Office of the Access to Information and Privacy Commissioner
New Brunswick

Commissariat à l'accès à l'information et à la protection de la vie privée
Nouveau-Brunswick

REPORT OF THE COMMISSIONER'S FINDINGS

Right to Information and Protection of Privacy Act

Breach Notification Matter: 2016-3303-AP-1787

Date: April 18, 2017

Case about privacy breach (stolen briefcase containing personal information)

INTRODUCTION

1. The present Report of Findings is made pursuant to subsection 60(1) of the *Right to Information and Protection of Privacy Act*, S.N.B. c. R-10.6 ("the *Act*").

2. On June 25, 2016, a Department of Social Development employee left his personal vehicle unlocked with a briefcase inside containing documents with personal information of public housing tenants. The briefcase was stolen. The Police was notified immediately upon discovery of the theft the next day. The Director of Policy, Legislation and Intergovernmental Relations Branch of the Department reported the privacy breach to the Access to Information and Privacy Commissioner as part of the Department's initial notification.

ROLE OF COMMISSIONER

3. The Commissioner serves as an independent oversight body for public bodies in relation to their obligations under the *Act*, including the protection of privacy regarding personal information they have collected and use as part of their programs and services.

4. Although not mandatory, the Commissioner can be notified of privacy breach incidents by public bodies for the obvious benefits that are derived from doing so:

    - The Commissioner will seek to uncover all of the relevant facts to fully understand the events that led to the breach and steps taken by those involved once the breach was discovered;
    - The public is assured that an organization not associated with the public body is looking into the incident and will report findings;
    - The public body will receive guidance in how best to handle the matter, where necessary;
    - The Commissioner will ensure that all those affected have been notified; and,
    - The Commissioner can identify any factor or cause that should be addressed to prevent a recurrence of a similar event.

5. In other words, the Commissioner's role in a privacy breach case is to conduct an independent and impartial investigation to determine whether the public body involved appropriately handled personal information in accordance with all of its obligations set out in Part 3 of the *Act*, report her findings, and where appropriate, recommend that practices be put in place to prevent a similar incident in the future.

INVESTIGATION OF THE PRIVACY BREACH INCIDENT

6. The incident in question occurred in the early hours of Saturday, June 25, 2016. A maintenance staff member of the Department's housing branch, left his personal vehicle unlocked and his briefcase inside the vehicle. The briefcase had documents containing the complete listing of public housing tenants, including their names, address, phone number, etc. The briefcase also had a set of unmarked master keys for all buildings, including individual tenant units.

7. The Department reported to us that maintenance staff keep these lists so they verify the accuracy of information should they get an emergency call after hours. In many situations, the listings are used to call other tenants in the building who are able to provide more information to assist staff in those situations.

8. In this case, the Department further explained that the list contained information about 20 buildings (which house 323 seniors), 124 Rural and Native Housing rental units throughout the Region, as well as 128 family housing units in the City of Fredericton. Specifically, the information on the list consisted of tenants' names, address, telephone number and monthly rent amount.

9. The Department's listing system of tenants does not track the number of household members living within a single unit and for that reason, the Department could not confirm the exact number of individuals who were affected by this breach.

10. As with all investigations into privacy matters, our primary objective was to uncover all of the relevant facts and details to fully understand the context in which the situation arose and what steps had been taken to contain and effectively prevent a similar breach.

11. According to the information provided to us during our investigation, at the time of the breach, a practice was established that maintenance staff kept tenant lists and the master keys with them at their private residences. The practice allowed for maintenance staff to provide assistance for emergency calls received after-hours, by referring to the lists to contact tenants who in turn could help staff to assess the emergency. Fredericton is a large region and some buildings are located more than two hours away from the maintenance staff's residences. The Department's practice was set up to enable staff to contact tenants to determine if staff had to respond in person.

12. The breach in this case occurred because a maintenance staff member was distracted due to unrelated circumstances; as a result, he left his briefcase, including the lists, in his vehicle. He forgot to lock his vehicle, which was not his usual practice.

13. The privacy breach therefore was caused by the loss of the lists containing all of the tenants' personal contact information, albeit not an intentional act, the loss was entirely preventable nonetheless.

STEPS TO CONTAIN THE BREACH

14. The maintenance employee in question realized in the early morning of Saturday, June 25, 2016, that the briefcase was missing. The police was called to look into the theft.

15. On June 27, 2016, the Department hired locksmiths to change the locks at all of the affected buildings and posted Security Guards at each building until such time that the locks were changed.

16. Despite the actions to regain security, the breach of privacy could not be contained as the lists in question were never recovered.

NOTIFICATION TO THOSE AFFECTED

17. We were advised of this incident on Monday, June 27, 2016.

18. Starting on June 27, 2016, the Department notified seniors of the breach in person and by letter. Those who were not seniors were notified by phone. Personnel went door to door to notify in person, and telephoned those who were not at home during those times. By December 12, 2016, all those affected had been notified.

19. When the Department notified those affected by the breach, however, the Department did not explain that they could contact the Commissioner's Office regarding the breach to raise their concerns directly with us. Our experience has shown that those affected by a privacy breach are reassured in knowing that, if they wish, their questions can be put to an independent office outside of the public body responsible for the breach. Doing so allows for them to raise their concerns directly, and for the oversight office to ensure that all of the elements of the breach have been reviewed and where necessary, to recommend corrective measures to prevent recurrence. This case is a good reminder for the Department to add this element to its notification process.

CORRECTIVE MEASURES UNDERTAKEN

20. As a result of this privacy breach, the Department adopted several corrective measures. In July of 2016, the Department reviewed the practice regarding after hours on-call service and handling of information of tenants. Following that review, a memo was provided to all housing staff outlining changes to the practice, as well as reiterating the importance of confidentiality of tenants' personal information.

21. We received a copy of that memo and reviewed it. The memo informs all Regional Program Delivery Managers and Housing Supervisors of new measures effective July 14, 2016, and includes for our purposes the following:

- That all master keys would no longer be identified by tenant name and/or unit address;
- That Regions will not distribute lists containing project names and/or unit addresses for after-hours maintenance staff, and those lists would now be kept at the Regional Offices only;
- That confidentiality and other guidelines and procedures be reviewed with all new staff upon hiring and on a yearly basis.

22. We also reviewed the Department's "Client/Tenant Confidentiality" policy and we describe it as being essentially an oath of confidentiality. An oath of confidentiality is an effective tool in making staff members aware of their obligations and of the seriousness of adhering to the rules at all times in protecting confidential information, such as personal information of tenants, and of the consequences when not doing so.

CONCLUSION

23. Based on the facts we gathered in this matter, we are satisfied that the Department acted promptly and appropriately upon becoming aware of the theft of the briefcase that contained lists of and keys with personal information of the Department's public housing tenants, including those of seniors.

24. The privacy breach was entirely preventable and was due to error on the part of a maintenance staff member for having left the lists in a briefcase overnight in an unlocked vehicle.

25. We point out, however, that the breach of privacy could not be contained as the lists in question were never recovered.

26. Those affected, i.e., those whose names were on the lists, were promptly notified of the breach.

27. We also found the Department implemented adequate changes to its practices that should reduce the risk of a similar breach. Preventing similar breaches will require that all staff members follow these changes in their security practices at all times when handling any personal information, including everyday documents such as lists of tenants' contact information.

28. The media reports that monitored this case certainly brought that message to the forefront.

29. No one intended to cause harm in this case, but lack of attention led to that event nonetheless. We believe all of these circumstances will be a valuable experience to the Department as the public entity ultimately responsible.

30. Nonetheless, based on all of the foregoing and findings, there is nothing additional in this case and the resulting implemented changes that requires us to issue further recommendations of corrective action. This therefore concludes our work.

Dated at Fredericton, New Brunswick, this _____ day of April, 2017.

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Anne E. Bertrand, Q.C.
Commissioner