Information and Privacy
Commissioner/Ontario

Commissaire à l'information
et à la protection de la vie privée/Ontario

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050050-1

A Medical Centre in an Urban Setting

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REPORT

FILE NO. **HI-050050-1**

INVESTIGATOR: **Gillian Judkins**

HEALTH INFORMATION CUSTODIAN: **A Medical Centre in an Urban Setting**

SUMMARY OF INFORMATION GIVING RISE TO REVIEW:

The Director of a medical centre (the centre) contacted the Office of the Information and Privacy Commissioner/Ontario (the IPC) to advise that during a videoconference with patient A, a second videoconference that was scheduled to follow afterwards was inadvertently linked in too. The error was recognized immediately and the videoconference was terminated. The Director was concerned that patient A would have been able to see patient B and vice versa. The IPC opened a file and worked with the centre to fulfill its obligations under the *Personal Health and Information Protection Act, 2004* (the *Act*).

RESULTS OF REVIEW:

The Director of the Centre provided the following information.

On the date of the incident, the Director had two separate videoconferences scheduled, the first at 1:00 p.m. and the second at 1:25 p.m. The videoconferences involved two separate patients located at two different sites. Towards the end of the first conference, a warning was to sound to indicate that there was only ten minutes left in the conference. The participants in the first conference were expected to complete their conference by 1:25 p.m. at which time the Teleconference Coordinator would end the first conference and allow the second videoconference to begin.

The Director advised the IPC that the warning to signal the end of the first conference did not sound and as a result, the second videoconference was linked into the Director's first videoconference.

The Director advised that for less than one minute, the two videoconferences were linked together and as a result, the participants of the first videoconference could see the participants of the second videoconference, and vice versa. As soon as this error was discovered, the call was immediately dropped and both videoconferences were ended.

The Director immediately contacted the provider of the service to begin an investigation into how this incident occurred and advised them of the IPC's involvement. The provider contacted the IPC and advised that they had contacted the Privacy Officers at each site to inform them of the breach and also began a review of their current practices. The provider stated that they are considering changing their current practice of linking the second conference in following the end of the first one, to ending the conference completely and having subsequent conferences start anew. This would mean that any participants involved in the first videoconference would have to end their first videoconference prior to logging back in for any subsequent videoconferences.

In addition, the provider is considering having a point person at each location who is designated to inform the provider if a call is expected to go over its allotted time. Finally, the provider advised that they are considering having a buffer time between calls that would ensure that one videoconference is not immediately scheduled after another. This would also make allowances for any videoconferences that go over their allotted time.

In order to fulfill his obligations under section 12(2) of the *Act*, the Director of the centre advised that he spoke to the patients at their next appointments to explain what had occurred and the steps that have been put into place to ensure that this does not occur in the future.

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

June 30, 2006

Ann Cavoukian, Ph.D.
Commissioner