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RESOLUTION of the rights protection procedure no. PT 47/2018, urged against the Consorci Hospital Clínic de Barcelona

Background

1.- On 18/09/2018 it was registered with the Catalan Data Protection Authority a letter from Mrs (...) (hereinafter, the person making the claim), in which she made a claim against the Consorci Hospital Clínic de Barcelona (hereinafter, the Hospital), for the alleged neglect of the right of access to part of the documentation of his clinical-work history, corresponding to the year 2005, when, according to the claimant, who is an employee of said hospital, he suffered an occupational accident which caused injuries to his shoulder. The claimant maintained that not being able to access this documentation prevented him from handing it over to his mutual, which caused him "a lot of problems with the withdrawals".

This claim gave rise to the rights protection procedure number PT 47/2018. However, before proceeding with its processing, by letter dated 10/04/2018, the person making the claim was requested to send the Authority a copy of the documentation certifying that they had previously exercised the right of access to the person responsible for the file or treatment, as required by article 16.1 of Law 32/2010, in accordance with the provisions of Organic Law 15/1999, of December 13, on the protection of personal data (hereinafter , LOPD), and with the requirements indicated in article 25.1 of Royal Decree 1720/2007, of December 21, which approves the Regulations for the deployment of the LOPD (hereafter, RLOPD).

On 10/19/2018, the Authority received a letter from the person making the claim, accompanied by copies of two emails sent on 06/29/2018 and 07/06/2018 by a member of the Lluitem Trade Union the coordinator of the Occupational Health Area of the Hospital's Occupational Risk Prevention Service, in which the union representative pointed out that the person making the claim had long ago requested access to and a copy of his clinical history -work, without getting any response from the Hospital.

2.- In accordance with article 117 of the RLOPD, by means of an official document dated 12/12/2018, the claim was transferred to the Hospital so that within 15 days it could formulate the legations that he considered relevant. At the Hospital's request made on 01/07/2019, this deadline was extended by 7 more days, by agreement dated 01/08/2019.

3.- The Hospital made allegations by means of a letter dated 01/16/2019, in which It stated, in summary, the following:

> "Unique.- Ms. (...), in his letter to the Authority he bases his complaint on "...I declare with this escrito that the company in which I work, Hospital Clínico de Barcelona, with domicile in calle Villarroel refuses to give me a part of my occupational medical history from 2005. At that time I had an occupational accident in which I injured my back and since I could not show my history to the mutual company, I have

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quite a few problems with casualties. During the year I have already contacted the hospital on several occasions and they tell me that they cannot find that part of the 2005 history...".

Before formulating the corresponding allegations, the HCB would like to point out that in 2005 occupational health clinical histories were collected on paper, it was not until 2008 that the history data began to be entered clinic through a computer application, the Tecnopreven program.

During the year 2008, the two ways of keeping the history were combined and from 2009, all the data will be collected electronically and the paper history will no longer be used.

All clinical records that were generated on paper are held in the HCB Clinical Record Archives area.

Regarding the specific case Ms. (...)(...), on September 27, 2017, she went to the HCB to request a list of the occupational accidents she had suffered as an HCB employee and a copy of her medical history of Occupational Health. At that time, prior to acknowledgment of receipt, the requested documentation is delivered.

Once the documentation that was given to Ms. (...) stated that he missed the clinical course of an accident he had suffered on March 27, 2007.

Although the HCB has evidence that she suffered that accident, there is an investigation into it and it is known that the worker was on leave due to professional contingency from 04/02/2007 to 04/12/2007.

The reason for the referenced leave was an accident for which she was attended to in the emergency room, which is why a copy of the report was requested from the HCB's Emergency Service.

The request was answered by the Emergency Service in the sense that, in accordance with current legislation, emergency reports are destroyed after 5 years, since it is not a question of any of the documents that Law 21/2000, of December 29, on the rights of information concerning the patient's health and autonomy, and the clinical documentation, obliges to keep for 15 years.

In the context of the above, we would like to highlight the following:

a) Ms. (...), indicates in his letter that he has not been given documentation relating to an incident that occurred in 2005, but the HCB has verified that the only information that could not be given to him is that relating to the incident that occurred in 2007.

b) Although the description of the incident does not appear in the clinical course, it is recorded in the HCB systems that Ms. (...), was on leave due to an occupational accident from 04/02/2007 to 04/12/2007.

c) The report requested by Ms. (...), is no longer available, since at the time it happened the documentation that was in paper format was destroyed and no copy existed in a computer system. The 2007 report was destroyed after the mandatory 5-year retention period set by the regulations referenced above.

d) We remain at the disposal of Mr. (...)to give him any document he may need in relation to his state of health."

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Fundamentals of Law

1.- The director of the Catalan Data Protection Authority is competent to resolve this procedure, in accordance with articles 5.b) and 8.2.b) of Law 32/2010, of October 1 , of the Catalan Data Protection Authority.

2.- The Hospital states that the person making the claim submitted the request for access to it on 09/27/2017. Therefore, although from 25/05/2018 Regulation (EU) 2016/679 of the European Parliament and of the Council, of 27/4, relating to the protection of natural persons with regard to the treatment of personal data and the free circulation thereof (RGPD), given that the access request had been made previously, the claim must be resolved in accordance with the previous legislation, and specifically the LOPD and the RLOPD .

Article 15 of the LOPD, in relation to the right of access, determines the following:

> "1. The interested party has the right to request and obtain free of charge information about their personal data being processed, the origin of the data and the communications made or planned to be made.
> 2. The information can be obtained through the mere consultation of the data through visualization, or the indication of the data that is the subject of treatment through writing, copying, telecopy or photocopy, certified or not, in a legible and intelligible form legible, without using keys or codes that require the use of specific mechanical devices.
> 3. The right of access referred to in this article can only be exercised at intervals of no less than twelve months, unless the interested party proves a legitimate interest for this purpose, in which case they can exercise it earlier."

For its part, article 27 of the RLOPD, in its first and second section, provides the following regarding the right of access:

> "1. The right of access is the right of the affected person to obtain information on whether their own personal data is being processed, the purpose of the processing that, if applicable, is being carried out, as well as the information available on the origin of the aforementioned data and the communications made or planned for this data.
>
> 2. By virtue of the right of access, the affected person can obtain from the controller information relating to specific data, to data included in a certain file, or to all their data subjected to processing.
> However, when reasons of special complexity justify it, the person in charge of the file may request the affected person to specify the files in respect of which he wishes to exercise the right of access, and for this purpose he must provide him with a list of all the files."

Likewise, also on the right of access, article 29 of the RLOPD establishes the following:

"1. The person in charge of the file must decide on the access request within a maximum period of one month from the receipt of the request.
After the deadline has passed without an express response to the access request, the interested party can file the claim provided for in article 18 of Organic Law 15/1999, of December 13.
In the event that it does not have the personal data of those affected, it must also notify them within the same period.
2. If the request is approved and the person in charge does not accompany his communication with the information referred to in article 27.1, access must take effect within ten days of the aforementioned communication.
3. The information provided, regardless of the medium in which it is provided, must be provided in a legible and intelligible manner, without the use of keys or codes that require the use of specific mechanical devices.
The information must include all the basic data of the affected person, the results of any computer processing or process, as well as the information available on the origin of the data, the transferees of the data and the specification of the specific uses and purposes for which the data was stored."

Apart from the general regulation of the right of access that has just been mentioned, in the case analyzed here it is also necessary to take into account the regulations for the prevention of occupational risks, as well as the health regulations governing the medical history .

On the one hand, with regard to the regulations for the prevention of occupational risks, Law 31/1995, of 8 November on the prevention of occupational risks (hereafter LPRL), establishes the following in article 22 of LRPL, entitled "health surveillance":

"1. The employer must guarantee the workers in his service the periodic monitoring of their state of health according to the risks inherent in the work.
(...)
4. The data relating to the health monitoring of workers cannot be used for discriminatory purposes or to the detriment of the worker.

Access to medical information of a personal nature must be limited to medical personnel and the health authorities that carry out the monitoring of the health of workers, without it being supplied to the employer or other persons without the express consent of the worker. (...)".

On the other hand, Royal Decree 39/2017, of January 17, which approves the Prevention Services Regulation (hereafter, the RSP), establishes the following in article 15.2, entitled "Organization and means of own prevention services":

"2. The own prevention services must have the facilities and the necessary human and material means to carry out the preventive activities they must carry out in the company.
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Without prejudice to the necessary coordination indicated in the previous paragraph, the health activity that, if applicable, may be there, must have, for the exercise of its function within the prevention service, the structure and means appropriate to its specific nature and the confidentiality of personal medical data and must comply with the requirements established by the applicable health regulations.
This health activity must include the specific functions set out in section 3 of article 37 of this provision, the activities attributed to it by the General Health Law, as well as those others that in the field of occupational risk prevention correspond according to their specialization."

And article 37 of the RGP, entitled "higher level functions", establishes the following:

"1. The functions corresponding to the higher level are the following: (...)

Health examinations must include, in any case, a clinical history - employment in which, in addition to the anamnesis data, clinical examination and biological control and complementary studies according to the risks inherent in the work, a detailed description of the workplace, the time spent in this workplace must be recorded , the risks detected in the analysis of working conditions and the preventive measures adopted.

Similarly, a description of the previous jobs, the risks present in these jobs and the length of stay for each of them must be entered, if any."

With regard to the applicable health regulations, Basic State Law 41/2002, of November 14, on Patient Autonomy (hereinafter, Law 41/2002) establishes in its article 18 the right of access to the clinical history in the following terms:

"Rights of access to the clinical history 1. The patient has the right of access, with the reservations indicated in section 3 of this article, to the documentation of the clinical history and to obtain a copy of the data contained therein . Health centers must regulate the procedure that guarantees the observance of these rights.
2. The patient's right of access to the clinical history can also be exercised by duly accredited representation."
3. The patient's right of access to the clinical history documentation cannot be exercised to the detriment of the right of third parties to the confidentiality of the data contained therein collected in the patient's therapeutic interest, nor to the detriment of the right of professionals who participate in its preparation, who can object to the right of access to the reservation of their subjective annotations.

4. Health centers and private practitioners must only provide access to the medical records of deceased patients to people who are related to them, for family or de facto reasons, unless the deceased has expressly prohibited it and be accredited in this way. In any

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> case a third party's access to the medical history motivated by a risk to their health must be limited to the relevant data. Information that affects the privacy of the deceased or the subjective notes of professionals must not be provided, nor that harms third parties."

Regarding the retention periods of the clinical history, it is worth mentioning, on the one hand, article 17 of Law 41/2002, which establishes the following in sections 1 and 2:

> "1. Health centers have the obligation to keep the clinical documentation in conditions that guarantee its correct maintenance and security, although not necessarily in the original support, for the proper assistance to the patient during the appropriate time in each case and, as at least five years counted from the date of registration of each care process.
>
> (...)
> 4. The management of the clinical history must be carried out by the centers with hospitalized patients, or those that attend to a sufficient number of patients under any other care modality, according to the criteria of the health services, through the admission and clinical documentation unit, in charge of integrating the clinical histories into a single file. The custody of these medical records is under the responsibility of the management of the health center. (...)"

For its part, Law 21/2000 establishes the following in art. 12, in its wording given by Law 16/2010, of June 3, amending Law 21/2000:

> "1. The responsibility for guarding the clinical history rests with the management of the health centers, or with the health professionals who carry out their activity individually.
> 2. The clinical history must be kept under conditions that guarantee the authenticity, integrity, confidentiality, preservation and correct maintenance of the registered healthcare information, and that ensure its full reproducibility in the future, during the time in which it is mandatory to keep it, regardless of the medium in which it is found, which does not necessarily have to be the original medium. 3. (...)
>
> 4. The following documentation must be kept from the clinical history, together with the identification data of each patient, for at least fifteen years from the date of discharge of each care process: a) The sheets of informed consent. b) The discharge reports. c) Surgical reports and birth registration. d) Data relating to anesthesia. e) The reports of complementary explorations. f) The necropsy reports. g) Pathological anatomy reports. 5. (...)

> 6. The documentation that makes up the clinical history not mentioned in section 4 can be destroyed once five years have passed from the date of registration of each care process.
> 7. Notwithstanding what is established in sections 4 and 6, the documentation that is relevant to care effects, which must incorporate the document of advance wishes, and the documentation that is relevant, especially for epidemiological purposes, research or organization and operation of the National Health System (...) The clinical documentation is also must be kept for judicial purposes, in accordance with current regulations.
>
> 8. The decision to keep the clinical history, in the terms established by section 7, corresponds to the medical management of the health center, at the proposal of the doctor, with the prior report of the unit in charge of managing the clinical history in each center. This decision corresponds to the doctors themselves when they carry out their activity individually. (...)
>
> 12. The prescriptions of this article are understood without prejudice to the application of the specific regulations for the prevention of occupational risks and the protection of the health of workers in the clinical histories relating to the monitoring of the health of workers."

Finally, article 16.1 of Law 32/2010, provides:

> "1. Interested persons who are denied, in part or in full, the exercise of their rights of access, rectification, cancellation or opposition, or who may understand that their request has been rejected due to the fact that it has not been resolved within the established deadline, they can submit a claim to the Catalan Data Protection Authority."

3.- Having explained the applicable regulatory framework, it is then necessary to analyze whether the response given by the Hospital to the request for access made by the person now making a claim, conformed to the precepts transcribed in the previous legal basis, although first of all, it is considered appropriate to make some considerations on formal issues in relation to the response given by the Hospital.

3.1. Analysis of formal issues.

With regard to formal issues, it should be noted that the Hospital has not proven to have made a written response within the one-month period provided for in art. 29 of the RLOPD to the request for access made by the person now claiming.

In the statement of objections presented during the hearing procedure, the Hospital stated that the person now claiming requested on 09/27/2017 access to "a list of the occupational accidents that had suffered as an HCB worker and a copy

of your Occupational Health medical history. At that time, prior to acknowledgment of receipt, the requested documentation is delivered. Once the documentation that was given to her was reviewed, Ms. (...) he stated that he was missing the clinical course of an accident he had suffered on March 27, 2007 (...) The request was answered by the Emergency Service in the sense that, in accordance with current legislation, emergency reports are destroyed after 5 years (...)". As indicated, it is not proven in the present procedure that the Hospital had provided the claimant with a copy of his clinical-labor history, nor that it had given him an answer about the specific medico-labor documentation that the claimant required later. And the response from the Emergency Service to which the Hospital refers in its letter of allegations, it seems that it would be an internal letter, not addressed to the now claimant. And in any case, the Hospital did not provide it during the hearing phase.

For his part, the now claimant stated in his letter of claim, for what is now of interest, that: "during the year I have already contacted the hospital several times and they verbalize that they do not find that part of the history of 2005". And from the e-mails that the claimant has provided before the Authority, sent to the Hospital on various dates in June 2018, it can be inferred that the Hospital would not have sent him a copy of the requested documents, all and that many months have passed since he made the request that is the subject of the claim, which according to the Hospital was on 09/27/2017.

Although the person making the claim has not focused his complaint on a formal issue, such as the lack of response or the lack of response within the deadline, it should be emphasized that the eventual verbal response by the Hospital to the request for access that is the subject of a claim does not allow the Authority to prove compliance with the requirements set out in the applicable regulations, such as the Hospital's compliance with the duty to inform in the resolution on the request, that the affected person can claim the protection of this Authority in accordance with the provisions of articles 18 LOPD and 30.3 RLOPD, and what is provided for in article 16 of Law 32/2010. Likewise, the fact that the claimant refers in the letter of claim to the part of his occupational medical history from the year 2005, and that the HC states that the documentation that the now claimant requested refers to or is the cause of an accident at work that occurred in April 2007 - and not, as the claimant maintains, in 2005 - would highlight the need even more than the response given by the Hospital had it been in writing, it would have helped to clarify this question, as well as others that are set out below, relating to the substance of the matter.

3.2. On matters of substance.

With regard to the substance of the claim, that is to say, the origin or not of the access request made by the now claimant, as a starting point it must be taken into account that articles 15 of the LOPD and 27.1 of the RLOPD configured the right of access as the right of the affected person to obtain information about their own personal data that is being processed and, where applicable, about the purpose of the treatment, as well as the information available about the 'origin of the aforementioned data and the communications made or planned.

The right of access is a very personal right, and constitutes one of the essential powers that make up the fundamental right to the protection of personal data. As has already been advanced, through the right of access the owner of the data can find out which data about his person are the subject of treatment. In addition, this right could be the basis for the exercise of other rights, such as those of cancellation, rectification or opposition.

This is why the limitations to this right of access must be minimal given that through its exercise the effectiveness of the fundamental right to the protection of personal data is guaranteed.

With regard to the reason for complaint made by the claimant in his letter of claim, regarding the denial by the hospital of access to certain information regarding him that would appear in his clinical work history (" ...the company in which I work, Hospital Clínico de Barcelona...refuses to give me a part of my 2005 medical history"), in the hearing phase of this procedure the Hospital has argued the impossibility of making the right of access effective, due to the fact that the requested documentation would have been deleted, justifying its elimination in the fact that it would be a medical report issued by the Emergency Service in 2007, when the clinical history was still made on paper, and that "in accordance with current legislation, emergency reports are destroyed after 5 years, since they are not any of the documents that Law 21/2000, of December 29, on the rights of information concerning the health and autonomy of the patient, and the clinical documentation, must be kept for 15 years".

Well, regardless of whether the 5- or 15-year retention period was applied - a question that is mentioned in the following legal basis - what is obvious is that if the document in question no longer exists, this circumstance implies that the data that was contained there is no longer subject to treatment by the Hospital, so that it is no longer possible to access it. That's the way things are, and without questioning the claimant's right of access to that document if it had been preserved, the same cannot be said when the data is no longer the subject of treatment by the person in charge.

This is why, from a substantive point of view, the present claim should be dismissed, without prejudice to the formal reasons indicated in section 3.1,
without proceeding but making any request to the Hospital regarding the lack of response in time, because through this resolution the affected person can already know the Hospital's response to his request.

4.- As has been said, given the Hospital's allegation that the document had been destroyed, the doubt arises as to whether such removal was appropriate based on the application of the 5-year period of conservation, or if, on the contrary, the application of the 15-year term or another term that could be applicable to the clinical-labor documentation proceeded. This issue does not apply, however, to address it within the framework of this procedure, which focuses on the right of access, which cannot in any way be enforced for the reasons mentioned. This being the case, it is considered appropriate to open a preliminary information phase in order to elucidate whether the Hospital could have

committed an infraction of the data protection regulations, in the event that personal data processing - deletion - could have been unlawful, due to premature.

For all that has been exposed,

RESOLVED

First.- Estimate, for formal reasons, the claim for protection of the right of access made by Mrs. (...)against the Clinical Hospital Consortium, and dismiss it in substance, without making any request to the Clinical Hospital Consortium, given that the documentation requested and to which he had the right to access, would have been deleted .

Second.- Open a preliminary information phase for the purpose of elucidating whether the Hospital Clínic Consortium has committed an infringement of the data protection regulations for having removed the clinical-labor documentation requested by the claimant before the applicable retention period has expired.

Third.- Notify this resolution to the Hospital Clínic Consortium and the person making the claim.

Fourth.- Order the publication of the Resolution on the Authority's website (www.apd.cat), in accordance with article 17 of Law 32/2010, of October 1.

Against this resolution, which puts an end to the administrative process in accordance with articles 26.2 of Law 32/2010, of October 1, of the Catalan Data Protection Authority and 14.3 of Decree 48/2003, of 20 February, by which the Statute of the Catalan Data Protection Agency is approved, the interested parties can file, as an option, an appeal for reinstatement before the director of the Catalan Data Protection Authority, in the period of one month from the day after its notification, in accordance with the provisions of article 123 et seq. of Law 39/2015 or directly file an administrative contentious appeal before the administrative contentious courts of Barcelona , within two months from the day after its notification, in accordance with articles 8, 14 and 46 of Law 29/1998, of July 13, regulating administrative contentious jurisdiction.

Likewise, the interested parties may file any other appeal they deem appropriate for the defense of their interests.

The director,