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BACKGROUND

On July 26, 2019, the Chief Executive Officer (CEO) of the Northwest Territories Health and Social Services Authority (NTHSSA) wrote to my office to notify me of a privacy breach reported to her by the Deputy Minister (DM) of Health and Social Services (HSS). The DM became aware of this breach on the 24th of July. A local citizen reported to a member of the legislative assembly (MLA) that they had found compact disks (CDs) at the Yellowknife Solid Waste Facility (dump) with patient identifiers written on them, possibly with medical information stored on them.

On the morning the citizen first came across the CDs at the dump, the CDs were "in stacks" on the ground. He took several photos of the discarded CDs, and then sent a message and the photos to the MLA. He then brought the CDs to the attention of the City of Yellowknife dump staff who assisted in gathering them into the bucket of a nearby front-end loader. The dump staff transported the CDs to the facility baling station for compacting, and disposal.

An internal NTHSSA email, on July 25th, confirmed that Yellowknife dump staff had "collected everything that appeared to be confidential" and had put the CDs into their trash compactor, "baled" them, and buried them in the back of the dump away from the general public. The CDs were described as then being "not reasonably retrievable".

The breach occurred during the week of July 22, 2019. This was the same week that old biomedical 'equipment', refuse and furniture was being cleared out of the recently closed, old territorial hospital and disposed of at the Yellowknife dump. The CDs found by the citizen appeared to have originated from the old hospital that was being decommissioned at the time of the breach.

IMMEDIATE BREACH RESPONSE

On the afternoon NTHSSA was notified of the breach, July 24th, an employee from Dexterra, the company contracted to NTHSSA to provide Facility Services at Stanton Territorial Hospital (STH) was dispatched to the dump. The Dexterra employee observed the location the CDs had been found, and reported back that "no additional information, documents, or CDs were observable" in the area. The employee did not speak with dump staff at that time.

On the same afternoon, just after 3 p.m., the NTHSSA project manager (PM) tasked with coordinating disposal of waste to the Yellowknife dump from the recently closed hospital, left a voice mail for the Manager of the Yellowknife Solid Waste Facility (dump manager) about the breach. The dump manager replied within the hour via email and confirmed he "had the waste facility staff scour the scavenger pile for any and all information". These items had been collected, compacted and buried.

NTHSSA then launched an "initial review" (initial investigation) into the incident. At 8:30 a.m. on the 25th of July, the Territorial Risk Manager (TRM) for NTHSSA, attended the dump in person, accompanied by the PM, and the dump manager. The TRM attended the site where the CDs had been discovered. No additional CDs were observed. She took photos of the refuse nearby that had been pushed into a pile by the loader operator. This pile was a mix of dirt, contractor waste like plywood, but also observable was biomedical waste - unused needles, a lead apron used in taking X-rays, binders, manuals, and an empty yellow plastic 'sharps' container - as well as furniture and other garbage that most likely originated from the old hospital.

The CDs and biomedical waste had been found in the area of the dump designated for disposal of construction waste. This location was somewhat unexpected to the PM. The PM had pre-arranged with dump staff for biomedical equipment from the old hospital to be brought to the dump and buried that week, expecting biomedical equipment to be buried in an area not accessible to the public, at the "back of the dump".

The day before the QRM and the TRM attended the dump, dump staff had done a thorough job of cleaning-up anything they had observed in the dump pile that they felt might be confidential, and had compacted, baled and buried these items. Thus,

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NTHSSA was unable to determine the extent of records that may have ended up in the pile and could not determine exactly what information was recorded on the CDs. The only evidence of the CDs found at the dump was the citizen's photos and witness statements. It was difficult then for NTHSSA to immediately determine the nature of the breach and the true extent to which PHI had been disclosed.

As part of the response to the breach the STH- QRM and other staff took steps to ensure the breach did not recur, and conducted another thorough sweep of the old hospital, top to bottom. This reportedly "resulted in them pulling out "lots of stuff.", including "information 'sensitive to the organization".

INDEPENDENT INVESTIGATION

After conducting an initial review (preliminary investigation), NTHSSA determined a formal investigation involving an external review of the matter was necessary and hired independent investigators for this purpose. My office was advised of the breach and of the decision to hire independent investigators in a letter to my office dated July 26th. At that time, NTHSSA advised me they were reviewing applicable policies and procedures, and taking steps to determine the identity of the patients who may have been affected by the breach.

In August, having heard nothing further about the breach, I wrote to the CEO of NTHSSA to inquire about the status of their investigation and to request a copy of the final breach report as per NTHSSA’s Privacy Breach Policy. Having received no response, in November I again wrote to the CEO and it was then that I was informed that a final report was anticipated to be completed by December. In January the CEO advised me that the final report from the independent investigator was completed, but did not provide a copy.

A full month later, in February, I was provided with a redacted copy of the investigator’s report (more than 90 pages) which included blank pages and no appendices. I also received a somewhat redacted 300+ page e-binder of evidence including policies, SOPs, protocols and email correspondence about the breach. The materials in this binder also explored related health operation issues beyond the scope of this review.

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As these redacted documents did not meet the needs of my office, I requested originals without redactions. A mostly un-redacted copy of the investigator's report was provided on February 21st, 2019. No un-reacted e-binder was provided. The blank pages in the report remained blank with no explanation for the omission of this information.

WHERE THE CDs CAME FROM

At the time of the breach, NTHSSA had already moved Stanton Territorial Hospital's operations into a new building. STH began offering health services from the new hospital in late May, 2019. The Department of Infrastructure (DOI) had taken over management of the old building ("Legacy Stanton") shortly after STH moved out of the old hospital. Decommissioning of the old hospital, overseen by the DOI, included ensuring the building was completely emptied of all furniture, old biomedical equipment, and refuse.

An NTHSSA project manager (PM) hired to assist with the "Stanton Renewal" project, and who had assisted with the project over the course of several years, was still engaged with the project that July, and at the time of the breach was coordinating purge activities from the old hospital, including disposal of refuse to the local Yellowknife landfill. It does not appear there were any other locations scheduled for moving at that time, so all items appear to have come from Legacy Stanton.

As part of purging items and refuse from Legacy Stanton, prior arrangements had been made by the PM to have biomedical equipment, furniture, and refuse brought to the dump by local movers hired for this purpose. The biomedical equipment was to be dumped, and buried "in the back" of the dump. Additional items, such as reusable furniture, were designated for disposal in the public salvage area of the dump.

Several loads of refuse from Legacy Stanton were brought to the dump over the course of two or three days starting around 8:30 a.m. on July 22nd, with biomedical equipment being the bulk of the first few loads. The last load of refuse from Legacy Stanton was allegedly disposed of around noon on the 24th. The CDs were discovered by the citizen between 10-10:30 a.m. on either the 23rd, or the 24th.

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As part of her preliminary investigation, the TRM requested more information from the PM about the removal of waste from Legacy Stanton to the dump. He reported that on the second day of disposing of refuse from the old hospital the movers, attending the dump with a truck full of refuse picked up from the old hospital, indicated they had found their route to the "back of the dump" blocked. Because they could access the front of the contractor disposal area, the movers disposed of one or more of these loads there, instead of further back.

From the evidence it seems all of these loads were actually disposed of in what is considered the contractor disposal area, either the front of it or further in, towards the back of the dump. The nuances of where loads where intended to be disposed of and what "buried" actually entails seems to be a difference in understanding between what the PM expected would occur and what the dump manager described to the PM. Both the CDs discovered by the citizen and the biomedical waste observed in the pile by the TRM were located in the designated contractor disposal area of the dump.

After reviewing the evidence, more than one scenario presented itself as to how the CDs came to be in the dump. The prevailing theory is that CDs were part of the biomedical waste, refuse and/or furniture that had been cleaned out of Legacy Stanton, and had been brought to the dump and disposed of with the rest of the waste in the contractor disposal area. When and how they were physically contained when disposed of, and if they may have been directed there purposefully or inadvertently remains unresolved.

LOCATION OF THE BREACH

The CDs were reportedly found in Yellowknife's Solid Waste facility (the dump) by a citizen, who may have at the time been dumping refuse or salvaging reusable items.

The unique characteristics of the Yellowknife Solid Waste Facility are relevant to the context of this breach. Yellowknife’s landfill permits the public direct access into the dump to dispose of household garbage, DIY project waste, and reusable items. Citizens can also salvage items from designated areas for reuse or re-purposing.

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Salvaging at the dump is a bit of a recognized activity in Yellowknife. A number of citizens actively salvage items on a regular basis and local salvagers often share their finds from the dump on social media. There's even a regular Northern News Service newspaper column, by Walt Humphreys, called "Tales from the Dump" which shares wisdom and opinions on how the dump is managed, as well as commenting on the great finds that salvagers have scored while salvaging.

The organization of the dump is also important context. Areas within the landfill are designated for specific purposes, and defined by barriers and signs identifying the specific category of refuse to be disposed of there – leftover paints in one area, wood pallets in another, scap metal in yet another, etc. One specific area is designated for items in good condition and public salvaging from this area is encouraged.

There is also an area in the dump specifically designated for use by commercial contractors to dispose of left-over construction materials. Unlike other designated areas, signage at the entrance to this area discourages the general public from using this space for dumping or for salvage. One sign suggests prior "authorization" is necessary, and another sign prohibits salvaging. The CDs were found in this "restricted" area.

The restrictions in this area, however, while posted, are not enforced. There appear to be no physical or administrative barriers prohibiting access, and despite the signs, this area is often plied by salvagers. In addition, non-commercial loads by private individuals are directed to the "restricted" commercial dumping area when comprised of construction material from DIY projects. I expect the intention of the signage is practical - to prevent bottlenecks and freeing the space of extraneous vehicles and salvagers who might get in the way of contractors wanting to safely and quickly offload. The signs indicating that it is off limits likely does keep some people out, but not all. Thus in reality the "restriction" functions more as a suggestion and in this case offered no level of security and no reliable protection from salvagers, to the CDs or any other items from Legacy Stanton left there in July 2019.

This background is relevant to the understanding of the exposure risk posed to the private details written and recorded on those CDs. The chances of the CDs being discovered by salvagers, laying on the open ground as they were, was almost certain, and given the popularity of social media sites these days, photos of the CDs could

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easily have been, but were not, uploaded and circulated on social media. Understanding these risks is also a key consideration in determining the types of safeguards that should have been put into place by NTHSSA to prevent this type of breach, but were not.

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THE RECORDS

Photographs were taken by the citizen who first discovered the CDs. These photos were shared with my office by the NTHSSA with their final report in February 2020. The photos show the citizen’s discovery of over 60 CDs. From these photos I observed that the CDs appear to be in good condition, with no dirt or damage apparent. Presumably they were at that time still machine readable.

The photos show some of the CDs in a stack with others spread out evenly on the ground, but not scattered widely. The citizen advised that when he first came across the CDs, they were "in piles", but he had spread some of them out to take the photos, thus the names and other details on some, but not all, of the CDs were visible in the photographs. Photos show the writing on the CDs is clearly visible on many of them with writing in black marker or commercially imprinted on the CDs. The writing was legible on most with the few that remained in a pile obscured from view.

Of the CDs that were observable and legible, all but one had personal health information written on them in clear black lettering, and many included all or some of the following types of personal health information protected under HIA:

- patient identifiers (full first and last name, date of birth, health care number);
- a description of the type of information recorded (e.g "breast exam", "scrotal");
- a date presumed to be the date the information was recorded;
- physician's names
- organization logos for southern health care facilities;
- the name of local or out of territory health facilities and/or health regions;

There was more than one CD with the same patient's name, indicating a series of related CDs, with some marked "Disc 1" and another "Disc 2", or marked "1/2", "2/2",

"3/3". Other CDs seemed to be single CDs with no additional copies visible that related to that patient.

As indicated from the writing on the CDs, the types of information they contained was mostly related to diagnostic image results. Many included but were not exclusive to breast screening services. Some included the words: "echo", "chest X ray", "mammo", "CT chest", "breast exam". One that was apparently part of a series of 3 CDs, looks like is says "CT chest for pulm embil" with the person's full name written across the top. The above describes just a sample of the CDs visible in the photos as reference.

The records appear to have been generated by different organizations. Some of the CDs were clearly marked "Stanton Hospital", while others appear to have originated in southern jurisdictions. One was marked "UAHY Edmonton. AB". Several were marked with "Northern Health", and one was marked "Alberta Health, Strathcona Hosp., and another with "Central Health". Some of these CDs included jurisdictional logos.

If the dates on the CDs are considered to be the date created, it appears the records had been created over the past decade. A sample of dates I observed included: "August 2010", "2011", "January 2014", A2015", and "June 2017". Some of the CDs were created more recently – one CD was marked January, 2019 and another April 2019, only a month before the old hospital closed and not long before the CDs were discovered in the dump.

I initially presumed most of the CDs, with the exception of the ones sourced from southern facilities, and except for the three clearly marked "copy", were originals. The independent investigators, based largely on several witness statements "believe the CDs in question are likely duplicates". As there is no way to confirm for sure what was recorded on the CDs, there is no way to confirm beyond doubt if an original copy of everything on each CD was retained by NTHSSA or some other organization. As some were marked "copy", this may or may not mean the rest are also duplicates.

However, one witness stated CDs are stored over the long term, especially those "from the south" [southern facilities], "due to the fact they are not stored [electronically] on Stanton's DI Pac's system", and they are kept in their physical form in cases," in cupboards" at the hospital. This contradicts several other witness statements stating

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sometimes images are uploaded electronically, and the copies are discarded if no longer needed.

I have considered the bulk of the CDs to be "copies", and am presuming there is an electronic original either at STH or at the southern facilities they originated from. However if these were STH's only source of the record collected from the patient, this is a primary record and may be required to be retained. This is an important point as, if they are "copies", it means some of them might not have needed to be need retained, and controlled destruction under a records disposition schedule would have been appropriate. If some were recent originals, and there is no other version held by NTHSSA, they should not have been disposed of outside of the requirements of a retention schedule. Unfortunately, the verifiable truth of the matter is largely buried in the dump.

Post breach, STH was subsequently able to find information about some of the patients that matched some of the names of the CDs to existing STH records, indicating at least some patients had been or were still STH patients. Some of the CDs with more recent dates matched current Diagnostic Imaging (DI) records, and Stanton determined two CDs may not have contained DI images. They had difficulty matching the dates on three older CDs to historical DI image records, with one of the three apparently not appearing in their electronic systems at all, suggesting that the original record no longer exists at STH, that it was generated elsewhere in the health system, or that there is not enough reliable information on that CD to positively identify that particular patient.

KEY PLAYERS

"Stanton Renewal" refers to project that resulted in building of a new hospital – a new Stanton Territorial Hospital – in Yellowknife which was completed in 2019. NTHSSA started taking over operation of the new hospital building in the fall of 2018, about six months before it officially opened to provide services to the public. Significant effort and coordination was required by NTHSSA to move staff, medical records, supplies, equipment, and other items over from the old hospital. NTHSSA staff and contractors were heavily engaged for many months in planning and prepping for the move into the new hospital and ensuring everything was taken out of the old.

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Private and Public Players Involved in Legacy Stanton "Purge"

Opening the new hospital obviously also required closing the old one, and to achieve this a complete "purge" of items for disposal had to be completed. By the time the movers started taking old biomedical equipment, furniture and refuse to the dump on the 22nd of July, 2019, almost two months had passed since the opening of the new hospital. In theory, everything of value to STH operations should have been removed from the old hospital building by that time.

There were many 'moving parts' to closing down the old hospital, and this led many players to be involved in one way or another in this privacy breach. These included NTHSSA regular operational staff, 'Stanton Renewal' staff, contracted service providers, as-and-when contracted services, the GNWT Department of Infrastructure, and the City of Yellowknife. These many entities were all involved in one way or another with closing the old hospital, moving items of value to the new hospital or to off-site storage, the GNWT warehouse or to the local dump.

Project Manager (PM)

To support the "Stanton Renewal" project, NTHSSA contracted a project manager who was apparently involved with the project over several years, culminating with the opening of the new, and the closing down of the old. In June and July, the PM coordinated disposal of leftover items to the dump by the movers with the manager of the Solid Waste Facility, communicating what would be dumped, when, and how items should be disposed of within the landfill, specifically in a manner that would prevent the public from sorting through the biomedical waste in particular.

Local Moving Company

A local moving company was hired by the GNWT to do the literal 'heavy lifting' and the clean out of furniture and other items from the old hospital, and to deliver these to the dump. The movers were hired on a standing offer agreement, a generic as-and-when contract usually used for transferring records, and moving office furniture and "large items". This contractor was used for moving items to the dump from Legacy Stanton. The dump manager had been given direction, but it is not clear what specific direction, if any, was provided to the movers about what, where and how items were to be disposed of, other than that it was "garbage", was going to the dump, and was required to be

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buried. It appears the movers delivered biomedical waste on the first day, the 22nd, but on subsequent days, finding their access apparently blocked, the movers dumped their loads at the front of the contractors' disposal area, which was accessible to them at that time. This is where the CDs were later found.

NTHSSA Records Management Staff

A NTHSSA staff person was apparently designated as a knowledgeable resource to direct records transfer to the new hospital, to storage and to the GNWT warehouse. This person provided NTHSSA with advice on the appropriate treatment of records being prepared for transfer, including what records needed to be retained and those that required destruction. Confidentiality of records was flagged as a high priority in communications sent to STH staff by the records management team.

According to meeting minutes, this advice was available to all managers interested in getting a start on purging as early as December 2018. With this direction, individual managers and regular staff members seem to have been responsible for preparing their own unit files for the move and for purging, but the actual move of boxes of personal health records was managed by the records management staff. For paper records this process was seemingly well coordinated, tracked and supervised. This same process was seemingly not applied to digital images on CDs.

Yellowknife Dump Staff

The manager of the Solid Waste Facility corresponded in June 2019 with the PM about requirements for NTHSSA to dispose of waste from Legacy Stanton. Several emails back and forth culminated with the dump manager receiving, as requested, a signed affidavit from NTHSSA to the City, declaring that the items to be disposed of had been both "decontaminated" and "decommissioned".

The Dump manager was told by the PM that the first loads would contain biomedical waste and should be located where the public could not have access to the disposed materials, and that subsequent loads included furniture items could be dumped in the public "salvage area". According to the final report, it was "agreed that the loads from Stanton were to be placed in the designated construction area" of the dump.

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It appears that when waste is buried in this area, YK dump staff used a front end loader to push, crush and pile the items, mixing the refuse with other debris and dirt, in effect "burying" the waste and making space for more refuse to be piled on top. This is how dump staff treated the waste disposed from Legacy Stanton. Dump staff were on hand when the citizen found the CDs and aided him by gathering, crushing and baling the CDs.

Dexterra

Facility Services at STH are provided by a company called Dexterra, a private southern company hired to provide housekeeping, cleaning, laundry and food services under contract. Dexterra handles all waste, including biomedical waste pick-up, from medical units. Dexterra apparently gathers but does not dispose of the waste. A different private vendor accepts biomedical and confidential waste from STH and provides shredding and other secure disposal services following procedures existing at the time of the breach.

At the time STH moved to the new facility, it appears that a number CDs (well over 200+) had been prepared by STH staff for disposal. The CDS were packed following STH protocol, in large yellow “sharps containers”. These had been "picked up by housekeeping", and in theory taken to the secure waste holding room on site – the Hazardous Waste Room. In theory, these sharps containers were then packaged in the holding room into transport boxes. Waste from this room was transferred on a regular basis to an on-site external storage unit to await secure destruction.

Responsibility for waste handling seems to be the reason a Dexterra staff person was dispatched to the dump initially, possibly by the PM, when the breach was first discovered by NTHSSA.

Department of Infrastructure (DOI)

DOI was responsible to ensure the old hospital was empty and decommissioned once NTHSSA staff had cleared the building of items they still needed and were responsible for, like medical records. At the time of the breach STH had somewhat reluctantly relinquished control of the Legacy Stanton building to the Department of Infrastructure. According to one witness, DOI did not give NTHSSA adequate time to ensure the old

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hospital building was thoroughly emptied before changing the locks on the doors of the old building, preventing NTHSSA operational staff from entering.

DOI had already commenced decommissioning the building prior to the movers taking items to the dump. DOI Warehouse staff had a well-worn process in place to check furniture items before they received these, and assisted with some of the final purging of items in the old hospital. DOI staff did find and return confidential information they came across during the purge. These items were returned to NTHSSA. Warehouse staff continued to assist in this way both before and after the breach.

DOI was not particularly helpful with the initial investigation launched by the NTHSSA.

The Security Guards

NTHSSA's investigation did not clarify which organization provided security in the Legacy Stanton. However, it does appear that security guards were stationed at the old hospital for the decommissioning of it, apparently under the direction of DOI while the movers were entering and exiting the building.

Of importance in this case, according to the final report on more than on occasion items observed to be "confidential" were given to the security guards. At one point they were given a box with CDs in it that had been gathered off the clinic floor, but it is not clear what the guards did with those CDs. In another scenario, confidential paper records that had been found in the facility were dropped off at a security desk, and seem to have been later retrieved by the NTHSSA staff, with or without any action by security personnel. Circumstantial evidence and witness statements suggest the guards did not recognize themselves as having role in protecting information found in the facility.

The Chief Operating Officer

Moving into the new hospital and purging items from the old was a recurring subject at regular STH management meetings for many months leading up to the move into the new hospital. The COO directed the same managers to ensure all items were purged from their respective units in the old hospital, and follow up emails sent to managers from the COO's assistant in May gave directions to clearly identify items for transfer to the new hospital. Directions were circulated on what to dispose of with some specificity in those instructions. Witness statements suggest there was no specific mention,

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however, of how to handle records that had been recorded on CDs. Special bins were installed throughout the hospital for staff to put documents into for later shredding by a secure private vendor.

KEY EVENTS

Stanton Territorial Hospital (STH) is a "territorial" hospital in that it serves the entire Northwest Territories, not just Yellowknife. Many people in the NWT were born at STH and continued to receive services from the hospital over time. This is an important point as personal health information for a large number of NWT citizens has been collected by the facility over the years.

Up until a few years ago when electronic systems increasingly came into use, records were captured in paper form. But even with new electronic systems in place, the hospital still maintains some patient records in paper. Transferring and handling records is a significant part of a move from one hospital to another. In theory, all records should have been accounted for and moved in a controlled manner regardless of whether they were for storage or destruction, and in whatever form they existed - paper or other media.

New Stanton and Old (Legacy) Stanton

On May 25th, 2019 the newly built Stanton Territorial Hospital was opened. The Authority had been busy preparing for the move for months, if not years. By the time the new hospital opened, many items had already been relocated and the bulk of the old hospital building had been purged of records.

Equipment, furniture and medical records had to be accounted for and moved into the new facility just before and also after it opened. Direction was given to staff about preparing items for the move into the new hospital, to off site storage, or to the GNWT warehouse for archiving or destruction. According to direction given by the COO, everything was to be gathered, "clearly labelled" and, for items going to the new hospital, there was to be a clear indication of where in the hospital they were to go.

Refuse gathered by staff was apparently differentiated by type. According to waste protocols provided as evidence, biomedical waste was to be differentiated from general

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garbage and contained in specially marked and designed containers. Confidential waste that was of a medical nature (e.g used IV bags with a patient's name on it) was to be clearly identified for secure disposal. Furniture and other unwanted items were to be sent to the dump, while reusable items were to be sent to the government warehouse for storage or sale to the public. CDs, in particular, were to be paced in large yellow sharps containers, sealed and boxed for transport to secure destruction facility.

As guidance, records staff drafted advice for purging that indicated copies of personal health information (PHI) was to be "shredded". Secure shredding bins were located throughout the old hospital during the purge for staff to use to dispose of any confidential records that needed to be securely shredded. This included documents not required for the provision of health services or for legal purposes, transient copies of documents, duplicate copies, or documents that did not pertain to official decisions. All of these were slated for disposal and could be put into secure shredding bins.

Paper Records

The hospital's paper records had been identified, boxed, and moved to the new hospital, off site storage, or archived at the GNWT warehouse. NTHSSA staff were assigned to ensure handling of these records met information management and retention requirements. The transfer of paper medical records was supervised at all stages by a designated records manager, and was seemingly well controlled, as reported:

> … process during the records management activities in the last 10 months at Stanton for the move of personal health information was to have … records staff visually observe the movers pick up boxes of files/information at Stanton and to visually observe the off-load of the boxes at the storage facilities. Count the boxes picked up and count the boxes off-loaded to the shelves. A spreadsheet was also used to track the number of boxes moved, the date the boxes were moved, and from which physical location and program area the boxes came from.

Emails suggest that these known records for retention were identified as such and should therefore have been at no risk of being diverted to the waste stream at the old hospital. That was for records for retention. I would have expected records for

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destruction would have been similarly identified and, in theory, directed in a similarly controlled manner for secure destruction, but apparently were not.

A Few Hiccups and "Finding" Records

During the purge, records that should have been previously attended to were "found" by STH staff. The final report states that during the purge, about "20 discs found in the PACs admin office were returned to the Specialists Clinics, mostly ortho cases," and "About 200 discs were found in the clerical area and the BSP area".

A witness to the purge process for CDs reported that:

> A special order of [three] 3 large sharps containers was put in to accommodate the purging. Staff were clearly instructed and aware of the proper disposal of these discs. At least 2 containers were used. They were picked up by housekeeping, following their usual process.

Witness statements show that during the purge, sharps containers were observed in the old hospital alongside general waste for disposal waiting to be picked up by housekeeping. Dexterra staff collected these and directed them into a holding room.

Moving an entire hospital to a new location is a complicated matter, and as one might expect, there were a few hiccups along the way. As for the CDS and other records that went astray, with many people and organizations involved and many moves and purging activities going on at the same time, it is possible items could have been differentiated incorrectly and directed to the wrong disposal stream more than once. It is also possible that staff simply did not recognize some items as being "records" or as being confidential, and this may have resulted in some records, like CDs, not being handled with care and/or being directed into the regular garbage.

Staff may have simply been unaware of the existence of some records hidden in furniture. Some may have been identified as true "biomedical waste" and as such, misdirected for disposal in the dump with biomedical equipment. The fate of the CDS may have reflected one or more of these factors.

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There were also other errors which occurred that placed records at risk. Internal STH emails in June 2019 indicate that some items that had arrived at the new hospital that should not have been moved there. These items were then moved back into the old hospital. This added a degree of risk to the ongoing purging operation at Legacy Stanton, as items that may not have been highly scrutinized before the move because they were simply moving to the new hospital, were then re-introduced into Legacy Stanton without being properly cleared. This situation would have complicated the job of keeping track of items that still needed to be cleared, and those having already been purged at the old hospital. There was clearly opportunity for error in this. I do not know if this was a contributing factor to the CDs ending up in the dump, but it certainly added risk of things becoming misplaced or misdirected or just lost in the shuffle.

Dump Day - July 22 23rd (24th)

According to emails from the PM to the dump manager, two days were identified for the refuse to be moved to the dump from Legacy Stanton, though three days were cited in other evidence collected after the breach - July 22 to late morning of the 24th. The logistics for collection of items from Legacy Stanton and disposal at the dump were pre-arranged by the PM with the Manager of the Solid Waste Facility. The PM and two NTHSSA staff certified that the equipment had been decommissioned and decontaminated prior to bringing it to the dump.

According to an email from the PM to the YK dump manager, the first loads from the hospital on the 22nd were "biomedical equipment”. These were to be disposed of by the movers at the back of the dump and buried by the YK dump staff. Subsequent loads were to be comprised of furniture and to be disposed of in the public salvage area. The last few loads carried by the movers seemed to have been remnants, likely mixed garbage, that had been collected into large grey wheeled laundry bins in Legacy Stanton, and the contents of these were disposed of in the dump as well as furniture for recycling.

According to a document which appears to be a STH draft with respect to procedures on waste management, "garbage" is "waste that is NOT recyclable, NOT compostable, and NOT biomedical and that is NOT hazardous and is NOT banned from the landfill." A witness interviewed by the independent investigators reports the items destined for the dump were described to them as being "garbage". I have to wonder exactly what

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instructions, if any, were given to workers handling this waste at Legacy Stanton, and to the movers about what, where and how items should be disposed of once at the dump.

There is no indication that any NTHSSA or DOI staff were on site to direct this operation when the items were physically delivered at the dump. It appears only the movers were on hand for physical disposal of the items. Thus, there is no first hand account by NTHSSA staff as to what items were actually offloaded and where at the dump, or any reliable account of what exactly was hauled on each load taken to the dump.

On the first day, items brought by the movers were apparently dumped and "buried" at the back of the dump as this was largely biomedical waste that needed to be made unavailable to salvagers. On the second day, according to the PM, the movers allegedly found their access to the very back of the dump "was blocked" and so they dumped their loads in the next closest location, which was the front of the contractor disposal area. There is some evidence the load could have been disposed of further back in the construction area, but no clear evidence the movers did indeed have access to the same location they had dumped items off on the 22nd.

I do not have a sense that these items were actually "buried" in the sense of being put in a hole dug in the ground for this purpose and then covered over completely. Once in the dump, waste was more likely moved around but not "buried". The loads were apparently pushed into a debris pile by the loader operator and eventually mixed with dirt and more refuse over time. Thus, they were piled, not really "buried".

It seems the last loads, on the 23rd or 24th, included furniture and mixed items. This furniture was identified in emails between the PM and the dump manager sent earlier in the month as being suitable for salvage such that it could be dumped in the designated area that was open to public for recycling. From accounts, a quantity of furniture was disposed of in the contractor’s disposal area, but some also went to the salvage area.

Subsequent Sweeps

The PM and STH staff, as indicated by the affidavit given to the dump manager, were responsible to ensure that all refuse and furniture destined for the dump had been "decommissioned and decontaminated". The citizen who found the CDs had observed there had been "cabinets and furniture", and also "yellow sharps containers", near

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where the CDs were found. Additional photos taken by the NTHSSA-QRM as part of her preliminary investigation show hospital waste (unused syringes and needles, paperwork, sharps container, binders, a lead apron, etc.) in the pile near where the CDs were found.

Photos taken by the TRM and statements by witnesses suggest that not only CDs but other hospital waste, some possibly confidential, may not have been sorted properly for disposal or should have been disposed of differently or at least disposed of away from where the public has an opportunity to observe and sort through it.

Emails show that once alerted to the breach, quality risk management staff with a small team swept through the left over furniture at Legacy Stanton yet again and despite the efforts prior to and during disposal of items at the dump, more items were allegedly found by them. This included records in the basement that should not have been there in the first place. It appears not everything of value had been purged from STH at the time of the breach.

APPLICATION OF THE *HEALTH INFORMATION ACT*

Several entities had a role to play in this case, both before and after the CDs were disposed of including the DHSS, NTHSSA and Stanton Territorial Hospital, the Department of Infrastructure (DOI), the private moving company, the Project Manager, Stanton's housekeeping contractor, and the City of Yellowknife. Some are public bodies and public custodians and others are private entities.

All of these entities except the City were health information custodians as defined in the HIA, or were acting as agents of either the Department of Health and Social Services or NTHSSA and were therefore were subject to the *Health Information Act* which protects personal information and personal health information (PHI). More specifically, when an employee of a public body or private vendor performs service and handles personal health information on behalf of a health information custodian, they are generally subject to applicable policy, procedures, and legislation that the custodian is subject to.

Handling of personal information by public sector entities in the NWT falls under the *Access to Information and Protection of Privacy Act* (ATIPP), and for personal health

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information, the *Health Information Act* (HIA). Private sector commercial transactions are subject to the *Personal Information Protection and Electronic Documents Act* (PIPEDA). PIPEDA falls under the jurisdiction of the Privacy Commissioner of Canada. In some cases, private contractors are subject to the requirements of all three Acts. The scope of this review is focuses on application of HIA, though the other acts may have application.

The CDs found in this case were attributable to the NTHSSA, a health information custodian under the HIA and that legislation, therefore, clearly applies. As such I have jurisdiction to review this breach of privacy.

ISSUES TO BE REVIEWED

This review focuses only on the matter of CDs found at the Yellowknife dump on or around the 24th of July 2019. It does not review the several other breaches of privacy that became evident during the investigation and review of this matter. I have not cited sections of ATIPP in this case, though there is clear opportunity to do so. The HIA suffices to address the scope of contraventions that occurred in relation to handling the CDs found at the dump, which are the focus of this review.

This review also does not deal with extraneous issues that emerged in association with the breach, including potentially hazardous waste and quantities of biomedical waste observed in an area of the dump that is clearly not only accessible to, but is regularly salvaged by the public. The independent investigators state "these materials were likely from the same load as the CDs" and have provided NTHSSA advice on these matters in their final report. The disposal of hazardous waste unrelated to personal information, however, is clearly beyond the scope of HIA and my jurisdiction.

The following key issue have been explored in this review:

1. Does my office have jurisdiction?
2. Does HIA apply to information collected prior to the Act coming into force?
3. Were records in the "custody or control" of the NTHSSA?
4. Did NTHSSA appropriately protect the records, as required by the Act?

a. Did NTHSSA manage records appropriately?

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b. The CDs were found in the dump "Were the records 'disposed of'?

5. Did NTHSSA respond appropriately to the breach?

ANALYSIS OF ISSUES

1. Does my office have jurisdiction?

Photos of the CDs taken *in situ* by the citizen who initially discovered them show patient identifiers (name, date of birth, some health care numbers, etc.) as well as types of information relating to diagnostic images, names of physicians, health facility names, and types of diagnostic exam. All this is written in large black marker ink on the face of most of the CDs. This type of information is identified under section 1(1) of the Health Information Act (HIA) as being "personal health information", which includes but is not limited to:

> 1(1) ...the following information in any form that identifies an individual, or in respect of which it is reasonably foreseeable in the circumstances that the information could be used, either alone or with other information, to identify an individual:
>
> (a) information about the health and health care history of an individual,
>
> (b) information respecting health services provided to an individual,
>
> ...
>
> (e) information collected in the course of providing a health service to an individual or information that is collected incidentally to the provision of a health service to an individual, including the individual's name and contact information,
>
> (f) a personal health number, other identifying number, symbol, or other particular assigned to an individual in respect of health services or health information,

Thus, HIA applies to the type of information written and possibly imaged onto the CDs.

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In its initial notice to my office, the NTHSSA states "the CDs were dumped there by movers". The movers referred to were associated with a disposal operation coordinated by the project manager (PM) who was, according to the independent investigators, "contracted by NTHSSA" as part of efforts emptying out the old hospital.

Given this and other evidence explored in this review, the dumping of CDs by "movers" was an action associated with the concurrent purge of Legacy Stanton, and any identifiable records that made their way into the dump, by association, were records NTHSSA was responsible for the management of. The movers and the PM were acting as agents of NTHSSA as defined in subsection 1(1) of HIA, and as such must abide by legislation NTHSSA is subject to with respect to handling records.

Further, preparation of records for removal to various locations from the old hospital before the final purge of the building was the responsibility regular health operations employees of the NTHSSA. Referencing section 1(1)(d) of the Act and according to the regulations, NTHSSA is identified as a "health information custodian" subject to the personal health information handling requirements of the HIA. Stanton Territorial Hospital is a regional component of NTHSSA, and its handling of PHI is thus subject to the Act.

I find that the HIA applies and that I have jurisdiction to review this matter.

2. Does HIA apply to information collected prior to the Act coming into force?

Many of the dates written on the CDs preceded the coming into force of the HIA, which occurred in October, 2015.

Section 196 of the HIA provides:

> 196. This Act applies to the use or disclosure of personal health information on or after the day this section comes into force, by
> (a) a health information custodian, even if the custodian collected the information before that day; or

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(b) a person other than a health information custodian and to whom a custodian disclosed the information, even if the person collected the information before that day.

I am satisfied therefore, that personal health information in the care and control of a health information custodian, including information collected prior to HIA coming into force, is subject to HIA.

3. Were the records in the "custody or under the control" of the NTHSSA?

Accountability for Regional Health Authority Records

I have already established that records created prior to and used or disclosed after the creation of the HIA, are subject to HIA. As some of these records pre-date the NTHSSA, similar clarification should be made with regards to records held by the old regional health authorities prior to the creation of the new "territorial" health authority, NTHSSA.

Stanton Territorial Health Authority (STHA), as an independent health authority, was likely the organization that held the records prior to August 1, 2016 when NTHSSA came into being. As STHA and several other regions were brought into the fold of this new territorial authority, all records in the custody or under the control of those regional authorities which joined NTHSSA became the responsibility of the NTHSSA.

This then makes the CEO of the NTHSSA accountable for STH's records, per HIA s. 7(b) and section 1(2) of the regulations, which states that the "Chief Executive Officer" is accountable "for the exercise of powers and performance of duties and other functions" as required under the HIA.

Origin of the Records

At least some of the CDs appear to have been generated at STH. Others likely came from service providers in another jurisdiction such as a specialist services in Alberta. These CDs are often carried with a client back to or from the NWT and shared with specialists and would contain medical information that service providers can refer to to support health service provision. Quoting the Independent investigators report "...the

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CDs acted as a conduit for information from the specialists clinics to specialist in other jurisdictions".

STH moved its operations into a new hospital in May 2019. Refuse was moved to the dump the week of July 22, 2019 from Legacy Stanton. The CDs were found in the dump on the 23rd or 24th of July, 2019. In their report the independent investigators concluded "the timing of the CDs being found by [the citizen] is consistent with the move from Legacy Stanton “and materials being taken to the dump". As the CDs were in such good condition, the investigators concluded that they must have been at the dump for a very "short period of time" before being discovered, and I concur with this finding. Taken together, this indicates the CDs were very likely associated with the cleaning out of Legacy Stanton that occurred the week of July 22, 2019.

Agents

According to the final report provided to me by NTHSSA, the "project manager" (PM) "…was on contract with NTHSSA to help with the move from the old Stanton Territorial Hospital ("Legacy Stanton") to the new hospital…". The PM was also tasked with coordinating disposal of items to the dump. The PM, and two NTHSSA staff having knowledge of biomedical waste and specialized medical equipment respectively signed off on a letter to the City, required as a condition to permit "removal of assets to the waste facility". The letter stated as fact that "equipment has been decommissioned and decontaminated".

The refuse from Legacy Stanton was permitted into the dump under the conditions of this letter signed by NTHSSA staff, and clearly under the supervision of "agents" for whom the NTHSSA is responsible in relation to the handling of records.

Under section 1(1) of the HIA, "agents" refer to people or organizations authorized to act on behalf of the health information custodian, and under subsection 9(1) such agents are responsible "in respect of the powers, duties and functions of the custodian under this Act relating to the collection, use, disclosure, management, retention or disposition of personal health information". As example, NTHSSA employees, contracted employees, contracted service providers, vendors and volunteers are all "agents" under the Act. These agents are responsible to ensure appropriate handling of records at all times, and this includes control of records for disposal.

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The HIA requires custodians to ensure agents appropriately manage records, including appropriate destruction of records under its custody and control:

> 10.(1) An agent shall comply with this Act and the regulations in the collection, use and disclosure of personal health information...
> (2) A health information custodian shall take reasonable measures to ensure that its agents comply with this Act and the regulations.

Custody or Control

Pursuant to section 4 of the HIA, the Act applies to "all records containing personal health information that are in the custody or under the control of a health information custodian ...". There is much evidence that the CDs along with other biomedical waste observed near the location the CDs were discovered originated from Legacy Stanton. There is more than one possible scenario as to how they arrived there, but all of them point to the records being in the custody and under the control of the NTHSSA, or to a loss of control by NTHSSA.

The Filing Cabinet Scenario. In a post-breach July 25 email to the NTHSSA Risk Manager, NTHSSA staff involved in the move propose a scenario for how the CDs may have ended up in the dump, one that clearly demonstrates a perspective that NTHSSA had lost control of the records prior to them being disposed of:

> "It is possible the offending materials were encapsulated in a filing cabinet (observable [in the photos] in the waste pile [at the dump] behind the documents) and broke loose during the delivery or management of the waste at the dump"… "additional material...appears to have come out of the Laboratory or Diagnostic Imaging areas of the old hospital. It is likely that this material was loose in an office and was not previously differentiated by Stanton staff... during multiple sweeps".

The Sharps Container Scenario - Another scenario is the CDs may have been in a large sharps container. Sharps containers were observed in the debris pile at the dump near where the CDs had been found. Over 200 CDs, some of a similar description to those found in the dump related to the breast screening program had in fact been identified during the purge and at least some were purposefully packed in two sharps

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containers purchased for just this purpose during the purge. Doing so is normal protocol for discarding of CDs by STH.

The containers had been correctly directed into a secure waste disposal steam for incineration at STH, but may have been gathered as part of the "biomedical" waste thrown in the dump when Legacy Stanton was cleaned out by the mover. The PM had in fact directed "biomedical" waste to the dump for burying so this is a likely source, and the CDs may have been part of the refuse identified as biomedical waste. When originally discovered by the citizen, he observed that the CDs were "in stacks". One might expect CDs released from a sharps container might retain their form from the container and pour out into a similar tidy stack. The container would have also have protected the CDs while in the dump pile from dirt and damage until they were released by the loader working the pile. I suspect these CDs were not observed during the prior sweeps of STH because they were in sharps containers, in the solid waste hold, and this room would not likely have been part of the "sweep" as items should have only been put in this room if they were for disposal.

The Cardboard Box Scenario - A third theory is that the CDs were collected at Legacy Stanton by workers during clean-up operations and brought with the miscellaneous garbage. Workers had in fact found between 40-60 CDs scattered on the floor of the clinic at Legacy Stanton and, rightly determining these were confidential and should not go in the garbage, the worker gathered them, put them in black bags, and the bags into a box. They then gave the box to a security guard to return to records management staff. Quite possibly either other workers or the guards then tossed the box into one of the large grey wheeled waste bins that were at that time being used to collect garbage in Legacy Stanton destined for the dump.

Regardless of how they got there, all these scenarios clearly indicate that NTHSSA had custody and control of the CDs at the time they were lost in furniture, abandoned in the clinic, and/or directed into the dump in sharps containers for inappropriate disposal.

Contractor Compliance

The Health and Social Services Contractor Compliance Policy outlines the responsibilities of agents of the custodian under contract. The policy binds contractors to the same rules as employees and management of NTHSSA. They are all "agents" of

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the custodian under HIA and whether full time employees or contracted employees of vendors or one-time service providers, all are subject to the Act. So the fact that NTHSSA staff – a nurse, or physician, or a record manager – was not the last person to physically handle the CDs does not make NTHSSA any less accountable.

As for the movers, the tender makes clear that "any information" obtained by the contractor in the course of the work is considered "confidential" without any emphasis on different types of information (for example, personal health information). What is more, the Authority is accountable for control of those records and generally for any related breach of privacy due to a failure of the contractor. In this case, I do not feel the contractor is particularly culpable, especially as NTHSSA had clearly signed off on all of the items going to the dump as "decommissioned and decontaminated" and I rather doubt they considered that the items being carried to the dump by them were anything other than "garbage" at that point.

I find that NTHSSA was responsible for the ongoing custody of any and all records that made their way to the dump. At some point, NTHSSA clearly lost track of and control of the records, allowing them to be inappropriately disposed of in an identifiable form in the Yellowknife landfill.

4. Did NTHSSA appropriately protect the records, as required by the Act?

The HIA requires health information custodians like NTHSSA to ensure protections are applied to the personal health information in their custody and control. Given that NTHSSA was responsible for the custody and control of the CDs in particular, it is important to clarify what protections were, and were not, in place to protect those records to prevent this breach from occurring and that would mitigate harms resultant from it.

The HIA requires that measures be in place for protection of information:

> 85.(1) A health information custodian shall take reasonable measures to maintain administrative, technical and physical safeguards for the protection of personal health information, including for protection

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(a) of the confidentiality of personal health information and the privacy of individuals the information is about;

...

(d) against loss or unauthorized destruction or other disposal of personal health information; and ...

(2) A health information custodian shall implement controls that limit the persons who may use personal health information maintained by the custodian to those authorized to do so.

About protection of records, HIA states in section 86 that they must be handled in a secure manner at all times:

86.(1) A health information custodian shall take reasonable measures to protect the security and confidentiality of records that contain personal health information, including measures to ensure that the records

(a) are maintained in a secure manner;

(b) are, if applicable, transferred in a secure manner; and

(c) are, on destruction or other disposal, disposed of in a secure manner.

Safeguards – Policy and Protocols

Protection of records requires proper management and this includes applying appropriate safeguards to all records containing PHI, including the information on the CDs. Safeguards are usually described as being administrative, physical or technical.

Physical safeguards include the such things as locking of drawers and cabinets. Technical safeguards include passwords and electronic roles-based access protocols that prevent the wrong people from accessing PHI. Administrative safeguards include policy and procedures for handling records, including staff training on such policy and procedures. Appropriate project planning that accounts for the need to maintain privacy of records would fall into this category.

Such requirements are set out under section 13(1) of the HIA regulations.

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13.(1) The administrative, technical and physical safeguards required under section 85 of the Act must include...

(f) measures to protect personal health information stored and transported on removable media;

(g) a requirement that personal health information be maintained in a designated area subject to appropriate security safeguards;

(h) a requirement that access to personal health information be monitored on an ongoing basis for the purpose of ensuring that only authorized access is occurring;

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Administrative Safeguards

With particular focus on administrative safeguards, a health information custodian is required to have policies in place to guide its administration and operations so that these align with the requirements of the Act or other relevant legislation. Subsection 8(1) and (3) specifically state:

8.(1) A health information custodian shall establish or adopt standards, policies and procedures to implement the requirements of this Act and the regulations, including the requirements under sections 85 to 88...

(3) A health information custodian shall comply with standards, policies and procedures established or adopted under subsection (1).

Policy and procedures must be in place to ensure agents manage records appropriately. This includes keeping track of records that are created and records that are identified for destruction, and for the storing of records in a safe place where they cannot be accessed by the wrong person.

The GNWT has standard retention protocols that guide retention and destruction of records, referred to as "ORCS" (operational records classification system) but as the independent investigators pointed out, NTHSSA does itself not seem to have a "fulsome records storage policy, standards or procedure for medical records...". NTHSSA does not have its own ORCS. As I am aware from the Ft. Simpson dump breach, this means

they actually cannot dispose of any primary records until such time as they have such a system in place. Without an ORCS it is not clear how copies of records are being consistently and systematically identified for disposal. STH does have an old policy, *Retention of Hospital Records Policy*, that pertains to retention and disposal and I expect suffices for this purpose given the lack of an ORCS in such cases.
The *Retention of Hospital Records Policy* which is a STH policy, not a NTHSSA policy, is particularly useful but is old – from 2010. This is about five years before the HIA came into effect. Three or four CEOs/COO's have come and gone without the policy having been reviewed and re-approved. It was last signed by CEO Kay Lewis in 2010.
This policy does reference "digital images" and "X ray films" and indicates a 5 year retention period for those records. As to disposal, and important to this case, the policy directs the disposal method for these records to be incineration. This policy and a "DRAFT" STH waste handling SOP "Handling of Health Care Waste", are not sufficient to address all issues. However, combined they are enough to make clear that CDs have to be completely destroyed, not just disposed of, which is a rather important difference.

The combination of the STH 2010 *Retention of Hospital Records Policy* and referencing other health agencies' completed ORCS seems to be how STH is managing retention and destruction of their records. It is likely time NTHSSA develop a retention and destruction schedule of its own to meet policy requirements under HIA.

Privacy Principles
Policies that require privacy principles be followed when handling PHI are another example of administrative safeguards that should have been implemented but which seem to be missing. In a previous review, NTHSSA pointed out to me "AD 035", an old Yellowknife Health and Social Services Authority Policy that NTHSSA claims is in force and applies to all of NTHSSA staff. This policy requires staff to abide by basic privacy principles, including with respect to destruction of records. Given this and other recent breaches I rather doubt the whole of NTHSSA has been made aware of or schooled in these principles, either under this policy or as best practices.

Other policies NTHSSA should have looked to for basic direction is the suite of "privacy" policies developed under the HIA, including the Contractor Compliance Policy and the Mandatory Training Policy which requires agents to participate in privacy training that would increase their awareness of how to protect PHI they came across or were made

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to purposefully handle as part of their job. Importantly, these policies make clear records are to be managed in accordance with the HIA when handled by agents of the NTHSSA.

Though some of these policy safeguards could use updating, clearly there are policies in place that, in theory at least, direct that safeguards be established to protect information and ensure it is handled appropriately. These are intended to ensure that staff are aware of privacy principles and provide protections to PHI. Unfortunately, there is little evidence in this case that these policies were properly applied, and a balance of evidence shows they were not well known by agents or abided by.

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Handling of Paper Records vs Other Media

As part of her initial investigation, the NTHSSA Risk Manager corresponded with a staff person assigned to manage the transfer of STH paper records out of Legacy Stanton. She determined that a strict process had been applied for the movement of boxes of paper records to their various destinations. For these records, a STH staff person was present when boxes were moved onto the truck and also when the boxed were off-loaded by the moving company and every single very box was tracked on a spreadsheet.

It is clear there was a controlled process was in place to securely handle the transfer of paper records for retention and storage for the move of operations into the new hospital. This process, however, seemed to apply only to paper records. Storage and destruction of other records, including CDs, was apparently not so prescribed. As for the CDs, the independent investigators discovered "there was no system of logging or tracking of CDs". The investigators mention in their report that storage of such records by STH staff, given other priorities, simply "may not been seen as a priority" in daily operation of the hospital and other than paper records, other types of records are not "being stored in a manner that ...protects client privacy".

I have to conclude that efforts were not made to 'keep tabs' on CDs with the same rigor applied to paper records. The investigator’s final report concurs: "CDs were handled with far less care and given far less scrutiny than some other documentation".

Biomedical Waste vs Confidential Information

In addition to the retention policy, STH did apparently have another policy, in draft form, that pertains to disposal of CDs and other types of hospital waste, called "Handling of Health Care Waste". This SOP in itself outlined a reasonably controlled process for disposal of items like CDs, and other waste. It specifically states:

> PROCEDURE:
> There are many different kinds of healthcare waste. Each type of waste needs to be segregated from the general waste stream (garbage to the landfill). By separating the waste into appropriate containers, we are able to divert materials that are recyclable, or require special handling and disposal.
>
> Healthcare waste is divided into the following categories:
>
> - Garbage
> - Glass
> - Recycling
> - Organic
> - Confidential
> - Biomedical
> - Cytotoxic
> - Pharmaceutical
> - Chemical

In an email to the NTHSSA QRM, the STH Human Pathology and Safety coordinator described how the process is supposed to work. This process involves the use of large "sharps" containers (usually used for used needle containment and disposal):

> When items are placed in sharps containers, they are considered "Biomedical waste".
>
> The sharps containers are sealed, and transported to the hazardous waste room by Housekeeping staff. The waste room is a secure location. Once there, the Facility Services staff appropriately packages the waste

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> into transport boxes (as per TDG Act and Regulations). Once packaged, the boxes are moved [to an onsite secure trailer].
>
> At regular intervals, the trailer is removed by our vendor and transported to an offsite location for disposal. Disposal for this type of waste is either autoclaving and shredding or incineration. Once destroyed, STH receives a certificate of destruction for the load. The certificates are maintained by the STH Facility Services department. You can rest assured, from a privacy front, the material is in fact destroyed.
>
> Unfortunately, this waste [CDs] is not Biomedical.

Obviously, there was a process in place to direct unwanted CDs into a secure waste stream where they would be destroyed beyond recognition and this destruction would have been tracked. No evidence of tracking was provided as evidence of disposal in this case. It is not clear why these protocols were not followed or why the confidential CDs were directed to the dump instead of a secure disposal service if they were in fact put in sharps containers for disposal in the first place.

It is of course not clear what the CDs fell out of at the dump: a sharps container, an old filing cabinet, or a box and bags. However, the evidence makes clear that use of large yellow sharps containers is standard for the purposes of containing CDs for secure disposal by STH, such containers were used as part of purging Legacy Stanton, and sharps containers were observed in the waste pile in the dump near where the CDs were discovered. The fact that CDs were treated as, but "is not biomedical waste", may have also been a factor in this breach.

Not Intuitive

CDs are not really "biomedical " in nature but are largely plastic disks with PHI "burned" onto them. They are in fact just another form of confidential "records", like paper records. In an email to the NTHSSA Risk Manager, the fact that CDs are not biomedical waste was flagged as a problem. Because the CDs are put in the sharps containers they are treated as "biomedical waste" even though they are really "confidential waste", and personal health information must be "destroyed". The containers and CDs cannot simply be buried. One STH employee shared that it was "not intuitive to put them in a

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sharps container", and this might have contributed to the breach, making CDs as "confidential " waste hard to identify once sealed in a sharps container.

As a means to protect PHI, this may not have been the best approach. Had they been disposed of through a secure disposal service the CDs would have been completely destroyed and a "certificate" provided as a record of destruction, ensuring appropriate disposal. No such evidence was provided so it appears these containers were amongst those that went to the dump.

Complicating things for NTHSSA, burying the CDs only makes them difficult to access in the near term with no guarantee of protection in future. The dump simply piles items and adds more refuse, so that over time they are "buried" however this does not happen immediately. There is no protection afforded by the location they were disposed in, the contractor disposal area of the dump. Suffice to say this is not a particularly good way to go about disposal of confidential medical records – not a means that complies with legislation.

Training as a Safeguard

With respect to training, NTHSSA is required to abide by the Health and Social Services Mandatory Training Policy. The policy was created to assist HSS in complying with the HIA to ensure all employees and agents are privacy aware. The policy requires that all employees – and this includes contractors and volunteers – complete privacy training when hired and thereafter on an annual basis. This means the PM, the movers, security staff, Dexterra staff, DOI staff and all other employees of NTHSSA should have completed this training. The training ensures that all of these individuals who may be exposed to PHI can ensure their actions do not risk patient privacy and that they also know what steps to take if aware of PHI that is not being treated appropriately.

The investigation report notes that the movers were not trained under this policy but were made to handle waste that contained personal health information, and further it seems they were also used to move paper records. NTHSSA is not, therefore, compliant. The investigators perceived a general lack of good understanding by those involved – "it can be stated that there are clearly gaps in understanding and/or practices with respect to confidentiality and privacy." All persons involved should have been properly briefed to prevent items entering the wrong disposal stream, to be confident in

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identifying confidential information as differentiated from other types of waste long before movers started carrying items out of the old hospital facility.

After the breach occurred, the Human Pathology and Safety coordinator took note of this gap and took immediate action to make the SOP and training more clear, and to improve on the process. In fact, before NTHSSA had even completed their initial investigation, the coordinator had already analyzed the situation, updated the SOP for clarity, and created new training materials to train staff about disposal of confidential waste and biomedical waste, including CDs. Internal emails show a new training module, now:

> ...outlines the process for confidential waste disposal (including mixed media like CDs). In the new process, the material is to be taken to Quality and Risk for content review. If the criteria for confidential waste is met, the material can be securely held and can be destroyed by DSS (our regular shredding company). As they have to run a special batch for mixed media, I would recommend sequestering the material and sending a batch once every quarter or 6 months (depending on volume).

Though these efforts are commendable, they were unfortunately too late to prevent this breach. I must agree with comments provided by one staff person who felt managers of each business unit needed to take "ownership" and be accountable for handling of patient information in their respective areas, including identifying and preparing records for secure destruction.

Were they Protected?

The Filing Cabinet Theory

Appropriate records management prior to the purge of STH, including appropriate and proactive records retention and disposal practices, and a dedicated purge of the facility and all items in it should have prevented this type of breach – all furniture should have been thoroughly gone through prior to STH moving into the new hospital. One person postulated the Digital Imaging and Lab area of the hospital as a possible source, but evidence suggests this area was actually thoroughly cleared, unlike the clinic and

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specialist areas of Legacy Stanton. If this is where the CDs originated, they were not protected.

The Sharps Container Theory
Putting the CDs in a biomedical waste container creates risk of the CDs being confused with biomedical waste, though this was the protocol used at the time at STH. If the policy and protocols that NTHSSA already had been followed by everyone involved, confidential media should have been tracked, securely handled, and directed to a secure waste stream for "destruction", and this would have avoided them being misdirected to the dump. If this is what occurred, the CDs were at least directed initially to the correct waste stream, but then were not protected from improper disposal. I find this theory to be a reasonably likely source of the CDs.

The Cardboard Box Theory
This scenario is based on the fact that approximately 20 to 30 CDs were found on the floor of the clinic in the old hospital, unsecured and un-cared for. They were then gathered off the floor and put into two "black garbage bags because they had names on them" by workers cleaning up Legacy Stanton. These black garbage bags were then put in a box and given to security. One theory was that the box was tossed in the garbage and eventually this box made its way to the dump. If this were the case, privacy training of agents, the existing STH retention policy, HSS privacy policies and processes, and a project plan, should have combined to prevent this loss and also caught the breach as it occurred. Perhaps this is the worst case scenario for NTHSSA, and demonstrates that it failed dismally to protect patient records on all fronts. This is the scenario that the independent investigators have found to be most likely source of the CDs discovered at the dump.

Whichever scenario actually applies, the Authority is not compliant with section 85 of the Act or with section 13 of the regulations, nor with relevant STH or HSS policies with respect to having appropriate measures in place to protect PHI.

4a. Did NTHSSA manage records appropriately?

> 86.(3) A health information custodian shall take reasonable measures to maintain records in an orderly manner and to maintain an organized

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system of record keeping, to ensure ease of access to the records when personal health information is required.

Records management needs to be addressed as a specific issue especially as it pertains to "orderly" management of records.

The final report indicates records management was not a high priority of NTHSSA. This was supported by comments made by several witnesses. Staff in general are not trained on how to properly handle records, not just for disposal, but for everyday use in operations and management. There was some insight shared that suggests proper filing of records is highly under-resourced and under-prioritized by NTHSSA. To maintain focus on the breach and CDs, I have only briefly touched on this matter in this review. The independent investigators have included more extensive advice on this matter in their report to NTHSSA. If this and the Fort Simpson dump breach are any indication, attention to this issue is desperately needed by NTHSSA's CEO

Purge and Sweep

The independent investigators were told that the COO of STH, on May 24th, 2019 specifically directed managers and supervisors to conduct a final sweep of their business areas within Legacy Stanton after the new STH opened, to make sure areas were properly cleaned out and nothing was left behind. There is some indication that such efforts did occur and were successful in catching some items including hundreds of CDs. Other items found as part of this post move clean up included "old blueprints, audio tapes, triage records, dictation tapes" that would have certainly contained PHI. Staff also found items left over from the previous service provider of dietary services, Aramark Ltd., including "dietary requisitions, consults with patient's names, and other information on them".

The medical clinic, in particular, was described by one witness as "not in good shape" and the specialists' area was observed to have been "left poorly" with respect to having been cleaned out properly. Long after the hospital closed, the clinic area seems to have remained unattended to. In July, workers hauling garbage and furniture out of the facility reported that when they moved "desks, papers fell out of drawers", workers observed dozens of CDs scattered "on the floor" with PHI written on them, and other items were found, including a blank prescription pad (which is a controlled item).

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General refuse like file folders, loose papers and other "garbage" was gathered up in large grey wheeled bin used to collect refuse throughout the old facility and taken to the dump by the movers. The independent investigators concluded that it is possible that the box containing CDs that had been gathered off the clinic floor ended up in one of these bins. Movers reported that they "sifted through binders and documents to remove any material that they thought should not go to the dump" and turned these over to NTHSSA.

It is concerning just how many records were left behind, and as a consequence, the number of people made privy to that information who were not involved in those patients' health care. I expect other records may have unwittingly made their way into these grey wheeled carts and been sent to the dump.

The DOJ Filing Cabinet

The CDs were not the only records that were misplaced. At one point a filing cabinet was taken from Legacy Stanton to the Dept. of Justice (DOJ) for reuse. The DOJ reported items of a confidential nature were found in that filing cabinet, including a staff leave sheet and an employee sick leave note, and other items dating back to 2013. Records found by the DOJ contained personal information of employees which falls under the protections of the *Access to Information and Protection of Privacy Act* (ATIPP), and depending on the nature of them, may have fallen under HIA. The fact these records fell into the hands of the DOJ is yet another breach of privacy associated with the purge of Legacy Stanton.

With respect to this DOJ related breach, the independent investigators state "there was a failure to protect information in the care and custody of the government, as required by the ATIPP Act." It is important to recognize such additional contraventions of NWT legislation are also breaches of individual rights and of employee privacy.

More Records

In addition, when the breach was first discovered, staff at the Yellowknife City dump who were attending to the CDs may have also found more items with confidential information when they cleaned up the contractor disposal area, though the evidence of this is now buried under the dump. This indicated records were disposed of that either should not have been disposed of or were disposed of inappropriately.

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GNWT warehouse staff assisting to ensure furniture from Legacy Stanton was emptied also reported finding "confidential materials, including patient information, meeting information and meeting minutes".

This and other evidence strongly indicates to me that the purge of items from Legacy Stanton was not thorough, though it is clear several staff dedicated much time to clearing out and final sweeps of the building before the movers were engaged. There may simply have been a lack of control of items being moved in and out of and around STH while final sweeps of all areas were conducted.

Because these incidents were caught, the independent investigators referred to these events in their report as "a number of 'near misses'." While not excusable, the chaos with respect to wayward records is perhaps not unexpected given the number of years the hospital was in use. This, however, does not apply to the newer items like some of the CDs found at the dump and created in the month before STH moved locations. Perhaps the loss of records so recently created also speaks to the poor management of records by NTHSSA.

There is no question, the confidential documents found by staff and contractors should have been retained or disposed of in a controlled manner before the movers got there. These obviously were not "garbage" as described in STH policy on waste disposal. These events should not have happened and are contrary to requirements under NWT legislation and GNWT records management standards.

Other than the dedicated paper medical records, records were not managed in an orderly fashion.

4b. Were the CDs found in the dump 'disposed of'?

Usually when things are found in the dump they are no longer considered the property of anyone, and are “up for grabs”, which is good for salvagers but bad if it’s your private information. In this case, the evidence strongly suggests the CDs came from Legacy Stanton as part of "garbage" and were off-loaded in the contractors' disposal area. As such, one might conclude then that the records have been "disposed of" and NTHSSA is off the hook for their protection. But this is not so and is far from it.

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"Destroy" vs. "Dispose"

Among other factors in this case, an important nuance here is the difference between "disposing" of something, and "destroying" it. This is important to the context of this breach as it appears records and other items were not disposed of in an authorized manner. To properly dispose of PHI, records must be destroyed in a manner that they cannot be used alone or with other information to identify the individual the information is about. Put simply, if destroyed properly, all or part of the remnants of the records should no longer meet the definition of "personal health information" as defined under HIA 1(1).

In a July 16, 2019 email to the dump staff, the PM made clear that the first few loads would be biomedical waste, adding that ..."it is important that this equipment get "buried" and not picked through by the public". The PM stated in that email that the moving company "will also be bringing cube vans of standard salvage – desks, chairs, side tables, filing cabinets, etc. that can go in the salvage section".

It seems some loads were taken to the "back of the dump" which I sense is the far side of the contractor's waste area, and some were disposed of in the front of the contractor's area. Some, but not all, furniture items were disposed of in the salvage area.

It is clear some loads were not dropped where the PM expected and were not really "buried" as in the dictionary meaning of the word. Over time it may well be "buried" but at the time it had just been pushed and piled by the loader and mixed with other waste and dirt, not buried under the ground where it would be difficult to observe and retrieve. The refuse brought by the movers was not technically destroyed as this pertains to PHI and in accordance with NWT policy and legislation.

As for the CDs, after they were disposed of by the movers and retrieved by the citizen, they were again disposed of, this time by the YK dump staff, compacted with other items they had gathered, "baled" and "buried". It is conceivable that when the CDs were "compacted" they were broken and rendered unreadable, but it is also conceivable that not all of the CDs met this fate and that there are more CDs in the dump. Evidence indicates there were more CDs that likely went to the dump beyond those found by the citizen.

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The important distinction between “disposal” and “destruction” was alluded to by the NTHSSA "South" QRM assisting with the investigation in an internal July 24th email, and who immediately pointed out that "baled" might not mean they had been properly destroyed. Reflecting this concern, the dump manager told the PM in an email that:

> Private information such as documents and CDs would ideally be brought to Document Security Systems (DSS) for proper and secure disposal.

DSS is a local company that handles confidential waste for shredding and other disposal methods that render it destroyed. This is where the CDs likely should have been taken for secure destruction. As a best practice, when PHI is disposed of, it must first be destroyed in a manner that does not allow an individual's identity to be reconstituted from the remains of the discarded records over time.

Unfortunately, NWT legislation is not all that clear on this requirement. Section 86(3) and (4) of the HIA requires a custodian to "maintain records in an orderly manner", and "shall comply" with requirements set out in regulations with respect to retention, transfer, and destruction "or other disposal of records" containing PHI. There are, however, as yet no such regulations. Such regulations would provide clear direction on what NTHSSA is required to do when disposing of records.

Subsection 86(1) the HIA is more helpful, and requires that records "are, on destruction or other disposal, disposed of in a secure manner". However, there is no legislated definition of "secure manner" and the regulations are also silent, and "destruction" is not mentioned except, somewhat ironically, with respect to who is to be notified about a privacy breach where records have been destroyed.

Limits Set by the Custodian for Disposal of Records

HIA subsection 9(3) makes it quite clear that disposal of records is restricted to certain parameters and if these parameters are not followed, an "unauthorized act" has occurred. An "unauthorized act" may pertain to the collection, use, disclosure, management, retention "or disposal of personal health information contrary to any limits imposed by the custodian".

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What then are the limits that have been "imposed by the custodian" for destruction of records, that NTHSSA should have followed in this case?

Electronically Stored and Transferred Information Policy

The “Electronically Stored and Transferred Information” policy is one of several policies developed by the DHSS and issued by way of Ministerial Directive in May, 2017, and amended in September 2019. This policy does not mention CDs specifically, and it is directed at "portable devices" such as USBs, laptops, tablets and phones, but appears to apply to electronic information storage and transfer, described as "anything created, recorded, transmitted or stored in digital form or in other intangible form by electronic, magnetic, optical or other similar means."

The policy directs that stored information is to be protected "against loss, unauthorized access, manipulation, destruction, or theft." The policy discourages long term storage on such devices, requires devices be cleaned of data when no longer needed, and requires tracking when information is moved onto and off of the device.

It also requires password protection and physical security when not in use. It encourages transfer of information where possible over secure networks as opposed to use of portable media. As such, the policy is a useful reference, but not clearly directed at handling PHI for the purposes which the CDs in this case may have been used for, and does not provide much in the way of direction on destruction of such media.

Retention of Hospital Records Policy

As previously noted, STH has a 2010 *Retention of Hospital Records Policy*. This policy does reference the types of information we could expect to find on the CDs. In this policy, "mammography films" have a retention period of 6 years. The policy states "digital images" and "X ray films", have a 5 year retention period, and as to disposal, the policy directs these must be "incinerated". A "remark" referencing the Canadian Association of Radiologists is included with this direction.

This policy, combined with an existing STH waste handling SOP, “*Handling of Health Care Waste*" which states that biomedical waste (which CDs become when packed in sharps containers) is to be destroyed by either autoclaving and shredding or incineration, makes clear these should be completely destroyed prior to or in process of

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disposal. Though these STH policies could use revisions, there is enough guidance in them to provide appropriate direction to ensure CDs are destroyed, not merely disposed of. I will add that the guidance developed and provided for the purge of STH directed shredding of records, but in the case of digital images, the STH 2010 policy clearly states incinerate, and thus I would suggest the latter is more appropriate for such CDs.

In this case it is clear that these CDs were not destroyed. They were merely disposed of in the dump in their original condition, machine readable and with clearly legible inscriptions.

ORCS Requirements for Destruction

Having an ORCS in place is another administrative measure that provides direction on not just retention but also destruction of records. In the absence of a NTHSSA records retention schedule, the 2016 Operational Records Classification System (ORCS) developed by the DHSS, Territorial Social Programs (TSP) was used as a reference to the investigation. The TSP ORCS defines several classifications assigned to records that we can relate to STH operational environment. For example, "Active Records" are those that need to be kept handy for regular business use. A "semi active" record is "a record that is no longer required for constant referral in the daily course of business, but which is still of some use...because of administration or legal requirements". "Full Retention" records are "records maintained". Finally, records identified for destruction are flagged "destroy", and "the record will be destroyed in a manner that will prevent it from being reconstructed".

While this ORCS does not belong to STH, the direction evident from the TSP ORCS pertaining to destruction is sound and certainly could be relied on as a model by STH. Again, it is clear that records must be completely destroyed, not just disposed of.

Moving Service vs Disposal Services

These records should never have been handled by a moving company. Local movers were hired to move the items to the dump under an existing standing offer agreement managed by the Department of Infrastructure (DOI). And although the movers have delivered items to the dump many times over the years, it appears no separate contract, at least in this case, was let specifically for waste disposal or potential handling of personal health records.

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This generic tender for services was relied on by NTHSSA to take items to the dump. The tender describes the required services as "large delivery service and small office moves..." as well as "Pick up and delivery of records or files." The contract states the "Contractor must comply with specific rules in regards to records transfers" though no rules are attached as reference, and this particular job was to move garbage slated for disposal. This was clearly not a records transfer job. There is nothing helpful in the standard offer agreement wording that addresses risks associated with disposal of PHI, beyond a passing reference to "confidentiality".

I expect a dedicated waste disposal service would have a higher sensitivity to the appropriate handling of different types of hospital waste if it was being asked to move and dispose of records. It is not clear what preparation or training the movers had, and it appears they had no privacy training though they obviously had years of experience transferring records, and also the good sense on more than one occasion during the purge of Legacy Stanton to retrieve confidential items they came across.

Destruction of PHI is such an important part of records disposal that it is usually tracked and normally handled by professional companies that specialize in waste disposal and which have experience in destruction of confidential records (e.g bulk shredding of government documents). A local company is contracted to handle secure waste collected from many government offices, including NTHSSA. The evidence suggests STH biomedical waste, including sharps containers filled with CDs, is usually directed for secure destruction. CDs are normally securely disposed of so that they cannot be reconstituted. The CDs in this case should have been directed to this type of a service, both before and after they were discovered, not put into the hands of movers, and not baled and buried at the dump.

"No Unauthorized Access Beyond this Point" - "Secure" Disposal

HIA sub clause 86(1)(c) requires that records are, on destruction or other disposal, to be disposed of in a secure manner. I want to clarify that the designation of the construction waste area as "restricted" does not in any way meet the requirement for records to be disposed of in a secure manner.

NTHSSA was very quick to point out, when notifying me of the breach, that the CDs were found in the “restricted” contractor’s disposal area, quoting the wording on the sign

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posted at the entrance to this area of the dump: "No Unauthorized Access Beyond this Point". NTHSSA cannot rely on the restricted designation of the area. That area of the dump did not afford the CDs any degree of security or in any way meaningfully minimize the risk of disclosure to persons who should not have had access to that information.

The records were disposed of in an unauthorized manner. They were not destroyed. They were not disposed of in a secure manner.

5. Did NTHSSA respond appropriately to the breach?

Initial Responses

A health information custodian is required to respond when a breach of privacy occurs with respect to records in its custody or its control. Under section 14 of the HIA regulations, the following is required:

> 14. A health information custodian shall
>
> (a) take reasonable steps following a security or privacy breach to investigate the breach and to ensure that a breach does not occur again;
>
> (b) keep a record of any security or privacy breach and any corrective measures taken as a result; and
>
> (c) take reasonable disciplinary measures against an agent who fails to comply with a provision of the Act, these regulations or any standard, policy, procedure or safeguard relating to the Act or these regulations, having regard for
>
> (i) the nature of the breach,
>
> (ii) whether the breach was intentional or not, and
>
> (iii) whether the agent has previously committed a breach.

For the most part the initial response to the breach was appropriate, although a bit disjointed and slow. Once advised, three quality risk managers clearly invested much time, energy and dedicated effort into the initial investigation and in trying to ensure the breach did not recur. They went to the dump, they gathered information from several key witnesses, they went more than once to Legacy Stanton to sweep the space and

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furniture yet again, looking for left over records. They took steps to ensure no more CDs or other records containing personal information were in the building or had left the building in furniture for surplus.

I am, however, concerned somewhat about the initial notification of the breach to the quality risk managers who are ultimately responsible to investigate what happened. In my opinion, the NTHSSA QRM and the QRM for the region, as well as the COO should have been the first point of contact given the critical nature of this breach as they are responsible for conducting the initial investigation. Evidence suggested this did not happen.

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Time is of the Essence - Implementing a Breach Response

Section 8 of the HIA makes clear polices must be abided by, specifically, subsection 8(3):

> A health information custodian shall comply with standards, policies and procedures established or adopted under subsection (1).

The DHSS Privacy Breach Policy states that NTHSSA is required, as an administrative safeguard under the HIA, to abide by the policy. The policy states that the following is required to be completed as part of Schedule 1 "Initial Reporting", when a potential privacy breach is detected:

> Department and HSSA employees must report all detected potential privacy breaches as soon as reasonably possible… An employee reporting a detected potential privacy breach must:
>
> - Report the detected potential privacy breach to an Authorized Employee, and such report may include:
>   - A description of the situation;
>   - A reason or explanation why the situation is of concern;
>   - Date(s) and time(s) of the event;
>   - Person(s) involved in/ causing the concerned behaviour; and
>   - Any action(s) taken to date to stop the behaviour;
> - Provide any relevant evidence, i.e. notes or related documents;

- Maintain privacy and confidentiality during and after reporting; and
- Follow any directions received by the Authorized Employee in response to their reporting.

In this case the "employee" who first became aware of the breach after the MLA and the Minister’s personal advisor, was the DM of HSS, who reported it to the COO, who likely reported it to the Director of NTHSSA's Risk unit, who then notified the NTHSSA and two regional QRMS who assisted with the initial investigation.

Three problems stood out to me:

a) lack of a clear fan out list, including for the legislative assembly
b) the length of time taken to get the investigation going in earnest, and
c) who was involved in the investigation, and when.

The response was more or less appropriate except that the timing of the activities related to the initial reporting appears to have been delayed and, in my opinion, the wrong person was dispatched at first to the dump. One QRM reported that even by the end the day on the 25th "there was 'not a lot of information'" about the circumstances of the breach. This approach and lack of information was to the detriment of the investigation.

A representative of the Dexterra housekeeping staff attended the dump in the afternoon but obviously did not really understand what he or she was looking for as many items of interest to the investigation were observed by the NTHSSA QRM the next day. Failing to have a dedicated investigator visit the site as soon as possible may have resulted in a missed opportunity to discover what happened and why.

A swifter response in relaying the message to those who needed to know may have assisted NTHSSA in contacting the dump and prevented destruction of the CDs needed as evidence and to gather more information about the circumstances in which they were disposed of. This would have also limited the exposure of the CD information (photos) to fewer individuals within the GNWT.

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Documenting the Breach and Completion of a Breach Report

As required by the HSS Privacy Breach Policy, normally after a breach NTHSSA would complete a short investigation report and in this report would summarize what they had discovered, what likely went wrong, and state what short term and long term measures NTHSSA has and will put into place to prevent a similar breach. As part of its initial response to this breach, it appears NTHSSA took steps to review its records handling practices and the role private vendors played in aiding with records handling.

Initial and ongoing documentation of the pertinent details relating to a breach and the response are an integral part of NTHSSA's initial efforts to address any breach. I found, however, that the timelines related to the breach had not been well documented. The "date a time of the event" and "persons involved" in a breach is the most basic of information necessary in fulfilling initial reporting requirements under the HSS Privacy Breach Policy. The passage of time makes it difficult for those involved to recall dates months afterwards. It did not help that a full investigation was not initiated until mid-September, about two months after the breach.

In this case, I am unable to confirm if the breach actually occurred on the 24th, or the day before. Similarly, it is difficult to determine exactly when the CDs may have arrived at the dump with the movers. This could have been any of the three days when loads were allegedly taken to the dump: the 22nd, 23rd, or the 24th, with the 22nd and the 23rd mentioned with more frequency by witnesses and in correspondence.

NTHSSA did not complete a final report and instead hired an independent investigator to do so. The HSS Privacy Breach Policy states that "Where the initial review finds a likelihood of a potential privacy breach, the Department/HSSA must carry out a full investigation as set out below...."The Deputy Minister of the Department/Chief Executive Officer of the HSSA maintains discretion in determining whether… to have an external internal investigator...". Critically, there is no mention of a time-line for initiating a "full investigation" in the case where it has been made clear by the "initial review" that a "likelihood of a potential privacy breach" has occurred.

The Privacy Breach Policy goes on at length about how to pick an independent investigator, but timing of this is left entirely to the COO’s discretion. There does not seem to be any established criteria used in making this decision. In this case, the COO

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determined independent investigators were required, but the full investigation was not started until mid-September, almost two months after the breach. Some of the issues with preservation of evidence and memory of events may have been prevented had the full investigation been launched sooner, and if NTHSSA had completed the basic requirements of a breach report as outlined in the policy to preserve the key elements of the breach while awaiting the full breach report. There is nothing to prevent the NTHSSA from recording and writing its own brief report on the matter for more current reference while the investigators conduct their investigation. One would think the date the breach was discovered might at least be recorded.

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Notice to Affected Individuals

NTHSSA is required to notify individuals who have been affected by a beach. The HSS Privacy Breach Policy states the following:

> Where the initial review confirms the occurrence of a privacy breach, the Authorized Employee may proceed to notification as set out in Schedule 3.

Schedule 3 – Notification, states:

> Where the privacy breach has been confirmed upon the completion of a full investigation as set out in Schedule 2, the Department / HSSA must carry out privacy breach notifications in accordance with this Schedule... All reasonable efforts must be made to contact affected individuals.

Under Section 87 of the HIA notice is required to be provided to the affected individual as soon as reasonably possible after identification of a breach of their privacy:

> 87. Subject to any prescribed exceptions, a health information custodian shall give notice to an individual and, if applicable, to a prescribed person or organization, as soon as reasonably possible if personal health information about the individual is
> (a) used or disclosed other than as permitted by this Act;
> (b) lost or stolen; or
> (c) altered, destroyed or otherwise disposed of without authorization.

The policy is a little unclear on the timing of the notice. Where the initial review confirms the occurrence of a privacy breach, the custodian may notify affected individuals in accordance with Schedule 3. However, Schedule 3 provides that notice is to be provided when “the privacy breach has been confirmed upon the completion of a full investigation”.

Often, particularly in less serious breaches, NTHSSA gives notice immediately after the preliminary determination of a breach. In my opinion, in most instances this is the appropriate response. Section 87 of the Act, which has precedence over the policy, requires notification “as soon as reasonably possible”.

I suggest that where it is evident from the outset that there has been a breach, notice to affected individuals should not be delayed. In this case, notification of some of the identifiable individuals could have commenced in earnest in July or August 2019. However, NTHSSA has not confirmed whether any notification has taken place to date.

As for notifying patients, I can appreciate that the CDs found at the dump were no longer easily accessible and had been reportedly "baled" and "buried" before NTHSSA could physically inspect them, and that the photos provided by the citizen do not show the face of all of the CDs with the writing on them. However, one can easily identify several of the names on the CDs. I am aware steps were taken by NTHSSA to identify these individuals and match the information on the CDs as feasible with existing medical records. Steps should have already been taken to notify as many of those individuals as possible right after NTHSSA completed their initial investigation.

In this case, s. 87 (a)(b) and (c) HIA were not complied with, and information was lost, disclosed and disposed of contrary to the legislation. If they have not been already, the affected individuals must be notified. Until NTHSSA provides evidence of notifying these individuals I have to assume that they have not been notified.

Ongoing Risk

There were more than 60 CDs visible in the photos taken by the citizen, however, the evidence makes clear many more CDs were disposed of by STH as a result of the purge of the old hospital. Not all of these CDs were necessarily disposed of in the

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dump, but there is a high likelihood there are more that remain at the dump, and in a form that permits identification of patients. It is not clear what steps NTHSSA took at the time, or has taken since, to prevent any additional CDs from “surfacing” out of the pile. If no steps were taken, they should have been, and if steps were taken, they should be documented in the NTHSSA's investigation report.

Further, there is a good possibility that there were more CDs at the landfill not properly disposed of and anyone could have picked them up before or after the breach was discovered. I am not aware whether NTHSSA made a public statement about the breach, so the public was not encouraged to come forward if they came across these items at the dump.

In such cases, once the preliminary investigation is done and the situation is controlled, it might actually be helpful to notify the public about such breaches and to provide them with direction on how to respond so such incidents can be quickly addressed.

DISCUSSION / CONCLUSIONS

I concur with the following concluding remarks of the investigators:

> Regardless of the HIA and the ATIPP Act, the courts in Canada have made it clear that clients seeking health services have a legitimate expectation that their personal information will be treated with care and respect. Their privacy will be honoured. The way the information on the CDs in question was handled, in addition to the way other documentation was handled, in no way protected the reasonable expectation of clients.

There are multiple aspects to this breach that reflect varying levels of compliance, or lack of compliance with the HIA as well as with the application of privacy best practices and principles, or a lack thereof. Though not exhaustive, I have reflected on some key observations arising out of this breach.

Another Dump Breach

It is disappointing from my perspective that this incident occurred shortly after mental health records were allegedly discovered at the Fort Simpson dump. It is also difficult to

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ignore the parallels between the two breaches. Not only does this storyline involve the local dump, but also a 'clean-up' of old records and refuse from a health facility, lack of privacy awareness by agents, and likely misidentification of records - in this case as "garbage", and in that case as "junk". That breach also, apparently, was first reported to an MLA before NTHSSA quality risk managed staff became aware of the breach. It would not be hard to find more similarities, but the point is that something very similar had just happened less than a year earlier, and one would hope that NTHSSA would be on high alert and have put measures in place to prevent a similar event to the Fort Simpson dump breach.

The move of items to the dump was not properly supervised by NTHSSA. In the final stages of the move/clean-out, subject matter experts were not utilized to identify what should be disposed of, where, and how. As a key risk mitigation measure, the NTHSSA should have ensured a knowledgeable person with a technical understanding of what was being moved as refuse from a hospital was present for all loading onto and off of the truck, as was done for transfer of paper records into storage by having a records technician present. Perhaps project staff should have worked more closely with Dexterra, the infection control staff, and records management experts on staff.

The myriad of records, supplies, and pieces of furniture that needed to be purged while at the same time relocating services to the new hospital and closing down the old was clearly a complex undertaking. It was not, however, unmanageable. There was some effort to clean-out items but not under any apparent controls. These failures contravened requirements of HIA to protect PHI and patients, as well as to follow policy and procedures for information handling.

It appears that NTHSSA failed to manage records in its possession for many years. If these CDs were all copies, they should have been destroyed as soon as they became redundant. If they were STH’s only copy or the record they should not have been disposed of for at least 5 years after creation, and they certainly should not have been disposed of in the dump in this manner. They should have been taken to the local secure disposal service or sent with biomedical waste for incineration if they were no longer needed. This is a not only a project management issue but a records management issue.

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This incident also highlighted the confusing chain of command for privacy breaches. The long, single point of contact chain of communication used to report the breach delayed

NTHSSA's ability to address the breach immediately. I note reporting of the breach was also an issue in the Ft Simpson Dump.

Crucial evidence was destroyed that might otherwise have been used to better understand the breach as well as to notify the affected individuals had the NTHSSA QRM been notified more immediately. A cumbersome, ill-defined and lengthy reporting chain is inefficient. Stakeholders need to invest in a shorter, more efficient, reporting scheme a priority. A fan out scheme with the NTHSSA QRM being a first point of contact is required.

Further, the breach occurred around the 24th of July and the independent investigation did not commence until mid-September and by then witnesses recollection of events seems to have waned considerably such that even simple facts like the actual date on which the CDs were found could not be determined.

Privacy Best Practices – Preservation of Evidence

It is a bit of a catch 22 whether to destroy personal information that has been received in error as soon as possible to prevent further disclosure of the information, or to preserve it as evidence and thereby risk further loss or mishandling. The latter would have been much preferred in this case.

I don't want to take away from the good Samaritan efforts of the individual who discovered the CDs and the helpful dump staff, as they in some ways saved the day, but a privacy breach is like a crime scene and preferably should be preserved until investigators have had some opportunity to scrutinize the evidence, and some evidence may need to be kept at length to permit access by the persons whose information has been compromised, or for further investigation.

The CDs were crucial evidence and could have been better controlled to allow for each CD and its contents to be documented before being destroyed after a reasonable period of retention. Because a very lengthy and slow regular chain of command was followed,

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not one that would reflect a critical situation, the QRMs seem to have not been given the opportunity to immediately investigate key evidence in this case. As a result, key evidence, including dates of key events, do not seem to have been recorded by NTHSSA, and dates that came to light from various sources and witnesses during the investigation were inconsistent. The independent investigators commented on this, and were themselves unable to make headway clarifying dates, including the date the CDs were discovered.

The investigators concluded the CDs were "most likely" taken to the dump on the 22nd, and on this point I concur. The investigators state they believe the CDs were found on the 24th, but presented no conclusive evidence. I can only say I believe they were discovered in the morning of the 23rd, or the 24th. I find either of these dates are quite plausible.

The sequence of events and the dates seem small details but they impact understanding the scope of the breach and the response by NTHSSA, and reflect what needs to change. If NTHSSA had written a brief breach report, separate from the independent investigators, this surely would have preserved this key information.

Train – then Do

In my experience as Information and Privacy Commissioner, I have repeatedly observed HSS failing to invest adequate resources into staff training. This breach is yet another example where insufficient training was a likely cause. Had the staff and contractors involved in the closing down and moving out of the old hospital all been given even a 25 minute crash course on privacy and what to look for during the move, so they were at least aware of the ten basic privacy principles, it would have helped. Everyone acting as an agent for NTHSSA, including private sector workers, should know their obligations under the Act with respect to accountability, purpose, consent, limited collection, use, disclosure and retention, accuracy, safeguards, openness and right to access and challenge. In fact, the legislation requires it.

Training would have empowered these workers to handle records more appropriately, and to identify adverse situations and intervene quickly where they saw information not being handled correctly. They also would have been better prepared to react in a more timely manner to any instance of a breach of privacy.

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Point Person

The effort to purge Legacy Stanton of records and items and the move to the new hospital involved many workers and many different organizations, in both the private and the public sectors. It is clear that there was poor control of all of these efforts as this pertains to records other than those that were paper medical. Several of the witnesses suggested that in future there needs to be a "point person" to control the various aspects of these activities within the larger project, and across departments and agencies. Co-ordination, logistics, and oversight was desperately needed not so much to make sure people were doing their job, but to create a plan, be highly attentive to the plan and sensitive to deviations from it, to address loose ends as they occurred and to ensure these were addressed in a timely manner.

In particular, a representative of NTHSSA should have been at the dump ensuring appropriate disposal was completed and dealing with any unanticipated situations or items that might not have been intended for disposal in this fashion. This would have included ensuring items were actually buried as expected, and in a manner they could not be salvaged, though as mentioned this would not meet requirements for the CDs.

In the Spirit of Cooperation and of Legislation

I was alarmed to observe from the evidence that DOI, for example, was not exactly communicative about the decommissioning of Legacy Stanton or helpful with NTHSSA's needs to access the space to complete the purge. They were similarly not entirely helpful with the initial investigation into the breach.

According to the investigator’s report, the DOI apparently prevented STH staff from entering Legacy Stanton shortly after the move to the new facility despite STH administration voicing concerns about not having access. They were apparently denied access with little or no advance notice from DOI. This likely had a direct impact on the final clearing out of old furniture and last looks around for stray records by STH staff.

The independent investigators noted this and commented it was "very concerning", and in their view "NTHSSA officials needed to be in the driver's seat", so they could ensure the space they had occupied for decades was purged appropriately. As a result, respect for the confidentiality of information still on the premises was not given the attention it should have had. The independent investigators concluded that "That the Department of

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Infrastructure had too much control over the course of the move, and timelines to start the decommissioning process." This was a handicap to STH efforts to protect information.

As the independent investigators pointed out, DOI seemed to be the "driver of the decommissioning process at Legacy Stanton". As the "driver," they then were responsible for clear communication with all involved during the decommissioning. DOI also should have demonstrated a commensurate level of concern for the breach of privacy related to the CDs as STH did and been more helpful with their initial investigation. Though I have not delved into the matter here, I and the investigators note that there was some completely inappropriate 'attitude' shown STH staff by DOI in response to NTHSSA's lawful efforts to understand the context of the breach as its related to decommissioning of legacy Stanton. A more positive spirit of cooperation in the public interest is required.

Privacy Was Breached

I disagree with the finding of the independent investigators who concluded that "there is no indication the information was reviewed by anyone". Whether electronic images or other data were contained (recorded) on the CDs or not cannot be confirmed with certainty as the evidence has been destroyed. However, the names and other personal health information of patients were very clearly viewable in large black marker, scribed on the face of many of the CDs found at the dump. There was no need to "read" the CDs electronically in order for PHI to be inappropriately disclosed in this case, and clearly the information on the CDs has now been reviewed by many people in the GNWT as a result of addressing this breach, as well as the MLA the citizen and dump staff.

A privacy breach cannot be “undone” – once out there, the information is out forever and the potential for harm to an individual continues at length and can extend well beyond the life of the individual the information is about to family, community and in some cases, to next generations.

Destroyed?

I disagree with the finding of the independent investigators who concluded that the CDs had been "destroyed". In reference to the lengthy section of this review focusing on

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disposal, the CDs were not "destroyed", they were compacted with other refuse and "buried". While it is unlikely they could be recovered in a useable condition at this point, they were not destroyed in accordance with rules imposed by the custodian for destruction of records. The HIA required "secure disposal", STH's own records retention policy requires digital images be "incinerated". The manner in which the CDs were disposed of, including the fact NTHSSA lost control of them and did not prevent them from being disposed of in this manner, does not meet the requirements of the HIA. The records have not been "destroyed" as required.

Lack of Governance

One of the conclusions reached by the independent investigators that I strongly agree with has to do with their observation of a lack of governance and direction on records management that was a factor in this breach as well as previous breaches. They state:

> NTHSSA needs to address the serious lack of governance and resources it has with respect to record's management. It is important that NTHSSA develop a consistent and uniform storage policy throughout the authority. If NTHSSA officials believe there are certain basic principles that apply to document storage, then any discrepancies between regions or program areas cannot be justified.

Paper based medical records in tidy folders from the records department were handled in a controlled manner by STH, and some CDs were initially handled correctly. Other records were clearly not handled properly or treated with respect. Patient information scattered on the floor of an old clinic in particular, is simply unacceptable.

Permitting a *laissez faire* environment where PHI can be treated with indifference and/or unwittingly directed for destruction in a manner that does not "destroy" the information, is contrary to the Authority's obligation to its patients under NWT legislation.

Having a policy, implementing a policy and following a policy are three different things. In this case, DHSS, GNWT STH policies should have aided in preventing this breach, but clearly these were not applied. Clear direction in the form of policy, procedures, regular and situation specific training, and retraining of both full time employees, as well as contractors and volunteers, are all necessary to ensure records are handled

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properly and patient’s sensitive information is protected from unauthorized use and disclosure. This includes proper storage of records over time within the operational context and is a matter the investigators have delved into in their report at great length. Their wealth of experience and advice on this matter must be heeded by NTHSSA.

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Poor Planning and Preparation

I agree strongly with the following high level finding of the independent investigators that sums up much of what went wrong, and that contributed to this breach:

> ... there was a lack of a written plan with respect to the move of personal health information and confidential information, a lack of coordination, ...inappropriate security ... and a lack of communication with and between [all those involved] and a lack of accounting of the materials after the events.

In this case the plan to take refuse to the dump from Legacy Stanton was too lightweight and as a result this breach occurred. Purging, cleaning out the old hospital, delivering and disposing of items at the dump, all relied greatly and optimistically on the *ad hoc* response of the miscellaneous workers, DOI Warehouse staff, quality risk staff, the movers, the security guards, the dump staff, and in the end, the citizen, to failsafe the "plan". These individuals served, in effect, as the primary measure that counterbalanced poor records handling demonstrated by STH operational staff, and amplified by poor project planning, and, as evidenced, on many occasions these workers redirected abandoned records.

Warning Signs Went Unheeded

Even after the hospital was thoroughly purged "lots of stuff" remained scattered throughout the hospital. If we exclude the CDs found at the dump, there were a myriad of other privacy breaches associated with purging of Legacy Stanton that demonstrate without doubt poor control of records containing personal information and PHI.

There were clear indications a major breach would occur. The investigators called these incidents "near misses". I call them warning signs. Most are actually breaches of privacy, as those records were often handled contrary to requirements of HIA.

NTHSSA leadership failed patients and agents by not having a plan that included pro-active measures to ensure PHI was handled appropriately and that policies and procedures in place were abided by. The purging plan relied too much on others to pick up the pieces. As a helpful analogy I offer the following: a ship needs to have lifeboats, lifejackets, and a watch person, but such safeguards should only be relied on when best laid plans go awry.

Such safeguards are fail-safes, they are not "the plan", they are the emergency plan. The emergency plan in this case - agents haphazardly picking up the pieces, literally - is what NTHSSA was relying on to prevent breaches of protocol from becoming the breach that it did…and it almost worked, until it didn't. This is not a failure of the agents. It's not the watchman's fault. This is the fault of the Captain, of NTHSSA leadership. They apparently never told the watchmen what to look out for.

This could have easily been a much bigger disaster than it was. The person who found the CDs could have easily posted them to Facebook or Instagram for the world to see. NTHSSA should give a world of thanks to the individual who found them for being a seaworthy lifeboat in their emergency plan.

Redacted Report to IPC – Legislated Requirements

The law requires production of full documents requested by my office when doing an investigation. I was initially provided with only a redacted copy of the independent investigator's final breach report by the NTHSSA. The electronic binder of attachments that was key evidence was also redacted for most names, email address, telephone numbers, signatures, but not the narrative. The provision of a sanitized breach report speaks to the NTHSSA's lack of understanding of its responsibilities under the Act. I asked for and received the "original" version of the report in which most of the black redactions were removed, except for one that hid the name and email address of a person on one piece of correspondence. Two pages were still blanked out. An un-redacted e-binder was not provided. The appendices referred to in the report were provided.

Both the HIA and the ATIPP Act clearly provide that the Information and Privacy Commissioner shall receive any documentation requested to be produced for the purposes of IPC investigations. I expect to receive un-redacted copies of such reports in

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future unless the custodian/public body is given leave by this office, on request, to withhold portions of a record.

Disciplinary Measures

Sub section 14(c) of the HIA speaks of disciplinary measures that might change an employee's actions towards better alignment with the HIA and privacy best practices. Such discipline is to be applied as a result of, and after a breach has occurred and has been clearly attribute to their actions, or a failure to act. The independent investigators concluded that no one employee is responsible for the breach.

While there may not be one responsible employee who can be identified, there are certain positions that bear the obligation to ensure compliance, and these positions, therefore, are ultimately responsible for the breach. Given this is a repeat of a similar concerning breach, action by these individuals which might have prevented this breach is more than expected, and was wanting. On the heels of and with particular emphasis on the findings of the Fort Simpson dump breach, this failure is ultimately the NTHSSA CEO's, as the breach could have been prevented by NTHSSA leadership. The cause of this breach was essentially particularly poor planning and preparation and resource allocation put into the purging aspect of the transition of services, as well as systemic poor management of records collected on other media.

I find the independent investigator report over-emphasizes the actions of movers, the dump workers, and the minutiae of legal contracts, etc.. These actually only came into play after NTHSSA had already failed to prevent those records from being mishandled by health care workers and health administrators in the first place. If the CDs were not discarded, abandoned, misplaced, mishandle, mismanaged or misdirected by NTHSSA, the breach would not have occurred.

The independent investigators point to a general "lack of coordination" of the movement of items to the dump from Legacy Stanton. During the purge, there were lots of workers, but no mention of leaders being present, no MBWA (management by walking around). When asked, staff could not provide an email from the STH COO or NTHSSA CEO asking staff to be vigilant about handling records during the purge or of any more detailed direction about controlling all records during the move. There was such direction from the records management team, but we know staff will pay more attention

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if it comes from a CEO or COO, and the stakes were high. There was evidence of a high level meeting of the COO, directors and managers, and word was apparently supposed to trickle down from that, but apparently it did not trickle very far or have the desired effect.

Vigilance

After the Fort Simpson dump breach one would think there would be a particularly heightened attention especially considering the rather obvious potential for things to go wrong. There were numerous well documented instances of personal information and PHI effectively having been mishandled and/or abandoned by NTHSSA before the YK Dump breach as if it were foreshadowing this event.

The gravity of this repeat situation requires an appropriate response by the Minister of Health and Social Services. Acknowledging that having DOI in the "driver's seat" was not helpful, the CEO for the NTHSSA nonetheless failed to provide adequate leadership to ensure measures were in place to prevent a breach from occurring or to protect records in their custody or control, and to manage records appropriately.

The territorial Authority's failure to invest appropriately in records management to meet administrative and operational requirements desperately needs to be addressed to meet professional requirements, to protect privacy, and to repair waning public trust.

Final Word

Once again, personal information of a very sensitive nature entrusted by citizens of the NWT to the GNWT for safe handling has made its way unceremoniously into the dump. Mirroring my comments and similar findings made with respect to the Fort Simpson dump report, this breach has also brought to light the very real possibility that there are many more similar records sitting around in neglected storage areas in other health facilities, ripe for a similar breach to occur. This applies not only to STH but all regions and all health information custodians. Due to the changing of hands and responsibility for health service over the years, and various leadership structures and service provision models, there are likely dated records that are being stored without being properly protected and or archived in accordance with privacy protective principles and general best practices in records management. This is hugely concerning.

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Privacy is not an 'add on'. It is an integral part of health service provision. I appeal to GNWT leadership to make a concerted effort to take tangible steps to prepare the health system to properly handle PHI, and ensure appropriate disposal and ongoing management of records in operations and administration of the NWT health system to protect information and respect patients' privacy.

RECOMMENDATIONS:

The following are my recommendations to NTHSSA based on my review of this breach. A few of these appeal to NTHSSA to reach out to their counterparts in other Departments and agencies in order to move toward best practices in information management and protection of privacy. Though I appreciate that NTHSSA cannot accept recommendations on behalf of other custodians or public bodies, this breach does not only concern this custodian. I encourage a holistic and coordinated response.

1. Part of the objective in amalgamating the various Health and Social Services Authorities into one territorial Authority was to standardize health administration and service delivery where appropriate. I therefore recommend that NTHSSA update its records retention policies and disposal policies, create an appropriate ORCS schedule, and make the Waste Management Policy developed by STH, currently designated as a "regional" policy, applicable to all of NTHSSA.

2. Reiterating a recommendation made by the independent investigators from the final report, I recommend that NTHSSA sufficiently resource its records management needs, including hiring more records management staff and instituting a dedicated and federated records management system. I further recommend training all staff on records management best practices.

3. I recommend that NTHSSA work with DHSS to ensure that regulations are created pursuant to section 86(4) of the *Health Information Act* to direct appropriate destruction of records.

4. I recommend that when NTHSSA identifies records for destruction, strict protocols be applied to control such destruction in alignment with policy and legislation.

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5. I recommend that when physical records containing personal health information are sent for destruction they are disposed of in a secure manner so they cannot be reconstituted (i.e. destroyed, not just disposed of).

6. I recommend that when physical copies of digital records are scheduled for disposal, they be destroyed in accordance with guidelines as to process for that type pf media (i.e. incinerated).

7. I recommend that a strict inventory of items be created when health facilities are moved into a new building, and if an item is found to have been moved in error, that it be documented and handled in a controlled manner with full awareness and participation of the sender and subsequent recipient of those items.

8. I recommend that when NTHSSA disposes of anything from a health facility the disposal is planned and supervised by a point person from beginning to end.

9. I recommend that when NTHSSA is disposing of anything from a health facility into a landfill or for warehousing, NTHSSA document the nature of the items being disposed, including time, date, location and those involved.

10. I recommend that NTHSSA hire specialists in waste disposal when biomedical waste containing personal information or when untreated "confidential" information is to be disposed of from health facilities, where feasible.

11. I recommend that no PHI for disposal (biomedical or other type of waste) be handled by all-purpose "movers" until after the records have been purposefully identified for destruction, and destroyed according to requirements of a recognized records retention and destruction schedule.

12. I recommend that contracts for services which expose vendors and service providers to personal health information be written in plain language and make clear that the HIA and policy requirements of the custodian and the GNWT are applicable and are to be adhered to. HIA has primacy over ATIPPA where there is inconsistency, so when personal health information is concerned, the stricter requirements of the HIA must be reflected in such contract.

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13. I recommend that before contractors handle personal information or personal health information, they are trained as per the requirement of the HSS Mandatory Training Policy and advised about what risks might be associated such records (including how to identify records containing personal or personal health information) as well as how to address a breach of privacy.

14. I recommend that initial investigations into privacy breaches be concluded within a reasonable period of time (e.g. within a week of a breach) and if it is determined that an independent investigator should be hired, that the full breach investigation be also commenced within a reasonable period of time (eg within two weeks of concluding the initial investigation). These timelines should reflect the reasonable needs of the initial investigation and contracting process, with time being of the essence.

15. I recommend that NTHSSA take steps to train all staff on appropriate disposal and destruction of records, including what should be disposed of and what should not, and appropriate methods of disposal/destruction.

16. I recommend NTHSSA ensure there be checks and balances applied before staff can dispose of any records in any format. This may simply be approval by someone of authority with knowledge of records disposal.

17. I recommend that if independent investigators are hired to conduct an investigation, unless there are circumstances related to the evidence (and not the investigators) that delay the investigation for good reason, the final report be provided to NTHSSA within three months of commencing the investigation

18. I recommend that NTHSSA adopt a learning management system territory wide, similar to STH, where employees and contractors can complete required privacy training modules and meet completion deadlines set by the organization.

19. I recommend that when health facilities are renovated or mothballed, that dedicated plans are drawn up, implemented, and followed to specifically control transfer of items for retention, archiving and destruction.

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20. I recommend that subject matter experts be hired and be available to aid in trouble shooting security, privacy, records management and biomedical issues when renovating or mothballing old health care facilities

21. I recommend that NTHSSA invest significantly in order to transition their reliance on paper records to more modern electronic records. I highly support the similar recommendation made to NTHSSA by the independent investigators in their report, and recommend that NTHSSA recognize the Authority's significant need for and reliance on good records management practices, and invest considerably in additional and appropriate resources to improve and achieve orderly management of records.

22. I recommend that NTHSSA discourage the use of CDs in its own operations, and work with partner organizations to ensure diagnostic images are transferred to NWT health facilities in the most privacy protective, efficient, and secure manner.

23. I recommend that when NTHSSA participates in P3 or similar projects, efforts be made to ensure partners (including other GNWT departments) are sufficiently apprised their ongoing responsibilities as agents of NTHSSA in relation to the legal and professional responsibilities to protect patient and staff privacy and to make clear the requirements for strict handling of records in its custody or under its control.

24. I recommend that the CEO of NTHSSA work closely with her Risk Management team, the DHSS and other relevant departments and the legislative assembly, to identify a “fan out” list that will ensure swift communication about reported privacy breaches to those that need to know immediately, and that the NTHSSA QRM or other designate responsible for the actual initial investigation of breaches be amongst the first to be notified.

25. The investigators made lengthy comment about the inappropriateness of DOIs work and response to NTHSSA before and after the breach. I recommend that these comments be shared with the CEO's counterpart at DOI.

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26. I recommend that NTHSSA work with the DHSS and other relevant departments to assist municipalities with how to respond to a privacy breach, particularly in waste disposal sites managed by municipalities and provide guidelines to them.

27. Similar to above, I recommend that NTHSSA work with their counterparts at the DHSS towards publishing guidance for the general public on what to do if a citizen experiences a breach themselves, or discovers personal health information in the NWT that may have been improperly disclosed by the GNWT, including what information to gather, who specifically to contact (e.g. a regional or territorial QRM or the Office of the Information and Privacy Commissioner) how to preserve evidence, and above all emphasis on protecting the privacy of the those individuals the information is about. The same information might be shared with all GNWT staff and contractors.

Elaine Keenan Bengts
Information and Privacy Commissioner

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