Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 245

Complaint HA21-00121

City of Toronto - Seniors Services and Long-Term Care

May 31, 2024

Summary: This decision deals with two issues arising out of an access request made under the *Personal Health Information Protection Act* to the City of Toronto's Seniors Services and Long-Term Care (the custodian) for records relating to a former resident of a long-term care home. The issues are the custodian's search for records, and the legibility of records that were originally paper-based, subsequently scanned and released to the complainant by the custodian. In this decision, the adjudicator finds that the complainant has established a reasonable basis to conclude that further records exist regarding complaints that were made to the custodian about the health care provided to the resident. As a result, the custodian is ordered to conduct a further search for records relating to these complaints. Concerning the legibility of the records, the adjudicator finds that it is not necessary to order the custodian to re-scan the records because the custodian did so after the conclusion of the review of this complaint.

Statutes Considered: *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, sections 53 and 54.

Orders and Decisions Considered: Order MO-4357 and PHIPA Decisions 18, 214 and 226.

BACKGROUND:

[1] This decision resolves the issues raised as a result of a request made under the *Personal Health Information Protection Act* (the *Act*) to a specified long-term care home (the care home) for access to the requester's deceased mother's records of personal health information, including all of the records created at the care home, records created

at hospitals during short stays there and other records which were not normally stored with his mother's records on the unit at the care home. The requester's mother had been a resident at the care home for over six years and was still a resident at the time she passed away. The health information custodian of the long-term care facility is the City of Toronto – Senior Services and Long-Term Care (the custodian). As a result, the requester re-submitted his access request directly to the custodian.

[2] The custodian located records and provided a fee estimate to the requester. The requester paid the fee and the custodian provided access to the records.

[3] After receiving the records, the requester - now the complainant - wrote to the Information and Privacy Commissioner of Ontario (the IPC) advising that he wished to file a complaint with respect to the custodian's decision regarding its search for records, as well as the quality of the records themselves.[1]

[4] During the mediation of the complaint, the complainant advised that many of the records he had received were illegible, and that he believed there were records missing. The complainant confirmed that he provided the custodian with this information, which I refer to as the deficiency list.

[5] The custodian responded to the complainant's concerns regarding the search, the missing records, and the quality of the copying of the records that were provided to him, set out below.

Search

[6] With respect to the search conducted for records responsive to the request, the custodian explained that all records kept during the resident's (the complainant's mother) time at the care home were paper records. The custodian advised that the usual practice is that once a resident is discharged, the resident's health records are kept in the care home for only one year. After the year, records of all former residents are archived and stored at an offsite facility managed by another division with the City of Toronto, and are kept for a further nine years.

[7] The custodian explained that upon receiving the initial request, the care home retrieved the resident's complete medical records from the offsite archive storage location. As they consisted of paper records, the care home was required to scan and send all paper records to the head office. The custodian advised that this is common practice within the division and the staff are well versed on the process.

[8] The custodian advised that the search for responsive records was conducted by office administration staff at the care home and the Assistant Administrator managed the entire process. The Assistant Administrator confirmed that an extensive search was completed. The Director of Nursing also confirmed that any and all available

[1] The fee is not part of the complaint.

documentation found at the time was gathered and scanned.

[9] The custodian noted that given the multiple volumes of thick and aged paper, the search was difficult to organize and scan. The custodian advised that the custodian's head office worked jointly with the care home, as it does with all long-term care homes, to process and release records.

[10] The custodian stated that it is confident that a reasonable search was conducted to locate all records belonging to the resident. All paper records were scanned and sent to head office where they were reviewed, organized, and combined by the privacy support assistant into a complete chart. It submits that management at the care home confirmed that an extensive search had been completed. The custodian maintains its position that a reasonable search was conducted to locate all of the records responsive to the request.

Missing records

[11] With respect to the complainant's concerns about missing records, the custodian advised that it was difficult to determine whether records were missing or if there was simply no documentation available for that specified day. The custodian noted that documentation may not have been completed while the resident was away from the home due to hospital transfer(s), medical appointments, leave(s), or if the care was uneventful. The health care provider may not have been required to document based on their clinical judgement/care if there were no changes or reportable findings.

[12] With respect to pages identified with no entries, the custodian advised that all records that were located responsive to the request were released to the complainant in full. Incomplete or blank assessment forms that were labeled with the resident's address were also included as part of the responsive record.

[13] The complainant did not accept the custodian's explanation regarding the missing records. The complainant's position is that there are too many gaps and days where there are no records. He believes that it is not possible that there was such a significant gap with no records being created. The complainant's position is that the custodian's explanation that documents may not have been generated because of hospital stays and other short-term absences does not explain why there are months long gaps in many periodic (weekly/monthly/quarterly) reports. The complainant noted that it also does not address the reason that there are multi-page documents where some, but not all, pages are missing. The complainant also noted that based on the records he received, "Progress Notes" were continually generated during hospital stays, i.e., nurses would call hospitals periodically, and enter notes to the record.

[14] It is the complainant's position that the custodian did not organize the documents as described because he believes that if they did then the custodian would have recognized that so many documents were absent, the documents were not in proper order, that he was given multiple copies of the same documents, and the release included

pages that the complainant believes are not relevant such as fax cover sheets

[15] Finally, the complainant noted that he also included in his request a request for Investigation Reports that were not kept with the health records, but that these records were not provided. The custodian did not provide a response addressing investigation reports.

Legibility of Records:

[16] With respect to the complainant's concerns about the copying of the records, the custodian advised that the records released were extremely old and were lengthy paper-based health charting dated as early as 2006. The condition of the records may have been worn off at part of the natural process (dog eared, faint, aged paper, etc.). While the resident was active in the home, the chart remained on the unit and was handled by many healthcare providers. The edges could have potentially torn off as a result of frequent handling and use. All records were paper-based and ink was used for documentation. Healthcare providers have different handwriting pressures which can result to lighter ink pressure on the paper resulting in fainter printed ink. Humidity, temperature, and lighting also affect the printed ink's longevity. The printed ink will fade over time and this chart was over 13 years old when it was released. In addition, each providers' handwriting legibility was also different from person to person which could have contributed to increased difficulty to read the handwriting. The paper-based health records were hole punched in order to file in the 3-ring health record binder. There were unavoidable cut off areas around the hole punches as a result.

[17] With respect to the blank records, the custodian advised that the blank pages in the records could have been a result of the double-sided scanning. Some records were documented only on one side, leaving the back side blank. The custodian advised that the paper chart was scanned on both sides to ensure all information was included for release. Even though the blank pages were included in the released records, they were not calculated in the fee structure.

[18] The complainant advised that he was not satisfied with the custodian's response related to his concerns about the legibility of the records. The complainant's position is that certain records were not scanned or copied properly. The complainant advised that pages were folded obscuring text/info, originals were not squarely placed on copiers, which led to text and information on edges missing from the copies or information near the edges or corners cropped, and in some instances, copies were enlarged leading to images not fitting the copier paper. The complainant further advised that the above issues identified in the records at issue were things that have nothing to do with the quality of the originals.

[19] The complainant advised that he wished to pursue the issue of search and the poorly scanned and illegible records at the adjudication stage. The file then moved to the adjudication stage of the complaint process where an adjudicator may conduct a review.

The adjudicator assigned to the complaint conducted a review. She sought and received representations from both the custodian and the complainant, which were shared between them.

[20] The file was then transferred to me to continue the review. I read both party's representations and determined that I had enough evidence before me to make a determination in this complaint. I note that some of the information provided by the parties in their representations reiterates information they provided during the mediation of the complaint. I have not reproduced these arguments below but have taken all of the information provided both during the mediation and the review into consideration in making my findings.

[21] For the reasons that follow, I find that the complainant has established a reasonable basis to conclude that further records exist regarding complaints made to the custodian about the health care provided to the resident. As a result, I order the custodian to conduct a further search for records relating to these complaints. I also find that it is not necessary to order the custodian to re-scan all the remaining paper-based records and release them to the complainant because the custodian did so after the conclusion of this review. I discuss this further in Issue B, below.

ISSUES:

A. Did the custodian conduct a reasonable search for records? Should the custodian have located the specific records that the complainant has identified as missing?

B. Is the custodian required to provide the complainant with legible records or records of better quality?

DISCUSSION:

Issue A: Did the custodian conduct a reasonable search for records? Should the custodian have located the specific records that the complainant has identified as missing?

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

[23] The IPC has extensively canvassed the issue of reasonable search in orders issued under the *Freedom of Information and Protection of Privacy Act* (*FIPPA*) and its municipal counterpart the *Municipal Freedom of Information and Protection of Privacy Act*

(*MFIPPA*). It has also addressed the issue of reasonable search under the *Act*.[2] In addition to what is set out in PHIPA Decision 18, principles outlined in IPC orders addressing reasonable search under *FIPPA* and *MFIPPA* are instructive to the review of this issue under the *Act*.

[24] The *Act* does not require that the custodian prove with absolute certainty that further records do not exist. However, the custodian must provide sufficient evidence to show that it has made a reasonable effort to identify and locate responsive records. [3] To be responsive, a record must be "reasonably related" to the request.[4] 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.[5]

[25] Although a requester will rarely be in a position to indicate precisely which records the custodian has not identified, the requester still must provide a reasonable basis for concluding that such records exist.[6]

[26] The complainant takes the position that not all records responsive to the request were located and that additional responsive records should exist. In its representations, the custodian was asked to address both the records that the complainant alleges are missing and the search that was conducted for the responsive records.

Representations

The custodian's representations

[27] The custodian submits that: it had ongoing discussions with the complainant during the processing of the request, including issues related to the administration of the resident's estate; it released 4,762 pages of records to the complainant; and it provided an explanation to the complainant about the blank pages, scanning irregularities and the condition of the file.

[28] With respect to the search for records, the custodian submits that administrative staff at the care home, including nursing clerks and the Assistant Administrator, conducted the initial on-site search for records and also requested that the resident's records be sent from the city's Record Centre to the care home. The records were received by the care home, but then returned to the Record Centre because the resident's estate status had not been resolved. Once that issue was resolved, the records were transferred back to the care home from the Record Centre and disclosed to the

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[2] PHIPA Decision 18.
[3] Orders P-624; PO-2559.
[4] Order PO-2554.
[5] Orders M-909; PO-2469; PO-2592.
[6] Order MO-2246.

complainant.

[29] The custodian further submits that during the mediation of the complaint, it reviewed the deficiency list prepared by the complainant, which suggested a reasonable basis for establishing that there may be missing files. The custodian responded by again retrieving records from the city's Record Centre and reviewed for any responsive records on file with those indicated in the Excel files, but no further records were located as a result of its review.

[30] The custodian goes on to submit that it has policies and procedures in place relating to the storage, security, and retention of resident's records.[7]

The complainant's representations

[31] The complainant's position is that the custodian has not provided sufficient evidence to meet its burden of proof that it conducted a reasonable search for records based on the following:

- There is a reasonable basis for supporting that further records exist,
- There is no evidence that the custodian took steps to search for the records identified by the complainant,
- The custodian's representations do not address the specific records identified by the complainant, including the investigation reports,
- The custodian's arguments should be given no weight given the inaccuracies and omissions in them, and
- Even if the factual assertions made by the complainant are accepted, they do not establish that a reasonable search was conducted.

[32] The complainant submits that there has only been one access request for the same information throughout the process, and that at no point did the custodian seek to clarify the scope of the request with the complainant. The communications from the custodian during the processing of the request related to issues surrounding the authorization to seek access and not the records themselves.

[33] With respect to establishing a reasonable basis for believing that further records exist, the complainant submits that there are month and year-long gaps in the "routine" health records the custodian released to him, and that none of the missing records were from periods when the resident was in the hospital. As an example, the complainant provided an instance, among others, where there are missing records such as a 3-quarter

[7] For example, the custodian provided a copy of its Retention Schedule.

gap in the Quarterly Assessments amounting to 60 missing pages.

[34] The complainant submits that the custodian's explanation for why records may not exist is that the clinical staff document based on their clinical judgement if there are changes or findings to report, and do not document if there are not. The complainant's position is that there is no evidence that many of the records described in the deficiency list are discretionary and that many of the records themselves indicate that they are periodic and regular, such as medication administration records and quarterly reviews.

[35] The complainant further submits that there were no investigation reports released to him, despite the fact that investigations were conducted in response to complaints made about the resident's care. In this regard, the complainant submits that the custodian is not in compliance with section 11 of the *Act*, which deals with the accuracy of personal health information.

[36] Regarding the search conducted by the custodian, the complainant submits that the custodian's idea of a search appears to be the "pulling of boxes," conducted by unidentified administrative staff with no familiarity of the resident's records, and that the custodian has failed to provide details about how the search was actually conducted.

[37] Further, the complainant submits that despite the custodian's assertions, there is no evidence that the custodian conducted a further search for records after the complainant provided it with the deficiency list of the missing records.

The custodian's reply

[38] The custodian submits that during the mediation of the complaint it agreed to review the deficiency list, and subsequently sent 225 pages of re-scanned records to the mediator. The custodian also submits that following receipt of the Notice of Review during the review of the complaint, it conducted another review of the records sent to the complainant, and conducted a further search for records.

[39] In particular, the custodian submits that while preparing its reply representations, it compared the scanned records that it had provided to the complainant with the original records that are the subject matter of the access request. In doing so, the custodian became aware of records management errors which "resulted in the inadvertent and premature disposition of 2909 of the 4762 pages of the original paper-based records that were scanned as part of the access request in question." In other words, 2909 pages were lost/destroyed.[8] The custodian then compared the 4762 pages of the scanned records with the 1853 original records that remained. In addition, for the first time the custodian searched its healthcare software, GoldCare, and located further records that had not been previously found. The custodian was unable to determine why staff who were responsible for responding to the access request did not search the GoldCare

[8] The custodian states that it is currently investigating the "inadvertent premature disposition" of these records.

records.

[40] The custodian concedes that some of the records have missing pages and some pages have been duplicated but that in all cases, no further records other than the GoldCare records were located as a result of the second search done during the review stage of the complaint. In addition, the custodian submits that some records are not always produced on a quarterly basis and that others, such as progress notes, are created by exception – which means that entries are made when there is a change in a resident's condition.

[41] Concerning the investigation records, the custodian submits that the complainant's position is that emails between the complainant and the care home will show that investigations into the issues raised should have taken place. The custodian submits that it conducted a search for any retrievable emails but confirms that emails from the time of the resident's stay could not be recovered. The custodian states:

> The City Clerk's Office confirmed emails from the time of the resident's stay could not be recovered. The City Clerk's Office indicated emails sent and received during the period of the resident's stay were subject to an automatic 90-day delete rule. All deleted emails from this time period were stored in GroupWise, an email system used by the City between [specified dates]. All archived emails from GroupWise were stored in the SilverDane Archive which was decommissioned by the City in [specified date].

[42] Finally, the custodian submits that its second search did not produce any records related to complaints and/or investigations involving the resident.

The complainant's sur-reply

[43] The complainant submits that before the custodian submitted its reply representations, it: asserted that all of the records were paper-based, refused to conduct any further searches for records, refused to re-scan records, and ignored the complainant's request for access to investigation reports. All of these circumstances, the complainant submits, have created a barrier to his efforts to obtain the resident's personal health information, and it may now be impossible to do further searches for missing records, and it is definitely impossible to attempt to re-scan or view original records that have now been destroyed.[9]

[44] The complainant further submits that the custodian's reply representations are replete with statements that contradict its original representations. For example, the

[9] The complainant raises the issues of the loss/destruction of the original records and the deletion of the emails regarding complaints made about the resident's care. In November of 2023, I advised the custodian that the issues in this complaint remain the search for records and the legibility of the records, and that the complainant may file a new complaint with the IPC in regarding the loss/destruction and deletion of records.

custodian states that during mediation, it agreed to review records in the deficiency list and subsequently sent 225 pages of re-scanned records to the mediator. The complainant then refers to the mediator's report, which makes no reference to re-scanned records and in fact states that the custodian declined to review the deficiency list due to a lack of resources. Further, the complainant argues, the custodian's original representations do not refer to any re-scanned records being sent to the mediator. Another example the complainant refers to is the fact that the custodian states in the original representations that all of the records were paper-based, yet refers to GoldCare electronic records in the reply representations.[10] The complainant's position is that these examples demonstrate the custodian's disregard for the access rights to personal health information and that the representations of the custodian should be given no weight beyond the few facts accepted by the complainant.

[45] In addition, the complainant submits that the custodian appears to have limited its second search for records to only the original scanned items and the GoldCare records and has made no effort to locate originals that were not properly stored – it is possible that some of the resident's records were misplaced and misfiled and no efforts have been made to find them. Regarding the investigation records that should exist, the complainant argues that it has not provided any information about the processes and systems in place in response to complaints made about residents' care and in fact the custodian did not even locate the actual complaints that were made, either by email or hand-delivered written complaints.

Analysis and findings

[46] As previously stated, the *Act* does not require that the custodian prove with absolute certainty that further records do not exist, and although a requester will rarely be in a position to indicate precisely which records the custodian has not identified, the requester still must provide a reasonable basis for concluding that such records exist.[11]

[47] I am satisfied that the complainant has established that records should exist relating to complaints made to the custodian about the health care provided to the resident at the care home. Despite the fact that that emails from the time of the resident's stay could not be recovered due to automatic deletions and the decommissioning of its email archives, I find that it is reasonable to conclude that records beyond emails would be created in response to complaints made about a resident's health care at one of the custodian's care homes. Consequently, I will order the custodian to conduct a further search for records relating to these complaints.

[48] Turning to the complainant's position that the custodian's search for other records was not reasonable, I find that the custodian's initial search for records was not

[10] The complainant confirmed with IPC staff that he received copies of the GoldCare records "belatedly" during the review of this complaint.
[11] Order MO-2246.

reasonable for the following reasons:

- There is no evidence that the custodian conducted a further search for records during the mediation of the complaint, despite its assertion that it did so,
- The custodian did not conduct a search for electronic records during the request stage and provided no acceptable explanation as to why this search was not conducted, and
- The custodian lost and/or destroyed close to 3,000 pages of paper- based records sometime between processing the access request and the review stage of this complaint.

[49] However, I note that the evidence before me shows that the custodian conducted a further search for both paper-based and electronic records during the reply stage of the complaints process. For this reason, I find that it would serve no useful purpose to order the custodian to conduct a further search for records, subject to the search I will order regarding complaints made about the health care provided to the resident.

Issue B: Is the custodian required to provide the complainant with legible records or records of better quality?

[50] The complainant's position is that some of the records are of bad quality, rendering portions of them illegible. He takes the position that the custodian is required to provide him with legible copies of the records. After the review of this complaint was concluded, I was advised by the custodian it had re-scanned all of the remaining paper-based records and released them to the complainant.

[51] While this issue has not yet been considered under the *Act*, it has been considered under *FIPPA* and *MFIPPA*. Both of those acts contain provisions that stipulate that when access is granted to an individual's own personal information, it is to be provided in a "comprehensible form."[12]

Representations

The custodian's representations

[52] Although provided an opportunity to do so, the custodian did not object to the relevance of the considerations under *FIPPA* and *MFIPPA* described above.

[53] The custodian reiterates the information it provided during the mediation, namely that:

[12] See section 48(4) of *FIPPA* and section 37(3) of *MFIPPA*.

- the records were paper-based, worn as part of the natural process with ink that varied based on handwriting pressure, humidity, temperature and lighting,
- handwriting varied from person to person, and
- the records were three-hole punched for filing, which caused cutoff areas.

[54] The custodian also submits that re-scanning the records would not produce better quality record because they were scanned from the original copy.

The complainant's representations

[55] The complaint submits that some of the resident's personal health information was not captured effectively in the scanning of the original paper records and that the custodian is obliged to make efforts to improve the scanning wherever reasonably possible. For example, the complainant argues that some of the pages were cropped or could be improved with adjusted scanning settings, such as unfolding dog-eared pages, ensuring that no information is lost near the margins, placing the original squarely on the scanner and adjusting the contrast settings.

[56] The complainant further submits that there is no evidence that the custodian compared the scanned records with the original records during the scanning process. After the complainant provided the custodian with the deficiency list, there is no evidence that the custodian compared any of the records identified in this list with the original records.

The custodian's reply

[57] The custodian submits that after discovering that many of the paper-based records had been inadvertently destroyed, it compared the remaining 1853 pages of paper-based records to those itemized in the deficiency list. It determined that of the 238 scanned records located in the deficiency list, 166 of them no longer existed. As a result of this review, the custodian concedes that some of the scanned copies sent to the complainant at the request stage were not sufficiently legible. The custodian goes on to submit that it rescanned 52 pages alleged by the complainant to be illegible, that these pages are now more legible.[13]

The complainant's sur-reply

[58] The complainant submits that he received the re-scanned records – the records listed in the deficiency list - that were attached to the custodian's reply representations and notes that their quality is superior to the originals. The complainant also notes that

[13] The city sent a number of records to the IPC with its reply representations. The city does not indicate whether it released these re-scanned records to the complainant. However, the complainant confirmed that he received a copy of these records.

the records listed in the deficiency list were only the clearest examples of indecipherable information and that the remaining records should be re-scanned in order to improve their quality and provided to the complainant at no additional cost, given that the new scanning process that the custodian has used provided a remarkable improvement in legibility and quality. The complainant also advised that during the review of this complaint, he submitted a new access request under the *Act* to the custodian to view the records in person.

Post-review

[59] After the conclusion of the review of this request, the custodian notified the IPC that it had re-scanned all of the remaining paper-based records and released them to the complainant.

Analysis and findings

[60] As previously stated, the *Act* does not contain a provision that addresses the comprehensibility of records of personal health information, but *FIPPA* and *MFIPPA* do. The custodian was provided with the opportunity to consider the relevance of the considerations under *FIPPA* and *MFIPPA*, and did not object to them.

[61] As I explain below, it is not necessary to draw on the *FIPPA* and *MFIPPA* considerations in this appeal. It is undisputed between the parties that legibility of the records is a relevant consideration. The dispute between them is whether further steps must be taken to improve the legibility of certain records.

[62] Section 1 sets out the purposes of the *Act*. I find that section 1(b) is relevant to the issue of the legibility of the records. Section 1(b) states:

> The purposes of this Act are:
>
> > (b) to provide individuals with a right of access to personal health information about themselves, subject to limited and specific exemptions set out in this Act;

[63] Given the one of the central purposes of the *Act* is to provide individuals with a right of access to personal health information about themselves – or in this case – the personal health information of a deceased individual by the estate trustee – I find that the right of access is only meaningful if the records are legible. In the circumstances of this complaint, I find that the complainant's right of access would be undermined if the records are not provided in legible format.

[64] I acknowledge that after the conclusion of this review, the custodian re-scanned the remaining paper-based records and released them to the complainant. As a result, I find that it is not necessary for me to order the custodian to do so. However, I note that had the custodian not re-scanned the remaining records on its own initiative, I would

have ordered it to do so.

ORDER:

For the foregoing reasons, pursuant to section 61(1) of the *Act*:

1. I order the custodian to conduct a further search for records relating to complaints made about the resident's care by **July 2, 2024,** and provide the complainant with a written explanation of the steps taken in this search.

2. If the custodian locates records as a result of this search, I order the custodian to issue an access decision to the complainant by **July 2, 2024**.

Original Signed By: May 31, 2024

Cathy Hamilton
Adjudicator