Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 150

Complaint HA18-113

Hamilton Health Sciences

July 9, 2021

Summary: This decision deals with the issues of access to records of personal health information, and reasonable search. The access request, made to Hamilton Health Sciences, was for psychological testing data relating to the complainant. In this decision, the adjudicator finds that the records at issue are excluded from Part V of the *Personal Health Information Protection Act* by virtue of section 51(1)(c). The adjudicator also finds that the hospital's search for records responsive to the request was reasonable.

Statutes Considered*: Personal Health Information Protection Act, 2004, S.O. 2004, c. 3;* sections 4(1), 51(1)(c), 53 and 54.

BACKGROUND:

[1] This decision disposes of the issues raised by an access request made to Hamilton Health Sciences (the hospital) under the *Personal Health Information Protection Act* (the *Act*). The request was for a copy of psychological testing data in relation to the requester, who was a patient in the hospital's Autism Program. In particular, the request was for "original [standardized psychological] test materials containing the name of the test, the date the test was administered, his [the requester's] name and his [the requester's] answers." The requester was represented by his mother in making this access request.

[2] In response to the request, the hospital's legal services department issued a decision letter, stating:

> . . . we have repeatedly explained that we are under certain obligations and restrictions, including copyright restrictions, that do not allow us to provide a copy of the test materials. . .
>
> We have attempted to address [the requester's representative's] concerns, and ultimately we provided the psychological test scores to both [the requester's representative] and to a private psychologist per [the requester's representative's] instruction, with the offer to meet to explain what the test scores represent. The test scores were transcribed by [a named psychologist] and I have full confidence said transcription was properly done, complete and fully represents the results of the psychological testing. Note that what we have provided to [the requester's representative] is consistent with standard practice, which was confirmed by the College of Psychologists of Ontario.
>
> We have taken some time to consider the request for redacted psychology test materials and have concluded the redactions we would have to make would result in producing the same information we have already produced, the test scores. . .

[3] The requester's (now the complainant's) representative had further communications with the hospital and then filed a complaint with the IPC with respect to the hospital's decision.

[4] During the intake stage of the complaints process, the hospital sent a letter to the complainant stating, in part:

> Enclosed you will find two charts containing granular, item-level raw psychological test scores relating to testing you underwent at Hamilton Health Sciences beginning in [a specified time period].
>
> The first of the enclosed charts, is an updated version of the Summary Table (containing aggregated testing results). You will note that compared to the version previously provided, there are seven highlighted corrected scores, which are the result of arithmetic errors discovered upon compiling the granular, item-level raw data. In all instances, the original scores are higher and indicate higher performance than originally reported.
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> The second enclosed chart is comprised of 16 pages containing item-level raw data associated with the data contained in the summary table. . .

[5] During the mediation of the complaint, the complainant's representative clarified with the mediator that she believed more records should exist because she could not locate certain data and information that she was seeking in the records that were provided to her. She also stated that she was seeking access to portions of the withheld test material. Specifically, the complainant's representative stated that she wanted access to the name of the test, the date it was administered, her son's name and his

answers.

[6] In response, the hospital wrote to the complainant's representative, stating, in part:

> Based on our discussion with IPC Mediator [name], we understand the current nature of your request to be for all health records and raw psychological test data pertaining to [the complainant] as a patient of Hamilton Health Sciences from [a specified time period].

[7] The hospital then advised that it conducted a further search of its internal databases, including:

- Electronic mail folders;
- Patient Experience files;
- Health Records databases; and,
- Psychology Program Archives.

[8] The hospital further advised that e-mail folders, Patient Experience files and Health Records databases yielded no new responsive records. However, it also advised that a review of the Psychology Program Archive identified program records pertaining to the complainant's time in the program, dating back to before the inception of the *Personal Health Information Protection Act* and the *Freedom of Information and Protection of Privacy Act,* as they apply to hospitals in Ontario. A total of 955 pages of records were identified and provided to the complainant's representative, along with an index of records.

[9] The hospital also advised that it was withholding the test materials in their entirety, claiming the application of the exclusion for raw data in section 51(1)(c) of the *Act*. It also stated that some information was removed from the Psychology File, as it related to individuals other than the complainant and was therefore not responsive to the access request.

[10] Following her review of these records, the complainant's representative stated that she was not able to locate reports regarding her son's eligibility for funding/services. The complainant's representative wanted to know whether the hospital provided all records responsive to the request. In response, the hospital sent an email to the mediator providing information about its search activities and confirming that, except for the test materials, all responsive documentation located was provided to the complainant's representative.

[11] The hospital then advised that, in an effort to release as much information as possible to the complainant's representative, it would be notifying the third party publishers whose records are at issue in this complaint. Following notification to three third parties, the hospital granted access to additional information. In its letter, the

hospital stated, in part:

> . . . we wish to advise you that our office sent formal request letters to three publishing companies on [a specified date], requesting permission to release redacted testing materials to you, notwithstanding the prevailing copyright. We did so, without prejudice to our ability to rely on s. 51(1)(c) of PHIPA with respect to the raw test scores, as well as our position that the standardized test materials themselves are not personal health information subject to a right of access under PHIPA. Our office received responses from two of the three publishing companies contacted.

[12] The hospital then granted access to records of testing materials relating to one of the three publishing companies that it notified. The hospital confirmed its decision to withhold the remainder of the test material under section 51(1)(c) of the *Act*. The hospital also advised that it was providing the complainant's representative with ". . . an index of all standardized tests on file at HHS, with the date they were administered, the name of the individual being tested/respondent, and the identity of the administrator (where available)."

[13] The complainant's representative advised the mediator that she was not satisfied with this response. She was of the view that when the hospital created the summary charts in response to the access request, her son's records were altered. The hospital replied that it did not alter the original test results, that errors in the original test results were made and that, to ensure the accuracy of the information being provided to the complainant's representative, it highlighted the errors and updated the scores on the newly created chart.

[14] This explanation was provided to the complainant's representative who confirmed that she wants access to the "original records" so that she can verify the information contained in the newly created charts.

[15] At the conclusion of mediation, the issues were the possible application of sections 51(1)(c) and 52 of the *Act*, as well as the reasonableness of the hospital's search for records. It is unnecessary to address section 52 of the *Act*, given my conclusion below that the records are excluded from the access rights under the *Act*.

[16] The matter then moved to the adjudication stage of the complaints process, where an adjudicator may conduct a review. I decided to conduct and review and initially sought and received representations from the hospital. I then sought representations from the complainant's representative, but she advised IPC staff that she would not be providing representations.

[17] I note that there is no dispute that the hospital is a "health information custodian" as set out in section 3(1) of the *Act*.

[18] For the reasons that follow, I find that the information remaining at issue is excluded from Part V of the *Act* (Access to Records of Personal Health Information),

and that the hospital's search for records responsive to the access request was reasonable. The complaint is dismissed.

RECORDS:

[19] The records at issue are standardized psychological test booklets, otherwise known as original test materials, which contain raw data from standardized psychological tests and/or assessments. In particular, the test booklets contain questions, the complainant's answers and the test scores.

[20] As well, the complainant's representative believes that further records exist.

ISSUES:

A. Are the records at issue records of "personal health information" within the meaning of section 52(1) and section 4 of the *Act*?

B. Does section 51(1)(c) exclude the record from the right of access in section 52(1) of the *Act*? If so, is there any part of the record that can reasonably be severed under section 51(2)?

C. Did the hospital conduct a reasonable search for records responsive to the access request?

DISCUSSION:

Issue A: Are the records at issue records of "personal health information" within the meaning of section 52(1) and section 4 of the *Act*?

[21] An individual's right of access to their own personal health information is set out in section 52(1) of the *Act.*

[22] "Personal health information" is defined in section 4 of the *Act,* in part as follows:

> (1) In *PHIPA*,
>
> > "personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,
> >
> > > (a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
>
> (2) In this section,

> "identifying information" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.
>
> (3) Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.

[23] In PHIPA Decision 17, this office adopted a broad interpretation of the phrase "personal health information" (see particularly paragraphs 65-68). This office has applied this broad interpretation in subsequent decisions and orders (among others, see PHIPA Decisions 52 and 82, and Order MO-3531).

Representations

[24] The hospital's position is that the standardized test materials do not qualify as "personal health information" within the meaning of section 4 of the *Act*. In the alternative, the hospital submits that while its position is that the test materials are not personal health information under the *Act*, in this case they do contain personal health information. In particular, the hospital submits that the name of the tests administered to the complainant's son in the course of his treatment at the hospital meet the definition of personal health information under the *Act*.

Analysis and findings

[25] In determining whether the records contain the complainant's personal health information, I am guided by the "record-by-record" approach that the IPC has adopted where the whole record, as opposed to individual paragraphs, sentences or words, are analyzed to determine if the record contains the personal health information of an individual.[1] In the circumstances of this matter, applying a "record-by-record" analysis requires me to review each record as a whole as opposed to segments.

[26] I find that each of the records at issue, as a whole, contains the personal health information of the complainant. In particular, I find that each of the records contains his personal health information because they include identifying information about him, as well as information described in subsection (1)(a) of section 4 of the *Act*, as they relate to his physical or mental health.

[27] As a result, applying the "record–by-record" approach the IPC has adopted, and

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[1] The "record-by-record" approach for dealing with requests for records of personal information is set out in Order M-352. This approach has been adopted by this office in reviewing records that may contain personal health information in PHIPA Decisions 17, 27 and 30.

having found that each of these records contains the personal health information of the complainant, I find that that the records at issue are records of personal health information. Therefore, the right of access in section 52(1) applies to them.

[28] I will next consider whether the exclusion relied on by the hospital applies to the records at issue.

Issue B: Does section 51(1)(c) exclude the record from the right of access in section 52(1) of the *Act*? If so, is there any part of the record that can reasonably be severed under section 51(2)?

[29] Section 52(1) provide that an individual has a right of access to a record of personal health information about the individual that is in the custody or under the control of a health information custodian. That general right is subject to number of exceptions.

[30] At issue in this complaint is section 51(1), which sets out certain exclusions from the rights of access and correction in the *Act*. Section 51(1)(c) states:

> This Part [Part V of *PHIPA*, setting out the rights of access and correction] does not apply to a record that contains,
>
> raw data from standardized psychological tests or assessments; or

[31] Even where a record contains information excluded under section 51(1) of the *Act*, section 51(2) may apply to give the individual a right of access to part of the record. Section 51(2) states:

> Despite subsection (1), this Part [Part V] applies to that part of a record of personal health information that can reasonably be severed from the part of the record that contains the information described in clauses (1) (a) to (d).

Representations

[32] The hospital submits that section 51(1)(c) excludes the records from the right of access. It submits that the records are standardized psychological test booklets, which contain raw data from standardized psychological tests and/or assessments. The hospital goes on to argue that these records fall squarely within the scope of section 51(1)(c) and are, consequently, excluded from the right of access under Part V of the *Act*.

[33] With respect to section 51(2), the hospital submits that it applied that section to sever and release the complainant's personal health information from the records at issue. In particular, the hospital submits that the complainant was provided with the following personal health information relating to the standardized psychological tests:

- Scores transcribed from the original test materials to a summary chart prepared by the Clinical Director of the hospital's Autism Program multiple times, including subsequent granular level data, and individual scored responses to test questions;

- The raw test data of the original test materials (with questions and other standardized information severed) from one of the publishing companies, with its consent; and

- An index of all 11 standardized tests that were administered to the complainant during the relevant time period. The index includes the name of the test, the date the test was administered, the name of the complainant and the identity of the test administrator, where available.

[34] As I state above, the complainant's representative provided no representations.

Analysis and findings

[35] On my review of the material before me, including the records, I accept the hospital's position that the records are standardized psychological test booklets, which contain raw data from standardized psychological tests and/or assessments. The complainant has provided no basis to dispute the hospital's submission. On that basis, I find that the information at issue is excluded by virtue of section 51(1)(c), meaning that Part V of the *Act*, which includes the right of access in section 52(1), does not apply to the records.

[36] I also find that there is no information in the records other than the raw data. As such, section 51(2), which preserves a right of access to the part of a record that can reasonably severed from the raw data, does not apply.

Issue C: Did the hospital conduct a reasonable search for records responsive to the access request?

[37] Where a requester under the *Act* claims that additional records exist beyond those identified by a health information custodian, the issue to be decided is whether the health information custodian has conducted a reasonable search for records as required by sections 53 and 54. If this office is satisfied that the search carried out was reasonable in the circumstances, it will uphold the health information custodian's decision. If it is not satisfied, this office may order further searches.

[38] The *Act* does not require a health information custodian to prove with absolute certainty that further records do not exist. However, it must provide sufficient evidence to show that it has made a reasonable effort to identify and locate responsive records.[2]

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[2] Orders P-624 and PO-2559.

To be responsive, a record must be "reasonably related" to the request.[3]

[39] Under the *Act*, a reasonable search is one in which an experienced employee knowledgeable in the subject matter of the request expends a reasonable effort to locate records which are reasonably related to the request.[4] A further search will be ordered if the health information custodian does not provide sufficient evidence to demonstrate that it has made a reasonable effort to identify and locate all of the responsive records within its custody or control.[5]

[40] The hospital was asked to answer the following questions:

1. Did the hospital contact the complainant for additional clarification of the request? If so, please provide details including a summary of any further information the complainant provided.

2. If the hospital did not contact the complainant to clarify the request, did it:

    a. choose to respond literally to the request?

    b. choose to define the scope of the request unilaterally? If so, did the hospital outline the limits of the scope of the request to the complainant? If yes, for what reasons was the scope of the request defined this way? When and how did the hospital inform the complainant of this decision? Did the hospital explain to the complainant why it was narrowing the scope of the request?

3. Please provide details of any searches carried out including: by whom were they conducted, what places were searched, who was contacted in the course of the search, what types of files were searched and finally, what were the results of the searches? Please include details of any searches carried out to respond to the request.

4. Is it possible that such records existed but no longer exist? If so, please provide details of when such records were destroyed including information about record maintenance policies and practices such as evidence of retention schedules.

5. Do responsive records exist which are not in the hospital's possession? Did the hospital search for those records? Please explain.

[41] The hospital was asked to provide this information in the form of an affidavit signed by the person or persons who conducted the actual search(es).

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[3] Order PO-2554.
[4] Orders M-909, PO-2469 and PO-2592.
[5] Order MO-2185.

Representations

[42] The hospital provided its representations by way of three affidavits sworn by the Coordinator of the Health Records Department, the Clinical Director of the hospital's Autism Program, and the hospital's Legal Counsel and Chief Privacy Officer.

[43] The hospital submits that it has taken exhaustive steps and undertaken significant efforts to understand the scope of the request, search for responsive records and provide as much information as possible to the complainant's representative. By way of background, the hospital submits that the original access request was for all of the complainant's records over a specified time frame. In response, the medical records department pulled the complete centralized health record and provided it to the complainant's representative on two occasions, as she stated that the first copy provided to her was not legible.

[44] The hospital notes that the centralized health record does not include psychology records, other than psychology assessment reports. Psychology records (other than assessment reports) are maintained in a manner similar to diagnostic imaging records in that the reports are contained within a centralized patient health record but the images themselves are stored in the diagnostic imaging library. With respect to psychology testing records, the source testing materials that contain the raw test data are maintained in a separate module, which can only be accessed by psychology professionals. As such, the hospital submits, the complainant's representative was referred to the administration of the relevant clinical program in order to address this portion of the access request.

[45] As a result, the complainant's representative and the Clinical Director of the Autism Program connected, during which time emails were exchanged, along with phone calls and in-person meetings. The hospital submits that the scope of the request shifted over these interactions, as well as during the IPC's complaints process. The hospital submits that its searches for records included searches of: the electronic medical record system, called ODISS (including the records in the psychology module); electronic mail folders; the Patient Experience Database; and additional medical record systems (Meditech and Sovera). The hospital goes on to submit that, "simply put," there is nowhere else to look for responsive records.

[46] The hospital goes on to submit that the complainant (and his representative) have been granted access to the following records:

- The complete ODISS record, excluding the psychology module, via the medical records department;
- All records contained within the psychology module, except the standardized test booklets, via the Clinical Director and the hospital's Privacy and Freedom of Information Office;

- All scored responses from the raw data in the standardized test booklets on charts prepared by the Clinical Director;

- An index of all standardized tests that were administered to the complainant, which include the date the tests were administered, the name of the complainant and the identity of the administrator of the test (where available); and

- Severed copies of the standardized test materials for all standardized tests produced by Brooks Publishing (with the company's permission), with the handwritten notes of the complainant visible.

[47] Lastly, the hospital submits that the only responsive records that have been withheld are the scanned copies of standardized psychological test booklets, and that it does not deny the existence of these records; they do exist and have been located, but have been withheld from the complainant's representative on the basis of section 51(1)(c).

Analysis and findings

[48] As previously stated, the *Act* does not require health information custodians to prove with absolute certainty that further records do not exist; rather, it requires custodians to provide sufficient evidence to demonstrate that they have made a reasonable effort to identify and locate responsive records.[6] A reasonable search is one in which an experienced employee knowledgeable in the subject matter of the request expends a reasonable effort to locate records that are reasonably related to the request.[7] In the circumstances of this complaint, I find that the hospital has provided sufficient evidence to demonstrate that it made a reasonable effort to identify all records responsive to the complainant's access request for all records relating to him.

[49] I am satisfied, based on the representations and the affidavit evidence before me, that the hospital's employees who conducted and oversaw the searches, namely the Coordinator of the Health Records Department, the Clinical Director of the hospital's Autism Program, and the hospital's Legal Counsel and Chief Privacy Officer are experienced employees knowledgeable in the subject matter of the request.

[50] I also note that there were multiple discussions over a lengthy period of time between the complainant's representative and the hospital in order to clarify the scope of the request, including during the mediation of this complaint.

[51] I am satisfied that in order to locate the responsive records, the hospital searched, on more than one occasion, its electronic databases relating to the complainant. Moreover, the hospital provided the complainant's representative with

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[6] Orders P-624 and PO-2559, PHIPA Decision 17 and PHIPA Decision18.
[7] Orders M-909, PO-2469 and PO-2592, PHIPA Decision 17 and PHIPA Decision18.

access to all of the records identified by these searches, with the exception of the standardized test booklets. In addition, subsequent searches were conducted in which more fulsome information was identified, compiled by the Clinical Director, and provided to the complainant's representative. Based on the evidence before me, I am satisfied that the hospital's search parameters were aligned with the scope of the request and were reasonable in the circumstances. I am also satisfied that the hospital expended a reasonable effort to locate records that are reasonably related to the complainant's request.

[52] As previously stated, although a complainant will rarely be in a position to indicate precisely which responsive records a custodian has not identified, the complainant must, nevertheless, provide a reasonable basis for concluding that such records exist.[8] In this case, the complainant's representative has not provided any evidence that additional records should exist that have not yet been identified and provided to the complainant. Therefore, I am not persuaded that there is a reasonable basis for believing that the hospital has not conducted a reasonable search for responsive records. Accordingly, based on the evidence provided by the hospital I find that it has expended a reasonable effort to locate records that are reasonably related to the complainant's request.

[53] Finally, I am satisfied that there is no reasonable basis for concluding that responsive records might have existed, but no longer exist because they have been deleted or destroyed or that they are no longer in the hospital's possession. For all of these reasons, I find that the hospital conducted a reasonable search for records responsive to the complainant's request in compliance with its obligations under the *Act*.

NO ORDER:

For the foregoing reasons, no order is issued and the complaint is dismissed.

Original signed by: July 9, 2021
Cathy Hamilton
Adjudicator

[8] Order MO-2246, PHIPA Decision 17 and PHIPA Decision 18.