diagnoses. The record-keepers examine each file upon its return and note deficiencies for correction, such as lack of signatures. Closing summaries and intake assessments are also sought out as necessary.

Six-to-twelve-month old files are kept in the office for easier access.

An "activity sheet" for each contact with a patient is maintained and updated on a computer.

All new staff and therapists are given an orientation to sound record practices.

No clients are left alone in treatment rooms with files.

Old files are kept in secure storage in a separate site; an automated index exists to old records, which are pulled when a patient is re-admitted as an outpatient. Intake files, as noted above, are received by the health record technicians. **Staff's concerns about access by patients to their own files**

Clinicians prefer to give out information to patients orally so they can give appropriate explanations.

Staff are prepared to let patients see their own files, with some provisos, but are concerned about the possible "anti-therapeutic" results of patients seeing their own records in certain circumstances.

Staff are also concerned about patients' ability to understand the technical aspects of their files without an explanation from a clinician, and there are time constraints on how long they can spend with a particular patient.

Staff find it difficult to assess third party information in a patient's file and how far they should go in severing or releasing it.

Training of Staff

While staff sign a confidentiality oath, it appears that no one actually sits down with new staff to explain what the oath means; all agreed that they would treat a breach of confidentiality very seriously.

ANALYSIS:

On 7 April 1994 Minister of Health Paul Ramsey announced that he had received confirmation from the Ministry of Attorney General and the RCMP that the release of third party information in their case was not an offence under the *Freedom of Information and Protection of Privacy Act* nor under the *Criminal Code of Canada*. The Minister also announced, however, that he was not satisfied that it had been appropriate to release the information in this case and that, as a result, the Ministry would be tightening the procedures for disclosure of such information in the future. The Minister said that all requests for medical records by patients would be handled differently and approved by the Deputy Health Minister before release.

I am not convinced that this process of formalization is a practical and viable solution. Prior to this incident, patients of Adult Forensic Psychiatric Out-Patient Services were able informally to request access to their own patient files and, after a review was done, these were made available. I am very concerned that access by such patients to their own personal information not be unnecessarily hindered, burdened, or made less timely. The thrust of the Act is to promote accessibility of information, and it is not my intention (nor the legislatures') that the Act should replace informal processes for access to personal information that are working.

If a formal request under the Act had been made by the complainant, a test of harm to third parties, if personal information had been released, would have been applied, a test similar to the one done by staff at the Adult Forensic Psychiatric Out-Patient Services. The informal process did not vary from the tests that would have been applied under the Act. It may be reasonable to suggest that, in future, in order to prevent unnecessary barriers to informal access, a test be adopted that, during the processing of a request for access to a person's own medical files, if there is no third party information and no perceived harm to the patient, the information be

released. If there is third party information in the file, it should be referred first to the Program Area Contact for the clinic and then, if necessary, to the Ministry's Information and Privacy Branch for review and severing, as appropriate. This should not cause undue delays for patients in accessing their information, nor formalize all requests.

It is unusual for a person to complain to our Office (or comparable offices elsewhere) about personal information that was requested and received. The complainant has violated his victim's privacy by bringing this issue before the media and publicly discussing information that was already known to him for the most part. I believe the victim's privacy has been violated by the complainant's subsequent behaviour, as well as the release of location information to him.

The complainant has not suggested that he has been harmed or had his privacy violated by the release of this information. The complainant's actions have put the glare of media attention onto his victim in a manner that is inappropriate and unethical. The victim should be aware that an unreasonable invasion of her privacy has occurred as a direct result of the complainant's actions.

RECOMMENDATIONS:

1. That staff of Adult Forensic Psychiatric Out-Patients Services receive in-depth training on the review of patient files for third party information, the disclosure of which might result in an unreasonable invasion of privacy, or which should be withheld for other reasons.

2. That trained staff of Adult Forensic Psychiatric Out-Patients Services continue to provide patients and other applicants with routine access to their personal medical information, in a timely fashion and, to the extent possible, by the offices responsible for the files.

3. That, before providing access, these trained staff review files to ensure that any disclosure of personal information to the applicants or patients concerned will not result in an unreasonable invasion of the privacy of third parties, nor in the release of other information that should be excepted from disclosure under the Act.

4. That, wherever staff are unsure about the disclosure of the personal information of third parties or other types of personal information, they refer the records in question first to their Program Area Contact and then, if necessary, to the Information and Privacy Branch of the Ministry of Health, either for advice on disclosure or for further processing, as appropriate.

5. That the Information and Privacy Branch of the Ministry of Health retain the delegated authority to approve exceptions from disclosure and be required to refer requests to the Deputy Minister of Health only in rare instances.

6. That the Minister of Health issue a public expression of his concern about the victim's situation. As the victim's current address and telephone number are not on the complainant's file, and the Ministry would have to obtain them from other government files, I do not feel it would be appropriate for the Minister to attempt to contact her directly.

I will follow up on these recommendations in approximately three months.

David H. Flaherty Commissioner

Investigation conducted by Lorrainne Dixon, David H. Flaherty, and Celia Francis Report drafted by Lorrainne Dixon and Celia Francis