

Report of Health and Social Care sector Level 2 Information Governance Serious Incidents Requiring Investigation recorded and now closed during

01st. October to 31st. December 2013

Purpose

This is the second published report of closed level 2¹ Information Governance Serious Incidents Requiring Investigation (IG SIRIs) recorded on the IG Toolkit Incident Reporting Tool. This type of report will be published on a quarterly basis as specified in the IG SIRI Publication Statement².

The report below consists of **31** incidents reported to the Information Commissioner's Office (ICO), Department of Health (DH) and NHS England (NHSE) by Health or Adult Social Care organisations or suppliers (as advised within the [IG SIRI Guidance](#) issued 1st June 2013). It covers IG SIRI level 2 incidents closed during the period of 01st. October to 31st. December 2013, following investigation by the local organisation(s) concerned. It contains the organisation name, date the incident occurred, scale (e.g. the number of data subjects affected presented as a range), a description of the incident and data involved. All information displayed below is as reported by the organisation(s) concerned.

Please note:

- A 'Closed' incident means that the incident has been investigated by the local organisation and no further action is required unless the ICO make a request.
- Closed incidents may still be under review by the ICO and any actions taken will be published on the [ICO website](#).
- This report does not include level 2 incidents which are still marked as open and therefore still under investigation by the local organisation.
- Any near misses, Level 0 and 1 incidents voluntarily reported by organisations are also excluded as these incidents are not currently being monitored by the Health and Social Care Information (HSCIC) Centre but are useful for gathering intelligence, analysing trends and learning from previous occurrences.
- Details of such incidents are held by the local organisations.

Next reports

The next closed level 2 IG SIRI report will be published by the end of April 2014 covering the period January to March 2014.

¹ Level 2 IG SIRIs are sufficiently high profile cases or deemed a breach of the Data Protection Act or Common Law Duty of Confidentiality, and hence reportable to the Department of Health and Information Commissioner's Office. Organisations have used the IG SIRI assessment of severity facility to determine this level and report the incident. Further information on this can be found in the 'Checklist Guidance for Reporting, Managing and Investigating IG SIRIs'.

² <https://www.igt.hscic.gov.uk/resources/IGIncidentsPublicationStatement.pdf>.

Closed Level 2 IG SIRIs from 01st October to 31st December 2013

Organisation Name	Date of Incident Closure	Scale of Incident	Details of Incident	Data
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	19-Nov-13	Information about 11-50 individuals	<p>On the 28th October 2013 a nurse made a home visit to a patient. The Purpose of the meeting was to conduct a Mental Capacity Assessment. However, the carer was in attendance and it was not possible to proceed.</p> <p>The nurse and trainee that was with her concluded the meeting and both state that the notebook and diary were in the bag. The carer saw them to the door and it is felt could have removed the note book but no allegations have been made. The Carer claims that he called the nurse on 29/10/2013 but there were no missed calls identified. On the 30/10/2013 a call was received by the team manager from a worker outside of the Trust who had visited the patient and been confronted by the carer with the notebook in his hand. This was the first time that the Trust knew that the notebook was missing as the nurse had not needed to refer to her notebook. The team manager immediately arranged to collect the notebook but did not establish that no copies had been taken. A follow up visit has now been arranged to check same and collect any further copies if taken.</p>	<p>47 names were named in a note book with a task by the side. No other identifiers were present. In 3 cases detailed sensitive information was included next to the name but no identifiers other than name. In one case a detailed case note was made and this included an address and names of third parties involved with the case. At this time it is not known if all of the data has been recovered and a meeting will take place on 5/11/13 with the patient and carer where the information was left.</p>

<p>CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST</p>	<p>30-Dec-13</p>	<p>Information about less than 10 individuals</p>	<p>Email received by Dr X on 28/10/2013 from the patient A reporting that searches on the patient's name using 'Google', returned a powerpoint presentation from the website 'Slideshare' which contained the patient's name and his HIV status. Later it was found that the presentation contained details for another patient (patient B). The relevant google result read - "New fill late adverse events audit June 2009 - Slideshare" The patient A was made aware of information being available in the public domain when a colleague (who was previously unaware of the person's HIV status) had used 'Google' to search for the patient A's name.</p> <p>A separate email was sent on 25/10/2013 by patient A to nurse A and a response sent to the patient by the nurse on 26/10/2013.</p> <p>This response by the nurse contained an apology, indicated that nurse A was unaware of the patient's name and other details having been included in the presenter notes of the presentation.</p> <p>The following actions were taken by nurse A: Content removed from 'Slideshare' Requested that Google refrain from showing any information about the slides on search results (to be implemented within 24 hours). Similar request made to Bing – another Search Engine provider. Offered the patient complete assistance with any complaints made. Emailed a copy of his response to the patient A to Dr X.</p> <p>The patient A sent Dr X a further email on 26/10/2013, attaching the response from nurse A and requesting that:</p> <ol style="list-style-type: none"> 1. The leadership team reflect on how they would feel if such a breach of confidentiality had affected them. Potential implications of the confidentiality breach for this person are referenced. 2. A request that a senior NHS IT Professional checks to ensure that any of his details are completely removed from any material associated with the project. 3. Independent review of the patient's formal complaint. <p>As nurse A no longer works for CNWL, it took some time to establish the facts. Once the actual slide presentation was available, it was noticed that another patient (patient B) was mentioned in the presentation and similar data disclosed.</p>	<p>Name, age, HIV status and when HIV positive became for two patients uploaded to a website in error.</p>
<p>NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST</p>	<p>16-Dec-13</p>	<p>Information about 11-50 individuals</p>	<p>2 x ward computers found to be not working. IT contacted for advice. IT staff member identified that hard drives had been removed from PCs.</p>	<p>Handover sheet including name, DOB and diagnosis</p>

Plymouth City Council	13-Dec-13	Information about 501-1,000 individuals	<p>A data sheet for five clients was extracted from the payroll system and from this data sheet only data relevant to four of the individual clients was extracted and sent to them. However the fifth client received the complete data sheet, rather than only their extract. The recipient realised the error and destroyed that data sheet. The other client's data was not provided to the public, but held briefly within a similar organisation.</p>	Payroll - name - NINO - pay - sent via encrypted transmission
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	31-Oct-13	Information about less than 10 individuals	<p>On the 20.09.13 clinically sensitive information sent to a solicitor not involved with a case in error via an insecure delivery email route, the trust procedure was not followed. The name of the client was not fully disclosed, only a first name. The name of the client's mother was fully disclosed, so the client could theoretically be identified but not without some effort, and this was unlikely given that a solicitor received the information.</p> <p>The solicitor complained on the 16.10.13 that he had brought this breach to our attention on 4 occasions and alleged that we had failed to do stop the breaches; this was an exaggeration the team having only been advised twice.</p> <p>The email was recalled. All involved were advised to discontinue using the email thread to communicate further. The solicitor confirmed that he had deleted the emails received in error. Then case worker then used the erroneous email to communicate further information, thus repeating the breach. Others in the thread did not notice that the original email had again been used and continued to communicate.</p> <p>The solicitor continued to receive information in error because individuals used the 'reply all' option to send more information, and each by insecure email.</p> <p>The breach was then repeated in reporting the incident to colleagues in the Trust by forwarding the original email rather than completing an incident form.</p>	Only first name of client was used. Data was limited in detail.
CALDERSTONES PARTNERSHIP NHS FOUNDATION TRUST	31-Dec-13	Information about less than 10 individuals	<p>The report had been written by the Responsible Clinician for the Client for a Tribunal and had been sent to the Solicitor but had not been checked for complete accuracy. The Client involved was distressed by this incident because of the nature of the sensitive information contained which was not relevant to his case. The incident has been investigated by the Clinical Director for the Trust.</p>	Personal data /sensitive data

KENT COMMUNITY HEALTH NHS TRUST	27-Dec- 13	Information about less than 10 individuals	Staff member believed she was being interviewed by two police officers when they were in fact private investigators. In contravention of policy, checks were not carried out to confirm the request for information was legitimate, prior to the information being released	Photocopy of continuation sheets (notes), which included the individuals statement and a referral form
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	04-Nov- 13	Information about 11- 50 individuals	Hotel Services Manager was contacted by Sunlight Laundry and informed that a file containing patient information had been found in a bag of dirty linen. The file was returned to the Trust the same day. The incident was brought to the attention of the Information Governance team 29th August.	The file contained the details of 14 patients (13 children) with congenital heart disease. For some patients the name, age, and name of procedure carried out, for others, name, dob, address and name of procedure carried out.
Worcestershire Health and Care NHS Trust	09-Dec- 13	Information about 11- 50 individuals	The handover sheet was from Evesham Community Hospital and was dated 20/08/13. It doesn't mention the hospital on the sheet but it does have a reference to the ward name. It has details of 18 patients' including their name, age, GP name, condition and treatment. It also contains a small amount of hand written notes.	Patient - name, age, GP name, condition and treatment. Also a small amount of handwritten notes.
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	08-Oct- 13	Information about 11- 50 individuals	Staff member returned home, parked on driveway, left car, closing doors but did not lock car. Went to make a sandwich and returned to car to find door open and bag stolen. Bag contained care plan of patient, diary containing patient's initials/names and contact details, Trust ID, smartcard and personal effects.	care plan and initials/names and telephone numbers of other patients
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	08-Oct- 13	Information about less than 10 individuals	Assessment letter sent to address on the database, which stated the wrong residence, but the correct road number and name	Letter following assessment

Derbyshire Healthcare NHS Foundation Trust	21-Oct- 13	Information about 11- 50 individuals	On 15/08/13 a nurse on nights on an elderly in patient ward sent a non-password protected document as an attachment to all NHS East Midlands staff (NHS Mail) in error. This document was intended for internal distribution to other ward staff only but should still have been password protected as per our Email Policy. Later that morning many of the recipients contacted the Trust to inform us of the breach and we initiated an investigation. The IG Manager required Director Level approval to access the email account in order to establish what information had been sent and to whom. The member of staff responsible was on annual leave and her Line Manager contacted her to inform her of the breach. The staff member provided her password to her Line Manager who accessed her account to send a Recall message. This was unsuccessful due to the time delay. This additional breach of policy will form part of the investigation- both staff members have been reminded of the policy and the password reset. The document that had been sent was 15/08/13 Patient Status at a Glance and it contained the personal, sensitive, confidential clinical details of all 17 patients on the ward. The majority of recipients who responded had not opened the document and 109 had left the organisation or not received it. A Datix report was submitted and this incident has been externally STEISS reported to our parent organisation. An Internal investigation is ongoing.	NHS Patient Data - Names, MHA Status, DNAR Status, Summarised Clinical needs
SOUTH WEST YORKSHIRE PARTNERSHIP FOUNDATION NHS TRUST	24-Oct- 13	Information about less than 10 individuals	Discharge letter included in error to the address of a second service user.	Informing of diagnoses, clinical presentation and medical treatment received whilst under the care of the team.
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	11-Oct- 13	Information about 11- 50 individuals	Handover sheet containing details of 17 patients found during house clearance. Staff no longer works for the Trust. BBC has contacted a number of patients from the list. BBC is informing the ICO.	Names, DOB, NHS number and details of symptoms and treatment.

<p>ADDACTION</p>	<p>11-Nov-13</p>	<p>Information about 11-50 individuals</p>	<p>A phone call was received on the 8th August from a partner agency stating that a filing cabinet had been purchased which contained our service user files. The partner agency is now in the building we used to occupy and have the same contact details. They advised they would pass on the contact details for the lady who made the phone call.</p> <p>On the 12th August the contact details were passed on to us. We verified that the files belonged to us and that the information had not been passed on to or seen by anyone else, she works for a company as a HR Manager and the cabinets were purchased by her manager on EBay.</p> <p>The files were collected on the 13th August and taken back to our offices. There were 16 individuals affected. The files contained personal and sensitive information with case notes.</p> <p>The individuals affected all accessed our service prior to its closure. The Thursday before the closure, all of the service user files were collected by a courier on pallets within filing cabinets to be taken to a secure storage and scanning company. A receipt detailing the number of cabinets collected was retained. The courier has confirmed that they have a receipt detailing their handover of the pallets to the scanning company. The following day Addiction staff checked that the building was empty prior to handover to the new provider.</p> <p>The files were scanned and the discs returned to us, the files are due to be destroyed by the same organisation. The owner of the scanning company has stated that he does not sell office equipment on EBay and that the cabinets have not come from him.</p> <p>The purchaser has provided contact details of the seller (who is not the scanning company) and we are contacting them for further information regarding where they purchased the cabinets from.</p>	<p>Service user files containing personal and sensitive information including case notes.</p>
<p>KENT COMMUNITY HEALTH NHS TRUST</p>	<p>27-Dec-13</p>	<p>Information about less than 10 individuals</p>	<p>Fax contained patient sensitive and adult protection information relating to a single patient. Fax number was input manually prior to sending and was one digit different from the intended destination number. The safe haven procedure for faxing confidential information was not followed. This was in contravention of policy</p>	<p>The information faxed related to an adult protection alert and included the patient name / address of residence / alleged neglect</p>

<p>BEDFORD HOSPITALS NHS TRUST</p>	<p>07-Nov-13</p>	<p>Information about less than 10 individuals</p>	<p>A letter was sent by recorded delivery to the wrong address. The letter was destined for a member of staff but was delivered to a member of the public. The letter contained confidential information regarding the outcome of a disciplinary investigation. The wrong address was the mistake of the hospital administration team when the address was incorrectly copied from the personnel file. Recipient of the letter called through to the maternity department to raise the incident. The member of the public contacted the local media after contacting the hospital and there was an article regards this incident in the papers. The letter was picked up by Manager from the member of the public who reported having received the letter in error. The letter had not been sent recorded delivery as normal procedure. Two copies were received by the member of the public and she only returned one. The Trust wrote to her to ask for the second copy. The patient whose details were included in the disciplinary was also contacted.</p>	<p>Disciplinary letter.</p>
<p>KENT COMMUNITY HEALTH NHS TRUST</p>	<p>27-Dec-13</p>	<p>Information about 51-100 individuals</p>	<p>13.15pm on 31st July 2013 a health professional had parked her vehicle outside a clinic where she was attending a training course. In the rear foot well of the vehicle was a locked laptop bag containing her work diary and two patient files containing new birth visit information and also family assessment information. The work diary contained approximately patient names and addresses, and also some dates of birth. The bag was put into the rear foot well as when visiting a patient she was parked in such a way that the boot could not be opened. However, she did not take this out of the car and put into the boot when the visit ended. This is in contravention of policy. The names and addresses in the diary are acceptable, however including dates of birth is in contravention of policy.</p>	<p>For the information in the diary, this only contained a name, address and possibly a date of birth. For the patient files, this included assessment forms for: 1) a new birth visit and 2) a family assessment form including health and social care information</p>
<p>BRADFORD DISTRICT CARE TRUST</p>	<p>13-Nov-13</p>	<p>Information about 5,001-10,000 individuals</p>	<p>The Trust was alerted on the 30th July 2013 (by email) by a member of the public who had been looking at Trust Board papers in the FOI section of our web site. He found that instead of the June 2013 expenditure report a spread sheet containing Member details, limited to names and addresses. This was not delineated to identify whether members are from public or patient constituencies. Staff member details were not included in the database as this was a database used to mail the Trust's quarterly newsletter; staff access this through the local intranet.</p>	<p>Names and addresses of 8,912 individuals.</p>

<p>NORTHERN DEVON HEALTHCARE NHS TRUST</p>	<p>11-Dec- 13</p>	<p>Information about less than 10 individuals</p>	<p>Incident was reported on 13th July 2013 to the On-Call Manager by the Clinical Site Manager (CSM) who in turn had received a phone call from a Staff Nurse at the Minor Injuries Unit (MIU). On-call Manager was informed that a relative of the patient had hand delivered an open envelope containing letters addressed to other patients. Letters contained person identifiable data and very sensitive clinical information relating to conditions and diagnosis. Information is not at present in the public domain, whoever there may be potential media interest should the relative who hand delivered the letters engage with the media. There is a potential risk of adverse reputation of the individual, team and organisation. Currently incident is being managed locally and a Serious Event Audit will take place.</p>	<p>NHS patient data</p>
<p>WALSALL HEALTHCARE NHS TRUST</p>	<p>04-Oct- 13</p>	<p>Information about 11- 50 individuals</p>	<p>A health visitor visited a family in the community on 3 July 2013. The Health visitor was carrying in her bag a list of 37 other patient details (all of which pertained to children's safeguarding cases). The list detailed the names of individuals, and in some cases their dates of birth, addresses, relative's details, and also a short bullet pointed summary of the key aspects of some of the cases.</p> <p>On 4 July, we were contacted by a partner colleague who had visited the family earlier that day who stated that whilst she was at the family's house, the Father showed her the list containing details of multiple patients stating that this had been found in the house following the Health Visitor appointment on the 3rd July 2013. We made immediate contact with the family and retrieved the list within 24 hours of the incident occurring. The Father states that he has not copied the list, nor has he read the full details. However we cannot be assured that this is the case.</p> <p>The Health Visitor states that at no point during her visit to the family on 3 July did she retrieve this list from her bag and therefore assumes that this was removed from her bag by one of the children present during her visit to the family.</p> <p>We have made direct contact with each individual on the list to inform them of the above event and the disclosure of personally identifiable information which in some cases was sensitive. We have given a formal apology to each individual for any distress or embarrassment that this disclosure may have caused and have offered to meet with them to share the outcome of the investigation once</p>	<p>NHS patient data</p>

			<p>this has been concluded.</p> <p>Our initial assessment of risk has identified that of the 37 individuals there was particularly sensitive information recorded about 9 cases. We do not believe that the 37 individuals will be likely to approach the media regarding this disclosure due to the sensitivity of the nature of the information and the rapid response from the organisation in retrieving the information and informing the families identified on the list. This cannot however be totally excluded.</p>	
BRADFORD DISTRICT CARE TRUST	26-Nov-13	Information about 101-300 individuals	<p>The data set was held within an excel spreadsheet. The person preparing it for disclosure had been working on the spreadsheet in order to strip out the personal data before transfer. A mistake has been made and the file has been saved incorrectly, and the wrong version transferred. It contained personal information about 226 individual patients. It contained patient identifiers including name, address and NHS number. It also included limited, but sensitive clinical information. One of the fields within the data set contained reason for referral, which for 39 individuals stated "mental disorder".</p> <p>The CSU alerted the Trust and the spreadsheet was deleted at the recipient end. There are no risks to further disclosure, or indeed disclosure outside of the NHS.</p>	<p>The data set contained personal information about 226 individual patients. It contained patient identifiers including name, address, Date of Birth and NHS number. It also included limited, but sensitive clinical information. One of the fields within the data set contained reason for referral, which for 39 individuals stated "mental disorder".</p>
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	21-Oct-13	Information about 11-50 individuals	<p>Information is only recorded for one or two patients per clinic, clinics are held on a Monday and Friday. Therefore we estimate that a maximum number of 50 patient details would have been recorded in the diary. The diary was always kept on site so it has been mislaid within the Trust.</p>	<p>Addressograph that contains the patient address, name, DOB, GP and hospital number. Clinical reminder to undertake follow up</p>
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	22-Oct-13	Information about less than 10 individuals	<p>The incident happened on the 25/06/2013, and an outpatient clinic letter was faxed to the patient's place of work rather than the GP. It contained sensitive information in relation to the patient's medication. Medical Secretary completed the letter in the clinical system and looked at the contact details on the patient record and telephoned what she believed to be the service users GP practice to obtain a fax number. She had telephoned the patients place of work, however did not realise this, took down the fax number and proceeded to fax the Clinic letter to patient's place of work.</p>	<p>Outpatient Letter that highlighted that it was from a mental health hospital.</p>

<p>TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST</p>	<p>30-Oct-13</p>	<p>Information about less than 10 individuals</p>	<p>A member of staff (Staff A) who had recently returned to work after on sick leave and had been temporarily assigned to a team which was providing clinical care to a family member of the staff.</p> <p>At no time, Staff A had mentioned to the team manager that any family member may be open to the team. Staff A overheard the name of the family member was mentioned by the key worker during a professional discussion in the team office and accessed the records of the family member on the Trust's patients electronic recording system. Staff then informed the team manager that the family member was active under their team. Only when the team manager informed Staff A not to access the family member's record, Staff A disclosed that already had.</p> <p>Immediate action taken by the team manager:</p> <ol style="list-style-type: none"> 1. Remove all paper records of the family member to where only accessible by the key worker and the team manager 2. Instruct the key worker to arrange the appointment with the service user i.e. the family member of Staff A, on the days when Staff A is off work; and to inform the service user that a family member was on the team. 	<p>Patient's case notes</p>
<p>NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST</p>	<p>27-Nov-13</p>	<p>Information about less than 10 individuals</p>	<p>Patient A was discharged from hospital and given a discharge letter in a sealed envelope. Discovered that this letter was for Patient B by the GP during the patient's appointment.</p>	<p>NHS patient data</p>

<p>UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS</p>	<p>01-Oct-13</p>	<p>Information about 101-300 individuals</p>	<p>Radiographer assigned to work on mobile van at Tesco in Warwick was unable to locate the work file for her day's work. The courier had delivered it to the van the previous day and a radiographer had used the file to change an appointment, hence assurance that the work had been delivered.</p> <p>Request for the work to be replicated at base and sent out to the mobile. Superintendent informed immediately. 115 screening sheets (only 15 containing specific medical data) plus a portable hard drive (empty) missing from kitchen area.</p> <p>All screening sheets contain patient name, address, date of birth, telephone number, and GP name. 15 sheets contain historical clinical details relating to breast screening (such as cyst left breast 2010).</p> <p>Trailer and local area searched. Police contact and also did thorough search of area - data not found.</p>	<p>115 screening sheets (15 containing specific medical data that a lay person could understand) plus an empty portable hard drive.</p> <p>Screening sheets contained patient name, address, date of birth, telephone number.</p>
<p>MILTON KEYNES GENERAL HOSPITAL NHS TRUST</p>	<p>03-Oct-13</p>	<p>Information about 5,001-10,000 individuals</p>	<p>"Having returned to the hospital on Monday 10th June I went to check the ID nos of the old field machines that were to be returned to Zeiss as part exchange for the new Fields Analysers already delivered. They had been kept within the ophthalmology department in a storage area awaiting return to the manufacturer. I noted that they were missing and then asked all staff present within the clinic to see who had moved/collected them but no one had realised they were gone. I have checked throughout the hospital and they have not been found on hospital premises. I checked with Zeiss technician and the hard drive within one of the machines still holds patient data of MRN, name and dates of birth together with a field plot"</p>	<p>DOB, name & field analysis test data</p>
<p>NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST</p>	<p>27-Nov-13</p>	<p>Information about less than 10 individuals</p>	<p>An inpatient was discharged on the afternoon of 22nd May 2013. His wife came back to PALS office with an unopened clinic letter belonging to another patient which had been stapled to the patient's discharge letter.</p>	<p>NHS patient data (within clinic letter)</p>
<p>EAST MIDLANDS AMBULANCE SERVICE NHS TRUST</p>	<p>08-Oct-13</p>	<p>Information about 1,001-5,000 individuals</p>	<p>A spreadsheet containing members of staff details was made available on the Internet.</p>	<p>staff data</p>

KENT COMMUNITY HEALTH NHS TRUST	27-Dec- 13	Information about 101- 300 individuals	Staff member's diary and case load left in bag overnight in the boot of the car. Removed from boot when rearranging seating, to accommodate passengers, and left on the side of the road at Tonbridge train station, Kent.	Diary
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Information Governance Assurance Directorate

External IG Delivery Team

Health and Social Care Information Centre