Information Governance incidents closed during 1st. January to March 31st. 2016

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Contents

Introduction

This is the eleventh published report of closed level 2[1] Information Governance Serious Incidents Requiring Investigation (IG SIRIs) recorded on the IG Toolkit Incident Reporting Tool. It covers IG SIRI level 2 incidents closed during the period of 1st. January to 31st. March 2016, following investigation by the local organisation(s) concerned.

Content of the report

The report consists of **25 closed incidents** reported to the Information Commissioner's Office (ICO), Department of Health (DH) and NHS England by Health or Adult Social Care organisations or suppliers - as advised within the IG SIRI Guidance issued 29 May 2015.

The report contains the organisation name, date the incident was closed, 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. Where necessary, personal information included within the incidents has been redacted.

An auto closure feature introduced in June 2015 closes all open incidents that have not been updated by the organisation for 90 days[2]. In Appendix A are **82 closed incidents** which have been auto-closed by the system.

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 makes 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 are 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 NHS Digital but are useful for gathering intelligence, analysing trends and learning from previous occurrences. Details of such incidents are held by the local organisations.

Next report

The next closed level 2 IG SIRI report will cover the period **1st. April to 30th. June 2016.**

[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] The organisation is notified by email 10 days in advance giving them time to update or close the incident before the auto closure occurs. If the organisation updates the record, it will not be auto closed. The organisation will also receive an email notification within 24 hours after auto closure, and if necessary can reopen the incident.

Closed level 2 incidents reported during 1 January to 31 March 2016

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/5234	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	31-Mar-16	42	A preadmissions list was sent insecurely to a new service provider. The documents contain 42 patient details specifically name, date of birth, mobile number, home number, date of admission, speciality and ward. The recipient is entitled to receive patient level information however the mode of transfer led to the incident taking place.	Name, date of birth, mobile number, home number, date of admission, speciality and ward.
IGI/5151	MARIE STOPES INTERNATIONAL	21-Mar-16	36	The organisation was advised that a number of client samples were delivered to an incorrect address in error. The incident was raised immediately on the in-house incident reporting system as a serious IG incident.	Patient identifiable information.
IGI/5133	SOUTH WESTERN AMBULANCE SERVICE NHS TRUST	23-Feb-16	1	An email containing details of a SI patient death investigation was correctly and appropriately sent to a number of email recipients. One email address was erroneously included by mistake.	SI Patient Death Investigation.
IGI/5078	REDCAR & CLEVELAND BOROUGH COUNCIL	02-Mar-16	2	Two deprivations of liberties assessment forms sent to relatives of service users but to incorrect or old addresses containing personal and sensitive person data.	Assessments contained name, residential address, date of birth, mental health assessment, and prescribed medication.
IGI/5035	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	04-Mar-16	20 approx.	A community midwife lost her diary when visiting a postnatal woman. The midwife most probably placed the diary on the roof of her car when leaving the address and drove off. Shortly after leaving the address the loss was realised and a thorough search was undertaken and steps retraced, but the diary was not found. The diary	Approximately 20 names, addresses, telephone numbers and brief post-natal information.

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				contained approximately 20 names, addresses, telephone numbers and brief post-natal details of post birth women. A list of women who were assumed to be in the diary is being compiled and they will be contacted to inform them of the loss and offered support.	
IGI/4984	HINCHINGBROOKE HEALTH CARE NHS TRUST	11-Feb-16	1	A volunteer was found to be reading through clinical information pertaining to her husband. The volunteer was removed from the situation.	Clinical data regarding husband's treatment.
IGI/4996	CLIFTON COURT MEDICAL CENTRE	02-Mar-16	1	A solicitor requested copy of a patient's medical record from NHS England. The patient's medical records were held by NHS England as there had been no contact from the patient for a number of years. NHS England forwarded the request plus the patient records to the Practice as we were the last Practice the patient was registered too. The Doctor checked the records and agreed that they could be sent out. A member of staff then copied the notes from the computer system. In doing so they failed to check the name and date of birth of the patient the notes were needed for and copied the notes of a patient with the same name.	Copy of patient's medical records.
IGI/4927	FRIMLEY HEALTH NHS FOUNDATION TRUST	09-Mar-16	2000	Community midwife left laptop and patient records in car and it was broken into overnight.	Patient post natal notes Community midwife diary with patient appointment details in - name, address, and contact numbers.
IGI/4912	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	06-Jan-16	1	Car window was smashed and a rucksack stolen from a seat well. The rucksack contained court papers pertaining to a family who live quite close	Court report containing highly sensitive information on an

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				to the area where theft occurred. The police were immediately contacted and a crime number created. The data was in a sealed stamped addressed envelope; it is illegal for any unauthorised person to open this envelope.	individual's health and forensic history.
IGI/4960	FOUR SEASONS HEALTH CARE LTD	08-Jan-16	1	A former patient requested a copy of their patient records. The request was not actioned, for reasons which are not now clear as the manager responsible has since left the company. The former patient made a further request, which has been acknowledged and looked into; the patient had been an inpatient at the hospital, and records from that period are held by Crown Records Management. A thorough search of the 7,000 files at Crown revealed that we no longer have the former patient's file or records and we have no documentation of the files being disposed or destroyed. We have written to the former patient to advise of the situation and apologise for the loss of their files.	The exact details are unknown, but likely to be detailed medical records and clinical notes.
IGI/4878	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	20-Jan-16	4	Patient was found by a member of staff in the de-escalation room reading a medical file belonging to another patient. The patient had four files in his possession. The de-escalation room was being used by the medics to re-write medicine cards during the afternoon and they were using the medical notes. It appears four sets of medical notes belonging to four patients	Current health record file of 4 inpatients - clinical information including medical and nursing notes.

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				were left in there instead of being returned to the filing cabinet in the nursing office.	
IGI/4849	DEVON DOCTORS LTD	18-Jan-16	300	Clinical data transferred onto a website for the purposes of triaging patients. This was in breach of our policies and procedures. Website was not secure or hosted within the EEA. Clinical information shared no demographics.	Electronic, clinical data of over 300 individual consultations.
IGI/4848	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	16-Feb-16	242	A service submitted via email a table of aggregated activity figures to the Information Team. The spreadsheet containing the table was holding PID 'hidden data' on a separate worksheet.	NHS Number, forename, surname, DOB, gender, address and some GP Out of Hours clinical/medical notes.
IGI/4835	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	13-Jan-16	1	Appointment letter sent out to service user from Gender ID service. Recipient contacted the service indicating that a letter for another service user was included in the envelope. Service user reported that on seeing the additional letter intended for someone else, the erroneous letter was burned on their fire.	Letter relating to a service user of Gender Identity Service.
IGI/5075	THE HEALTH CENTRE	08-Feb-16	1	A request was made for a copy of a patient's medical records. At a similar time, another set of notes were requested for a different patient. Both sets of notes were inadvertently put into the same envelope and awaited collection by the first requester. She returned the notes which belonged to another person with immediate effect to the Practice, but recognised that sensitive information was contained within the package.	NHS patient data.
IGI/4820	MEDWAY NHS FOUNDATION TRUST	12-Jan-16	130	Email sent from Trust email account forwarded to Gmail account of manager (Trust staff). Contained attachment with 130 patient details.	Patients' names, staff names, details of level of harm, date of incident,

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				Email was received and deleted.	location of incident, severity.
IGI/4863	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	15-Feb-16	1	A patient received another patient's copy of a letter to GP which had accidentally been included with his correspondence.	Letter to patient's GP which included patient's name, address, dob, hospital no. and diagnosis details.
IGI/4803	PENINSULA COMMUNITY HEALTH	08-Jan-16	Under 50	Encrypted emails containing patient demographics and clinical data sent to NHS.Com address instead of NHS.net address. NHS.Com is an Amazon cloud based email in the US. Emails have been sent on several occasions, the incorrect email address being saved into the system on the first occasion. Data encrypted so receiver would have to register for an account to access the data but this is possible.	Demographics and clinical data of cardiac patients.
IGI/4773	MERSEY CARE NHS TRUST	04-Jan-16	12	A list of 12 patients on a secure ward was pinned on the ward notice board by nurse within the secure locked ward which does not allow visitors - list on view for other in-patients for short period before being removed.	Details of 12 service users listed containing service users' initials, date of birth, named key worker & named nurse and section detained under.
IGI/4850	GENERAL HEALTHCARE GROUP	25-Jan-16	14,234 patients	BMI Healthcare has an NHS Standard Contract ("Contract") in place to provide services to the patients of certain CCGs (the "CCGs"). As part of the Contract management process, BMI is required to send to the relevant DSCRO a monthly Service Level Agreement Monitoring report ("SLAM Report") which sets out on an Excel spreadsheet patient level detail of activity	Each SLAM Report Excel spreadsheet contained the following: Provider Name ODS code Contract Name Commissioner Code Referrer Code

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				carried out by BMI under the Contract. A member of BMI's central informatics team in error sent a SLAM Report to three CCGs, not the DSCRO. (To be clear, each CCG received in error a SLAM Report with information related solely to that CCG's patients, no CCG received information in relation to patients of the other CCGs). One of the CCGs notified BMI it had received the SLAM Report in error. 46,851 records in total were sent in error with the information of a total of 14,234 patients included in those records. (The breakdown of that total patient number is as follows: one CCG received the information of 4867 of its patients in error; a second CCG received the information of 4316 of its patients in error; and a third CCG received the information of 5051 of its patients in error). Each SLAM Report sent in error included patient NHS numbers and UBRNs, but no other patient identifiable information.	GP Practice Code Referral Date UBRN POD; POD Description Local Patient ID NHS Number Activity Type HRG; HRG Description; Unbundled HRG; Unbundled HRG Description Tariff without MFF; Tariff with MFF PBR Treatment Specialty Code Treatment Specialty Description Date of Admission; Discharge Date No of Excess Bed Days Length of Stay Date of Attendance Treatment Function Code Chargeable Month CDS ID Key; Specialty Pre auth code Consultant Code Appointment Name BPT Flag.

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IGI/4952	LOCALA	06-Jan-16	Under 50	The Health Visiting Team keep an A4 file with clinical reports/lists containing names, DOB, address, of ante natal women due to be seen and 2-4 month and pre 1 year children for each month who are due a contact. This file is a safety net system to compliment the electronic system as occasionally clients have been missed and appointments not offered. This file was reported missing The file is kept in a locked tamba in the HV office which is always locked when no staff members are present. The office is not used by any other staff other than the HV team. The post is collected by the porter from the hospital 2-3 times per day and the room is cleaned daily. The porters and cleaners have worked in the hospital for many years and nothing has gone missing from the office previously.	Name, address, date of birth of antenatal women, babies 2-4 months, and children less than 1 year due to be seen in month.
IGI/4709	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	18-Jan-16	1	Temp member of staff has previously had history with client whereby a safeguarding alert was raised by client. This was investigated but taken no further due to lack of evidence. Temp member of staff began working in team where client is being treated and following a system audit it was determined that the temp staff member accessed the client's record on a daily basis for a period of 2 weeks and the line manager cannot determine a clinical business need for this access.	Clinical patient record.

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IGI/4588	NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	12-Jan-16	11-50	A Trust owned white van was stolen. The van appeared to contain patient records and internal mail. The Trust is currently assessing the impact of the potential disclosures. There is a possibility that no records where stored on the van overnight however this is being reported as a precaution.	There is the possibility that the vehicle contained a few patient records and internal mail which potentially consisted of patient appointment letters, staff details, personal records and other identifiable documents related to the Trust.
IGI/4722	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	08-Jan-16	3	It was identified that patient audiology history sheets/reports had been taken home by a staff member and were left in her house whilst she was on holiday. Following discussion, it transpires these were patient medical history sheets and results for 3 patients. The incident was recently discovered as one of the three patients attended for an Audiology Outpatient appointment where it was discovered their history sheet and report was not available.	3 patients Audiology medical history sheets and associated reports.
IGI/4734	PENINSULA COMMUNITY HEALTH	08-Jan-16	39	Data quality report containing 39 patients name, NHS No, DOB and service code sent by NHSmail to incorrect distribution list, which included Commissioners with no legitimate right of access to patient level data.	Name, NHS No, DOB, service code was the only data that could identify which service the patient was seen by if the recipient had access to the coding - in some cases the coding is obvious e.g. TB.

Appendix A

Incidents closed using the 'auto closure[3]' facility 1st. January to 31st. March 2016

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/5243	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	29-Mar-16	92	Patient information found in home of a member of staff, allegedly to create a presentation.	Radiology images - 60 discs and 92 names of patients on the discs or images.
IGI/5202	FRIMLEY HEALTH NHS FOUNDATION TRUST	09-Mar-16	2084	Excel spreadsheet containing patient information was sent to CCG in error.	Date of birth, full postcode and hospital number.
IGI/4895	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	1	A patient's Colonoscopy Report was accidentally sent in the same envelope as another patient's report.	Colonoscopy Report containing name, address, DOB, NHS & Hospital Number, and details relating to a colonoscopy examination.
IGI/5122	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	22-Mar-16	1	Member of staff inappropriately accessed family member's record.	Computer system.
IGI/4834	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	10-Mar-16	7,111	A single item of medical (ophthalmology) equipment with an in situ hard drive was submitted internally for disposal. The accompanying Request for Disposal form ('RFD form') stated the reason for disposal was that the item was 15 years old and was to be replaced by a new model.	Name, Date of Birth, Hospital Number & test reports (Ophthalmology Field Analyses).

[3] The organisation is notified by email 10 days in advance giving them time to update or close the incident before the auto closure occurs. If the organisation updates the record, it will not be auto closed. The organisation will also receive an email notification within 24 hours after auto closure, and if necessary can reopen the incident.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				On first stage completion of the Request for Disposal (RFD), the item was stated on the RFD form to have been inspected and considered to be redundant for the Trust's purposes with the recommendation that it was disposed of as fit for sale. On second stage completion of the Request for Disposal, the item was for disposal by way of auction. The item was sent to the Trust's nominated auctioneer for disposal of used medical equipment by auction. Following a routine inspection of the equipment, the auctioneer subsequently notified the Trust that the hard drive on the item contained Patient Identifiable Data comprising of the details of 7,111 patients (name, date of birth and hospital ID) with 42,909 test results on the system. **Note**: The Trust's auctioneers are an NHS-approved agency. The signed 'Agreement for Disposal of Assets' between the Trust and the auctioneer includes a section entitled 'Confidentiality and data protection' which includes that (summarised): • If the auctioneer receives confidential information from the Trust, the auctioneer will only disclose such information (i) in confidence to 'such persons as need to know' for the purposes of enabling the auctioneer to fulfil its obligations under the Agreement or (ii) to the extent it is legally	

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				obliged to disclose it. • The auctioneer will comply with the Data Protection Act 1998 and any applicable laws in relation to the processing or use of information or data that it acquires or creates as a result of the Agreement ('protected data'). • If either party discloses protected data to the other in connection with the Agreement or performance of services, the recipient (i.e. in this case, the auctioneer), will ensure that it only uses or processes the protected data for the legitimate purposes of the Agreement and will maintain appropriate technical and organisational measures to prevent unauthorised or unlawful processing of the protected data. The auctioneer has confirmed that the item has been and will be kept securely and no data has been or will be removed pending the return of the item to the Trust.	
IGI/4802	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	17-Mar-16	190	Doctor left his briefcase in the recovery room in the maxillofacial outpatient area to go into the restroom. When he returned the briefcase was missing. The briefcase contained details of 167 patients that had been identified for an audit of mouth cancer patients and several operation lists of approximately 20 patients. A personal laptop with no patient information was also stolen.	The audit details contain the patient name, hospital number and date of birth, and appointment details. There may be some hand-written clinical notes on the pages as well. The operation lists

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					contained patient name, date of birth and surgical procedures.
IGI/4810	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	01-Mar-16	80	Consultant's office was left unlocked and items were stolen - including a non-encrypted data stick which held personal data of approximately 80 patients. The rest of the data were about some articles from stroke and other professional medical journals, some presentations etc. The stick was not protected or encrypted and was kept in the Consultant's computer on the desk in the office and was not used on any other computers.	80 patient's names, DOB and NHS numbers, with some data about hospital arrival time, time from door to first specialist assessment, time of thrombolysis etc. but with no information about previous medical history, treatment, current diagnosis, home addresses or similar personal data.
IGI/4926	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	22-Mar-16	130	Following implementation of a new endoscopy system, it was identified by the IT Systems Team that endoscopy reports were being associated with the wrong patients. These reports were then being sent (both electronically and via hard copy) to the wrong GP - the reports were sent to the GP of the patient to which they had been incorrectly assigned. The subsequent investigation identified that a total of 65 reports had been incorrectly assigned, affecting 130 patients in total. The issue was identified as being due to the way in	The reports held clinical endoscopy data and patient demographics. Although the data has been disclosed to the incorrect GP, work is on-going to ensure that it is assigned to the correct patient record.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				which the system processed the reports when they were being added to the patient record. Following this initial investigation, use of the new system was discontinued and the Trust reverted to the previous endoscopy system pending further investigation and fault resolution. The investigation is on-going.	
IGI/5017	PENINSULA COMMUNITY HEALTH	16-Mar-16	19	Agency nurse took ill at short notice put ward handover sheet down when tending a patient and forgot to shred prior to leaving shift. The next day the ward sister found the patient's visitor reading the handover sheet which was found in the patient's magazine.	Handover sheet contained 19 patients name, NHS No, DOB, very brief summary of care.
IGI/4823	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	11-Feb-16	1	Correspondence was sent to a family which also contained one document pertaining to another child - this was handed back to the service at a later visit from CAMHS team.	Child's full name and mental health status.

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IGI/4650	LEICESTERSHIRE PARTNERSHIP NHS TRUST	23-Feb-16	2	Discovered that one patient had received a letter regarding a different patient. It appears the letter had been copied to the wrong patient. Patients seen in outpatient clinic: • Letters to GP and care plans for patients were typed up. • Letters were electronically checked by the consultant. • Correspondence relating to the clinic was sent out. • Telephone call from patient A's mother to say that they had received a care plan for patient B, mother enquired whether her son's care plan and blood forms had been sent to the other patient - not yet able to establish this. • Attempts made to contact patient A and/or his mother to arrange for collection of the letter.	NHS patient data - care plan, clinic letter.
IGI/4875	NHS STOCKPORT CCG	02-Mar-16	72	Sending out an email re Stockport Together Survey and copied list of Long Term Condition patients' email addresses into the CC box instead of BCC - therefore all personal email addresses could be viewed. As a result a complaint was received.	Long term condition patients' email addresses viewable by all email recipients.
IGI/4600	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	03-Mar-16	15	Notification received from the husband of the person who received an email from a member of staff which contained personal information about a 15 patients. Very little information was included with the original complaint, i.e. no email address to	The data included name, date of birth and NHS number.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				where the information was sent.	
IGI/4705	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	1	A copy of one episode of care for one patient in paper format was sent to the incorrect address. The records were sent Recorded Delivery as per Trust Policy.	1 set of paper healthcare records which pertained to one episode of care (not the whole medical record).
IGI/4601	NATIONS HEALTHCARE LTD	29-Mar-16	8087	Finance emailed clinical lead details of endoscopy activity for a specified period. The email was a personal address and therefore not secure. Although the clinical lead was the intended recipient, the secure email was not used. Within the email was an attached Excel spreadsheet, this contained a pivot table and a workbook with the data included.	Patient details including first name, surname, NHS number and hospital number, details of endoscopic procedure attended for. Appointment details including date, service type and HRG. Appointment value. GP and CCG code. Attending clinician and session name.
IGI/4816	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	26-Jan-16	10-50	Clinical notes which were not fully redacted were sent to NHS England for a cross organisational tender process via Arden GEM CSU procurement portal. These notes originated from North Bristol Trust (**NB**: UH Bristol notes were also uploaded via same process but these were redacted.)	Scanned clinical notes.

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				When reviewing the notes NHS England's clinical panel members noted that the operation notes and possibly the referral letters appeared to be non-redacted.	
IGI/4628	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	02-Feb-16	470	The CSU reported that the Trust have securely emailed a spreadsheet containing PCD to the CSU. Data of this nature should not be sent to the CSU and is the significant contributing factor in an IG breach at the CSU as they in turn sent it to a CCG. The impacts of this incident are that the data should not have been sent to the CSU in the format it was. It has stayed within the NHS environment and is, therefore, controlled. As the error has been identified, no further counter compromise action is required.	The data is sensitive personal data relating to mental health. It was sent securely (encrypted) but should have been anonymised.
IGI/4615	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	02-Feb-16	3	Complaint been received following the inadvertent disclosure of sensitive personal data for a Subject Access Request (SAR). The SAR was made by a service user and the response contained highly sensitive information about their parent (who is a member of NSFT staff). The extreme nature of the material incorrectly disclosed has caused significant embarrassment and distress to both parties. The investigation has also identified that whilst the Compliance Team have been at error, it was compounded by the records of both parties	Copy of health record released by virtue of a Subject Access Request.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				appearing incorrectly in the SAR requestor's health record.	
IGI/4461	SOUTH VIEW SURGERY	26-Jan-16	3	Patient A handed in information pertaining to patient B that had been enclosed in an envelope sent to their home address with their (patient A's) hospital appointment letter. Patient A returned the paperwork to the surgery reception. This was handed immediately to the Practice Manager who thanked patient A for returning it and apologised for the error. Patient A confirmed that only they had sight of the paperwork and was satisfied that we would be conducting a full investigation. Incident reported to the practice IG lead and the CSU. Also reported to the Child IG Dept. at the County Council which is sending the necessary paperwork to complete.	Patient sensitive information regarding an invite to a Child Protection Conference and reasons for conference.

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IGI/4480	NHS SOUTH EAST COMMISSIONING SUPPORT UNIT	23-Feb-16	20	Two emails sent by Continuing Healthcare Team in error to member of public (albeit an individual connected with the CHC). First email sent contained information relating to one individual patient that included patient first name and last name, and one or more of the following pieces of information: date of birth, next of kin/representatives name and phone number, patient address, and information related to patients discharge plan. Second email contained the same information but included data relating to 9 individual patients and their NOK.	Patient first name and last name, and one or more of the following pieces of information: date of birth, next of kin/representatives name and phone number, patient address, and information related to patients discharge plan. **NOTE**: Sensitive Personal Data was included only in respect of 10 patients. NOK data was personal only (name + email).
IGI/4474	NHS LITIGATION AUTHORITY	13-Jan-16	2	Two case files lost and then (presumably) destroyed by courier firm. Organisation 1 had attempted to return two case files to Organisation 2. These were not received. Organisation 1 has been informed that the courier believes the files have been destroyed.	One case file is a highly sensitive claim relating to a child whose parents have made a secondary victim claim.
IGI/4471	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	25-Feb-16	5	Member of staff posted photograph of their desk on Facebook, the photograph contained their diary with an open page. When enlarging the photo, 4 service users' names and ID numbers together with another staff member's name and the wording "disciplinary" are clearly visible.	Names and ID numbers.

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IGI/4543	AIREDALE NHS TRUST	02-Feb-16	868	The demographic details and some associated clinical information of 868 patients were disclosed in error and sent to 14 separate Commissioners across England. This also included a number of GP practices who were also in receipt of the information from said Commissioners. The information was sent via separate Excel files from the Trust direct to a Trust partner organisation that in turn processed the information and re-sent to the Commissioners. An amount of reporting data was to be provided, but the data set sent contained more than required. The data transaction itself is routine business, but in this case, additional fields of data were included in the report which was the error.	Patient demographics linked to the patient's recent episode of care. The clinical data listed was: diagnosis, current medication and treatment plan.
IGI/4562	CARE UK LTD	02-Feb-16	66	A disc was supplied to a patient with their x-ray images. However the disc also had a spread sheet included in error, with 66 other patients' details, which were: NHS numbers, dates of birth, addresses, area for x-ray and date of x-ray appointments. The disc had been corrupted with this data. The patient reported the issue immediately because they were failing to access the images.	Spread sheet with 66 other patients, NHS numbers, dates of birth, addresses, area for x-ray and date of x-ray.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4486	NHS EREWASH CCG	23-Mar-16	25	The provider forwarded to the CCG a monthly summary of activity via email. Contained within the email was an attachment which included details of the Telehealth consultations for 25 care homes patients. This information was not required by the CCG and the attachment was not looked at in detail by the member of staff receiving it. It was subsequently forwarded on to 8 healthcare professionals who were members of the project team before the CCG was notified by the provider that they had sent the patient detail in error. The email was recalled and deleted successfully after the CCG was notified. The provider has reported this incident through STEIS and is conducting their own investigation into the original breach.	Summary of Telehealth consultations for 25 patients within care homes. This data included some personal sensitive information relating to the nature of their consultation.
IGI/4407	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	14-Mar-16	132	Data relating to132 patients was accidentally emailed to a Pharmacist at Bedford Hospital instead of to a colleague in MK hospital pharmacy. E-mail sent to Bedford Hospital Pharmacist in error. • Bedford Pharmacist contacted MK Pharmacist to advise had received the email in error. • Email sent to Bedford Pharmacist to request confirmation that the email had been deleted. • Confirmation received that the email had been deleted.	Data consisting of MRN number, patient name, date of admission, date of transfer to particular ward and date of discharge for 132 patients.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4419	NHS SWALE CCG	19-Jan-16	1	Nurse Assessor (NA) sent a Decision Support Tool (DST) via email, password protected, to the patient's daughter to review and make further comments on ahead of a meeting the following week. The NA had not heard anything back from the patient's daughter so telephoned her. During the telephone conversation the daughter advised the NA she had received the DST of another patient, the NA apologised and asked the daughter verbally to delete it, which she confirmed she had done already. The NA then arranged to re email the correct DST, password protected. The NA resent the correct DST to daughter, via email - same password same day. The daughter acknowledged receipt. The NA did not advise of the breach until October, despite being aware of the need and importance of immediate notification of a breach. Incident investigated with IG team. Letters to both daughter and patient's advocate with information breach and DST sent.	Decision Support Tool containing detailed patient data of one individual.
IGI/4396	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	17	A worksheet with 17 patients' confidential information was found on the floor leading towards the Pharmacy. The worksheet was folded with no PID showing. The sheet was found during a time period of 30 minutes after being mislaid.	Details include: Ward, Name, DOB, Age, Gender, NHS & Hospital Number, Admission Date, Problem /Diagnosis, Investigation /Plan and Jobs.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4412	CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	21-Jan-16	900	TPP have recently identified that patient records that were in a 'logically deleted' state in RiO have been migrated as active records to SystmOne. These records are primarily records that have been 'invalidated' by the NHS Back Office. A proportion of them will be records that have been invalidated for the purposes of hiding a patient's identity in cases where their identity has been superseded. These records, which would not have been searchable or visible within the front-end of RiO, are currently active and visible within SystmOne. This represents an IG incident and creates risk of these patients' historical identities being viewed. The reasons why a record might have been invalidated by the NHS Back Office are as follows: 1. Duplicate NHS number (a client has been allocated two NHS numbers so the erroneous allocation gets logically deleted). 2. Record confusions. Where two separate patients' records have got confused and data from one has contaminated the other, both records get logically deleted and the clients get assigned new NHS numbers. 3. Adoptions. A client has been adopted and assigned a new identity so their old identity has been logically deleted to prevent access to the old record and to prevent any risk of associating their old identity with their new identity.	Full clinical record including demographics.

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				4. Gender Reassignment. Where a patient undergoes gender reassignment, the record associated with the old NHS number will be logically deleted so that a new identity can be created. 5. Witness Protection Cases. Very rarely, where a client is involved in a witness protection case, their national record will be logically deleted.	
IGI/4374	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	02-Mar-16	913	The incident related to 919 records, for 913 patients. The clinician had been reviewing referral patterns with the LMC and wanted to see summary data for a specific period by practice. This information was provided, however the clinician did not realise that the source data was also contained in the spreadsheet. The information, once identified, was immediately deleted and removed from the mailbox. Additionally the staff member confirmed that they had not reviewed the second sheet. This was confirmed via email.	NHS Number, Hospital Number, Full Name (and Title) GP Practice, Date of Referral and referral reason, which in this case was all the same 'Suspected upper gastrointestinal cancers'.
IGI/5080	WELBECK STREET	12-Feb-16	10 to 20	A patient clinic list from Retinal screening operating out of our Practice was accidently given in error to a patient when provided with their own documentation. The patient handed over the list to the Retinal screening staff in their appointment. Retinal screening staff notified the staff who they assumed had given the information. The Practice Manager was informed by Practice staff.	A list of patients' names and dates of birth.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4367	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	10-Mar-16	90	5 handover sheets have been misplaced by clinical staff during one month. The handovers contain about 20 patient names and some clinical information around diagnosis and treatment. The handovers were all found on hospital premises by members of staff.	There are around 20 names on 4 sheets and 8 on another sheet. There were no dates of birth or addresses or any other PID.
IGI/4319	SOUTH TYNESIDE FOUNDATION NHS TRUST	01-Feb-16	14	A training document covering the use of a clinical system was created using screen shots from the live rather than training system. These screen shots disclosed patient identifiable information. The guidance was emailed to approximately 500 staff.	14 Patients had their PAS, NHS no, Name, Date of Birth, Gender and Ward location disclosed. One patient had full demographic information disclosed.
IGCSI/4300	LEWISHAM AND GREENWICH NHS TRUST	15-Mar-16	1	A member of the public made a self-referral using the Trust's online maternity self-referral by completing a form on the Trust's external website. She used Google and the second search result was a link to the pdf-version of the maternity self-referral form containing all the demographic details (including next of kin) and clinical answers (including HIV, mental illness and auto immune disease) entered by the patient held on the Trust hidden and secure online Content Management System. She contacted the Trust's Maternity Department who escalated the incident (this link being available on the Google website for everyone who searched her name). The Trust contacted the supplier of the website content management system that contains the online referral system. The link to the online self-	Maternity self-referral form containing all the demographic details (including next of kin) and clinical answers (including HIV, mental illness and auto immune disease) entered by the patient. Link to data in content management system is encrypted. Data on the Google cache was not encrypted.

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				referral form was immediately disabled by the system supplier. The pdf-document of the patient's referral is no longer accessible, but the form data was still available in the Google cache. The Trust requested Google to remove this cached result as soon as they were made aware of it and the Trust contacted the system supplier for assistance in this matter. The supplier confirmed they have requested Google to remove the reference to the disabled page. The Trust has received this confirmation. The cached link was removed overnight and no search results relating to the patient's medical data are now coming up on Google (the results displayed when searching for the patient's name is not linked / no association to the Trust). To ensure that no other patients were affected by this incident the maternity service checked Google website with 30 patients who also used this referral system to see if their data is accessible to the public. None of the test patients were affected. The system supplier has also undertaken tests (including searching for any forms on the Trust website. This did not show any other patients' or other confidential information being available to the public on the Trust's external website. The IG Department will undertake additional checks over the next couple of days to assure	

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				the organisation that personal data is held securely within the external website. At present there is only one patient affected by this incident. The Trust has asked the system supplier to disable all forms across the Trust's external website until we can be assured that the website is processing data in a secure manner. This action was completed by the supplier. An incident panel has been established to oversee the investigation of this incident. The system supplier agreed to work with the Trust on the incident investigation and provide a full report of their findings. Representatives from the maternity management team are keeping the affected patient informed of the actions the Trust is taking. The patient is happy so far with the actions taken by the Trust.	
IGI/4401	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	10-Mar-16	6	During a check on the contents of black bags which go to landfill, 3 empty medication containers were discovered in the bag which had patient name on each item and the ward number. A further audit took place the following day from all of the wards and two wards were found to have 2 similar items from one ward and 1 from another. There were 6 items in total from 3 separate waste bags.	Patient name and ward on empty medication containers, mainly comprising of saline drips.

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IGI/4301	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	18-Feb-16	3000 (approximately)	Information was required urgently by a third party who was taking over a contract from the Trust. The database provider (external company) had been asked to extract the data from the database in a format which could be shared with the third party as part of the transfer of the contract. There was a significant delay in the data being provided in a suitable format by the database provider. To avoid further delays a member of staff from the Trust e-mailed the third party a spread sheet which contained data from a report that had been run from the database. The e-mail was sent securely from NHS net to NHS net and the spread sheet was password protected. The fields of data sent were: name, dob, immunisation details, blood results. The third party notified the Trust two days later when they realised that data had been sent in error. The third party confirmed that they had deleted the e-mail and the data from their systems. The spread sheet which was attached contained data which was required but also contained details of trust staff which should not have been shared. The correct data was re-sent.	Staff data.
IGI/4281	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	12-Feb-16	1	Confidential information relating to a member of staff within the organisation was included in minute documentation that was circulated via email to a large south Yorkshire network, including NHS England and Public Health England.	Name was not included, however Job Title was included and there is only one individual employed in that role so is therefore easily

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				The minutes divulged that a member of staff has currently been re-deployed within the organisation.	identifiable.
IGI/4282	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	29	Patient was discharged home, when the community midwife visited the following day the patient gave the community midwife a ward handover sheet that she had found in her notes. This was returned to the Maternity unit and an incident report completed. It is advised the handover sheet was in the patient's hand held notes prior to discovery for approximately 24 hours before being handed to the community midwife.	Handover sheet contains a total of 29 patient names, Day/Time Gestation, VTE, Brief observation details relating to the Mother, Brief observation details relating to Baby (non-identifiable).
IGI/4363	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	30-Mar-16	1	Staff nurse accessed the patient administration system to view the medical records of an extended family member on 40+ occasions throughout 2009, 2010 and 2011. The information viewed was then (allegedly) disclosed to other family members causing the complainant to be very distressed. Patient alleges information relating to the miscarriage of a baby has been disclosed without her consent to family members. There is an ongoing family feud (not known how long this has been going on). The staff nurse has been interviewed and states she does not remember accessing the records. Individuals in the Trust are issued with unique user names and passwords and agree to the	Medical records. Sensitive Personal Data.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				Terms and conditions of usage. The Trust has separate Internet, email, network, confidentiality and IG policies in place. The staff nurse confirmed that she has not shared her user name and password with any other members of staff. The member of staff has undertaken IG training in which inappropriate access is highlighted. An audit report has been produced which shows 46 occasions when this staff nurse has been into the complainant's record. HR investigation completed. Internal SI panel has been held.	
IGI/4278	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	1	The hand held post natal notes of an inpatient were unable to be located, later in the day a lady that had attended that morning, returned the notes which had been accidentally incorporated into her own hand held antenatal notes. The incorrect medical documents were with the second patient for approximately 12 hours before being returned. Duty of Candour undertaken with both patients: informed the lady of the error that had occurred and offered apologies and assured the patient that this would be investigated. This was documented in the notes (verbal duty of candour). The patient was content with the explanation and assured the Senior Sister that she understood the error and was not upset.	Maternal post-natal records. The notes contained personal data of name, address, DOB, discharge summary following birth and all care delivered post-delivery. There was no specifically sensitive information.

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IGI/4238	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	10-Mar-16	2,950	6 files were loaded onto Picker site which contained PID and CQC have access to the webpage. The NHS patient survey programme systematically gathers the views of patients about the care they have recently received. This survey co-ordination centre, run by Picker Institute Europe, co-ordinates the NHS acute, mental health and primary care patient survey programmes on behalf of the Care Quality Commission. Its role includes: • Developing questionnaires and accompanying documentation; • Advising on how to conduct surveys; • Collating, checking and analysing survey data. The CQC need to seek approval under Section 251 to have access to PID where it's not a regularity function. A login had not been issued by Picker with the survey; therefore an existing login was used from previously loading maternity data. Picker were notified by the Trust immediately afterwards that the files were available. Picker then reported that the CQC have access to the webpage therefore the Trust asked if they could delete the files however Picker had already notified the CQC and the files were removed shortly afterwards.	From the 6 files, 2 contained inpatient data (1250 patients), 2 outpatient data (850) and 2 A&E data (850). 3 files contained episode data and 3 PID.

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				Following some initial investigations the incident has been graded and logged within a couple of hours following being reported. A full investigation will take place and a report will be provided including actions and lessons learned in order to reduce the risk of a similar incident.	
IGI/4447	EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	10-Feb-16	2	An email with date of sickness for two members of staff was sent to all of the 111 Shift Leads, 111 Call Advisors, 111 Clinicians, 111 Trainers and Primary Care Managers. The information was also sent to an external NHS provider and the Clinical Commissioning Group and included a derogatory comment about the staff and the sickness leave taken.	A sickness date and derogatory comment regarding two members of staff.
IGI/4839	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	15-Feb-16	1	Appointment letter sent to wrong address by Gender ID service. Opened by erroneous recipient, who contacted service to inform them	Patient letter from Gender ID service.
IGI/4335	PORTSMOUTH HOSPITALS NHS TRUST	26-Jan-16	1	A Safeguarding Alert (patient A) was misfiled into another patient's records (patient B). This alert was seen by patient B's partner. The misfiled paper was immediately handed in to staff by the partner of patient B. Staff thanked the man and disposed of the paper in confidential waste. The man that discovered the document had poor comprehension of English, but knew that the document was not about his wife. The cause of the incident may have been that the document was "scooped up" with other papers that were on the nursing desk at that time.	Name Unique Identifying Number Heading / Title confirming a Safeguarding Alert.

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IGI/4302	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	02-Mar-16	1	Patient Z received 4 sheets (8 sides) of Patient G's records. These were returned as soon as it was realised (which was 7 days after the clinic). Patient G is a looked after child and is known to social services, she is also still a child and lives with relatives.	Name, Address, Data of Birth, Hospital Number, NHS Number, GP Data, Appointment information and Care Plan for unborn child.
IGI/4313	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	06-Jan-16	2	Two patients both undergoing minor facial skin surgery were given each other's consent form and nurse communication letter in error, the proper patient identification procedure not having been carried out. Although the information revealed was not sensitive in itself, this is not the first incident of this type, which is why it is being reported.	Name, address, NHS Number, diagnosis of wart on cheek/scaly skin, procedure of curettage and cautery.
IGI/4181	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	15-Mar-16	204	Sigma Camera is missing from the Orthodontic Clinic. Room was locked after cleaner left and then re-opened the next day. The camera was found to be missing from the clinic drawer.	The camera contained approximately 250 images of child patients of their faces, mouths, names and hospital numbers.
IGI/4150	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS	10-Mar-16	1	A set of patients notes consisting of 50-60 pages and a CD with radiological images that had been requested by solicitors A, were incorrectly sent to solicitors B. Solicitors B phoned the Legal Department to notify them of the mistake. The subject access request had been responded to within the designated	50-60 pages for one patient from their health record, and a CD containing radiological images (but no password was supplied, as it is sent separately).

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				timescale. The patient notes were put into the envelope with the label for the incorrect solicitors (firm B). The Legal Department have requested the return of the patient notes. The CD was not accessible as the password is sent separately. **Update**: the patient notes sent to the incorrect solicitor have been received by the Legal Department.	
IGI/4243	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	11-Feb-16	1	The patient attended a retinal screening clinic out in the community. A results letter for this appointment was generated and printed in the retinal screening department. This letter was processed through an automatic feed envelope machine, but unfortunately was not placed in an envelope. It was then placed with the batch in the envelope bag ready for collection to be franked by the post room and then despatched. The patient called the programme manager for retinal screening to advise that she had received her results letter minus the envelope and that the letter had been franked. Patient not happy that her letter arrived without an envelope for all others to read.	Results of retinal screening.
IGI/4121	PLYMOUTH HOSPITALS NHS TRUST	03-Mar-16	37	The IG team were informed a charity had contacted RCHT to make them aware that clinical data relating to 167 RCHT patients and approximately 40 PHT patients was given to them from an ex-employee of both RCHT/PHT by mistake in amongst a personal property donation. The charity directed all clinical data they received to RCHT who in turn securely emailed copies of the PHT data to the IG team.	Sensitive NHS Patient Data.

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IGI/4200	UNIVERSITY HOSPITALS SOUTHAMPTON NHS FOUNDATION TRUST	15-Mar-16	1	Child L is an infant boy. Shortly after birth the child was taken into care by the local authority and placed for adoption. The local NHS Trust at the place of birth referred Child L to a clinical speciality at the reporting Trust for treatment of a non-serious condition diagnosed shortly after birth. The child was seen by a Trust specialist in late July in a peripheral clinic held at the local hospital. Following the clinic the doctor dictated a routine letter to Child L's GP with instructions that a copy be sent to the child's foster parents and the child's prospective adopters who both attended the clinic appointment. The letter that was intended to be sent to the current foster parents was in error sent to the address of Childs L's biological grandmother. The letter contained the name and address of the family who were due to adopt the child. The prospective adopters of Child L were concerned that the biological parents of Child L might become aware of their personal details and seek to make contact with Child L in some way and raised their concern with the local authority social services who contacted the Trust.	Name and address.

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IGI/4099	HERTFORDSHIRE COMMUNITY NHS TRUST (RY4)	05-Jan-16	94	Staff returned home and left their computer bag in the car in error behind the driver's seat with intention of returning to bring the bag in. The following day was a non-working day. The bag stayed in the car. The staff member went out to the car and noticed the glove compartment open. The staff member noticed that the laptop bag was missing, the staff member then went in to the house to look for it in its usual place and it wasn't there. Within the bag: • Laptop, mouse and leads, encrypted laptop and paper records pertaining to an audit with 94 patient details. • Personal files and note pads.	Working file for Attention Deficit Hyperactivity disorder audit in progress containing children's name and DOB. 3 sheets of National Diabetes Audit data containing NHS numbers. Personal File containing, objectives, 1:1 meeting notes, holiday sheet personal salary slip. 2 note pads containing names and phone numbers of HCT employees and passwords to Meridian, data, expenses and personal work notes.
IGI/4147	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	1	Community midwifery assistant discovered the blood results and telephone call sheet of patient A in patient B's notes during an antenatal clinic visit. Patient A reported her Community Midwife called the assessment centre (MAC) during her antenatal check to highlight the low iron result from previous attendance on Delivery Suite. Requested MAC staff to ask for Obstetric review	3 x sheets: The MAC Telephone sheet contains Name, Hospital Number, Mobile Number and very basic abbreviated terms; Blood results contained Name, Hospital Number, Date of Birth and blood results (none

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				and plan of care and to notify patient. Copy of blood results printed out by MAC midwife (name and date visible on this print out) as was standard practice for subsequent review by Dr when next attending MAC. This call generated the Maternity Telephone Advice sheet and both these documents were later found in patient B's hand held maternity notes. On the same day, patient B attended MAC for a scan review - all normal and discharged home. Patient A called MAC as not heard anything re plan of care and concerned due to gestation (38 weeks). Invited into MAC for full assessment by MAC midwifery Sister. Staff alerted to delay in plan of care. Delivery Suite manager alerted to missed result from Labour Ward by MAC midwifery Sister. Results checking process shared to avoid repeat episodes. Patient A seen on MAC, Obstetric review provided and plan of care made. Patient B seen at antenatal clinic appointment where Maternity Telephone Advice sheet and blood results for patient A were discovered.	of which were of a sensitive nature).

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IGI/4082	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	12-Feb-16	36	Two ward handover sheets were left in a shop on Trust premises by a doctor. The traders handed the sheets into the Trust. The two handover sheets contained the personal information of 36 paediatric patients. The sheets have been retrieved and handed to Information Governance for formal investigation. Internal investigation commenced.	Patient names History Investigations/treatment Job/recommendations.
IGI/4049	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	03-Mar-16	16	A member of the district nursing team had been visiting a patient and found a colleague's diary at a patient's home. Diary was returned to the community matron team lead.	A diary containing personal information (name and address) for 5 patients along with their key safe codes. A further 11 patients with just their name and address and some health related information.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4020	MAYDEN HEALTH	31-Mar-16	2521	A member of staff reported that an email had gone out to approximately 110 key NHS clients which contained an excel spreadsheet. At first glance, the spreadsheet appeared blank. However pivot tables within the spreadsheet had hidden cache containing NHS numbers and some treatment data in coded form. The spreadsheet had been produced in conjunction with others and the exact source, content of the data was not initially known. An email was sent out informing the recipients of the issue, requesting they delete the attachment and informing them that Mayden would be investigating. An analysis of the spreadsheet shows that 2521 unique NHS numbers were included for two of our NHS clients.	Along with NHS numbers, the fields list dates of appointments and questionnaire scores. No other PID such as names, date of births or addresses were included in the sheet. A full list of the fields is below: NHSNO LPTID ORGCODEPROVIDER SERVICEID APPOINTMENT APPOINTMENTTIME STEPINTENSITY PRIMARYROLE ATTENDANCE CANCELLATION CONTACTDURATION APPTYPE CONSMEDIUM FFCOMM THERTYPE1 THERTYPE2 THERTYPE3 THERTYPE4 EMPSTATUS EMPSUPPORTIND EMPSUPPORTREFERRAL

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					PSYCHMED SSPIND PHQ9_SCORE GAD7SCORE WSASWSCORE WSASHMSCORE WSASSLASCORE WSASPLASCORE WSASRSCORE AGORASCOREACC AGORASCOREALONE AGORASCORE GENANXSCORE HEALTHANXSCORE OCDSCORE PANICSCORE PTSDSCORE SOCPHOBIAINVSCOR E SOCPHOBIASCORE SPECPHOBIASCORE.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4061	ROYAL FREE LONDON NHS FOUNDATION TRUST	12-Jan-16	Not known, approx. 500-1000	During an office clear out a sack of confidential waste was mistakenly included in general waste for disposal. An attempt was made to recover the sack but the waste contractor confirmed that it had been compacted and disposed on landfill. The landfill site is not open to the general public. Trust has secure confidential waste bins/consoles across all sites which are regularly emptied by contractors for secure destruction. Distinguishable confidential white hessian sacks are available when the confidential waste bins are full. Office where incident took place did not have a confidential waste bin/console installed.	The following data could have been included on incident forms / reports which were in the confidential waste bag, there is potentially much duplication: • Patient names. • Staff names. • Patient hospital number. • Details of Trust incidents that have been investigated.
IGI/4015	MERSEY CARE NHS TRUST	04-Jan-16	Not Known	9 bags of Mersey Care Trust (MCT) confidential waste left in a building on University Hospital Aintree site following relocation of MCT staff to new site. The building was secure however; builders had been undertaking work before new Aintree staff team moving into area. The bags were all marked as confidential awaiting collection by MCT Estates staff for destruction. During the move a job had been lodged with the Estates Dept. for the bags to be removed immediately after MCT team left site. The job failed to be actioned. Staff from Aintree Hospital moved into building and discovered the bags had not been removed and advised that builders	The data was a mix of patient, staff identifiable information together with organisational information which was contained within Confidential marked waste bags.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				had been in/out building & the bags were discovered opened. Aintree staff notified Aintree IG Lead who contacted MCT - bags were securely locked away overnight and then collected by MCT Estates. Investigation commenced by MCT.	
IGI/3991	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	30-Mar-16	30	A Community Cancer Nurse Specialist contacted the Trust. (She left DHUFT and NHS employ around the beginning of August 2014). The nurse had discovered some Bournemouth & Poole Cancer Genetic Risk Assessment Clinic notes in her home. Spanning a time period from 2008 to 2013, some of which she felt should have been referred on to the regional genetic centre for additional specialist assessment. The notes contained, sensitive personal information belonging to 30 patients. The notes were collected from the house straight away. There were actually 6 potentially 'high risk' clients that the ex-staff member assessed and had thought should have been referred to the tertiary centre. The ex-member of staff knew that taking home patient data was against Trust policy, but the Trust is grateful that she did come forward and alert the Trust of the client notes. The ex-staff member is devastated by her discovery. The Trust now has an electronic patient record system called 'System One'. The service scans the notes and clinic letters to the EPR; it would be very unlikely that a similar incident could now occur.	This is 30 client 'notes' in total. Some of the 'notes' just consist of a one page original referral letter, or fax, to the service requesting assessment of genetic risk; or may include the Family History questionnaire completed by the client, and pedigree drawing and calculations done by the Nurse. All the items related to this incident, are the nurse's Bournemouth & Poole Cancer Genetic Risk Assessment Clinic paperwork. Apart from the summary we send to the client, GP, referrer (if different), and tertiary centre (if indicated).

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4381	LANCASHIRE CARE NHS FOUNDATION TRUST	08-Jan-16	1	A patient received an appointment confirmation letter, with another patient's discharge letter to their GP printed on the back. This was discovered when the patient attended his appointment and presented the letter. This has most likely occurred due to batch printing using the double sided option on the printer.	Discharge letter will contain NHS Number, Clinical details.
IGI/3948	STOKE-ON-TRENT CITY COUNCIL	03-Mar-16	107	A member of the public discovered social care records in a recycling bin. The information had been in the care of an external care agency, contracted to provide services to the Council. Investigations have revealed that the information should have been recovered from a member of staff, before they left the agency.	107 service user names, key codes, medication notes, medication codes and category type. A staff rota with 29 service user names and addresses. A list with 58 staff names and telephone numbers. A selection of social care correspondence sheets.
IGI/3957	PORTSMOUTH HOSPITALS NHS TRUST	26-Jan-16	8,000	An Excel document, detailing around 8,000 dementia patients was sent to an incorrect recipient via NHSmail. The error occurred due to an incorrect number suffix (e.g. firstname.surname1@nhs.net) which differentiates between different NHS staff on NHSmail with the same name. The e-mail was sent to and from an NHSmail account. The Trust is currently liaising with the recipient organisation to ensure the email and attachment are appropriately deleted.	Name. Identifying Number. Summary / Limited Clinical Information.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/3976	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	14-Mar-16	30	A patient's relative returned to the ward to collect a book and mobile phone that had not been transferred with the patient to another area. The relative was handed a bag which they took away. The bag contained the following: • Book and mobile phone. • Cardiology Patient List x 2 – with patients' names, date of births and treatments both typed and hand written. • Several prescriptions in the name of another patient signed by Dr with address details and date of birth. • A list of medication and repeat prescriptions for another patient. • A list of person contact details for the family of the other patient. • Personal mail including correspondence between the hospital and other patient. The relative raised the issue with PALS, and this was followed up with an e-mail. The Cardiology inpatient lists and repeat GP prescription have been returned to the hospital via PALS. Investigation carried out.	Names, Dates of Birth, Clinical details, prescriptions, address.
IGI/3858	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10-Mar-16	3	2 x child appointment outcome letters accidentally placed in one envelope with another letter and sent to the parent. The letters were posted and the parent brought the letters back to the Trust. The department has a process in place following a similar incident, where printed letters are	2 x child appointment outcome letters containing details of diagnosis (leukaemia), investigations, medication, current issues and treatment plan.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				staggered in a criss-cross shape to avoid multiple correspondence being placed in the same envelope, and the Trust has implemented a double checking procedure.	
IGI/4066	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (EAST MIDLANDS)	06-Jan-16	100-200	Old diabetes nurse records stored in locked cupboard in locked room. These had been boxed by previous diabetes nurse; number of notes between 100-200 sets. When admin came to file them they had been moved and can't be located. Immediate action taken: • Contacted person who uses room concerned. • Contacted line manager. • Contacted sites & services. • Discussed with staff from other service areas at site. Based on above suspected that the notes were moved prior to CQC visit. Checked at other Trust hospitals. • Communications across other Trust sites. • Confirmed all parties unable to locate notes - Datix incident reported. • Suspect that, DCHS staff member previously managing the area where the notes were kept has information on where these could be now. This DCHS staff member is currently on long term sick - in her communications she has said that the Diabetes notes were	Patient records – patients who were previously on the active diabetes specialist nurse caseload.

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				sent to one of the Trust's hospital sites. • Records' service at that site is not aware of the notes. Given the volume of records the likelihood is that they have been appropriately filed but not tracked appropriately. This needs to be confirmed. These are not active caseload patients - the service was planning to archive the notes.	
IGI/3840	SOUTH TYNESIDE FOUNDATION NHS TRUST	01-Feb-16	4	At the beginning of a planned child protection conference HV shared confidential information via a report that was not intended for that family. As a result the family had access to personal information about another family within the safeguarding arena. Parent identified in the report indicated that a man had been to her old address looking for her (twice) On the second occasion he proceeded to tell the new occupants of her history from the reports shared during the conference.	NHS patient data, Safeguarding Children report.
IGI/3819	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	02-Mar-16	1	Notified by Patient X's mother that she has received the medical records for another patient, Patient Y. Agreed to collect the records from her directly. Reviewed the post room log and confirmed that two records were sent, both to Patient X and none to Patient Y's mother. Both address labels had the address as 35 instead of 45 - however the mail merge is incorrect as we have 45 down on the records. Additionally, we have found that whilst we had requested this package to go via recorded delivery and it was	Name, address, date of birth, hospital number, NHS number and blood results.

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				marked as such, this did not occur. Once the information was obtained, we could see that only one document from the medical record was removed and viewed by Patient X's mother. Upon collection, we took the information back to our office, obtained the notes and ensured that all information disclosed was there. Additionally, we re-printed the one document which had been viewed (as this had been slightly damaged). There are a number of actions ongoing, including an After Action review. Any additional information and actions will be added to this, once received.	
IGI/4018	NHS SWALE CCG	19-Jan-16	1	A funding letter, enclosing a patient's Decision Support Tool (DST) documentation, was sent to the incorrect address of the patient's mother (designated next of kin). The DST document contains personal details of the patient (name, address, date of birth, NHS number and details of the clinical review). This is the third recent occurrence by the Specialist Assessment & Placements Team (SAPT) of patient data being sent to an incorrect address. The original Checklist Tool was incorrectly filled in by the hospital and the SAPT team rightly returned it to the hospital for more info. Unfortunately the next info received was also incomplete, on this occasion the SAPT Nurse	Patient name, address, date of birth, NHS number and details of the clinical review.

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				completed the information when she met with the family at the hospital. The hand written notes were typed up by the SAPT Nurse, at which point we believe one number of the address was transposed (number 33 instead of number 32). When issuing the documentation to the next of kin, the incorrect house number was used. The SAPT Team were alerted by the next of kin that the DST hadn't arrived.	
IGI/3827	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	11-Mar-16	1	A member of staff faxed a patient assessment (17 pages) to a Care Home, however, 1 of the digits was entered incorrectly and the fax was subsequently sent to an unknown fax. When the Care Home did not receive the fax it contacted the Trust and the error was discovered. The member of staff then faxed a request to the 'incorrect' fax number to ascertain whether the patient assessment had been received. There has been no response; however, further investigation has linked the number to Lincoln Hospital. The assessment was later resent to the Care Home which confirmed receipt. A Serious Incident report has been completed and the outcome accepted by the CCG.	Patient clinical details including name, DOB, demographic details, cognitive and psychological details, diagnosis and medications.
IGI/3875	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	30-Mar-16	1000	An email was sent to all participants in the Bright light trial (a cancer related study) attaching their latest newsletter. Upon sending it quickly became apparent that the addressee email addresses had been made visible as the message had been sent using the 'Reply All' function. Addresses should have been hidden	Email addresses have been disclosed and by virtue of those, confirmation of a cancer diagnosis for each individual.

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				using 'BCC', which resulted in all addresses being visible to all participants in the study. A follow-up email was sent on the same day, with email addresses hidden, requesting participants disregard the previous message. Receipt of a cancer diagnosis is one of the main criteria for participation in the study and disclosure of the email addresses to others identifies the individuals as having received such a diagnosis. Disclosure of this information amounts to a breach of confidentiality and the Data Protection Act as no consent exists for such sharing to take place. As a result, all participants are now aware of the other individuals involved and are able to use their email addresses to obtain other information about them already in the public domain. There are 108 other data controllers who have supplied patient data to the trial who expect that data to be processed securely.	
IGI/4172	THE ROYAL WOLVERHAMPTON NHS TRUST	10-Feb-16	1	A patient file (medical records) was sent in a sealed envelope by Royal Mail recorded delivery to the CCG. When received, the envelope had been damaged in transit and therefore the patient details were clearly visible thus causing a potential confidentiality breach. Incident occurred due to the member of staff leaving who dealt with such requests. The new member of staff was unaware of correct process on sending. This has now been addressed and	The information involved was the full patient record requested by the CCG for a CHC claim they were processing on behalf of the patient.

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				all staff members are now aware of the correct process which should have been sealed in an Orange bag, addressed and taken to the post room for collection via internal hospital transport.	
IGI/4173	THE ROYAL WOLVERHAMPTON NHS TRUST	10-Feb-16	<500	Registrar had discovered at home some old handover sheets from when they had been on-call at two other Trusts. The information was used for the doctor's portfolio. The sheets were brought into work to dispose of them in a shredding bin. Along with this information the Registrar tidied the Registrar room whilst at work. Patient letters, test results and handover sheets were added to the papers brought in from home and placed in a plastic carrier bag. The bag was taken from the Registrars' room and over to the changing room where after getting changed to go home, the Registrar intended to take the information to the next building to be disposed of correctly. The plastic carrier bag was left behind and found the next day by a member of Trust staff still in the plastic carrier bag in the changing room.	The information in the bag was a mixture of information. The majority of the information was patient lists/ handovers and some patient letters and test results.
IGI/3785	WYE VALLEY NHS TRUST (RLQ)	18-Feb-16	1	A health assessment for a looked after child was sent to Brighton City Council instead of to our own local LAC team. Complete error. This clinical info has not been received at Brighton City Council by an individual although may have reached its destination address with no detail of named recipient.	NHS patient data from clinical health assessment.

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IGI/3714	WEST LONDON MENTAL HEALTH NHS TRUST	05-Jan-16	>3000	Information was sent via secure email and in a zip folder to one member of staff at the CQC as part of a workforce information requests for a CQC visit. An unlabelled tab in the document contained personal identifiable information about the workforce, in a level of detail which had not been requested. The CQC immediately informed the Trust of the error and deleted the information. Internally, the information was sent from the Workforce team to the Director of Governance and there administrative support, all of whom immediately deleted the information.	Staff Demographic Data.
IGI/4055	LANCASHIRE CARE NHS FOUNDATION TRUST	08-Jan-16	7	A lockable metal drawer filing cabinet containing seven confidential staff files was disposed of with several other office items at a recycling plant. The office equipment was disposed of to make space.	The staff files contained a range of documents including: • Staff supervisions. • CRB clearance. • Personal information • Emergency contact details. • OH referrals and reports. • Sickness review letters. • GP sick notes. • Certificates.

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IGI/3561	LEICESTERSHIRE PARTNERSHIP NHS TRUST	08-Jan-16	1	Care Team involved with a service user received a telephone call from a solicitor involved with the service user. Solicitor reported that a member of nursing staff on an inpatient area had emailed from their personal email account, information relating to the service user's recent inpatient stay to a family court judge and the solicitor. The member of staff has a child with the service user and is currently in a custody battle at the family court.	Clinical information about the service user's mental health state, medication and behaviour during their inpatient stay.
IGI/4117	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	26-Feb-16	78	An incident of fly tipping was reported to Charnwood Borough Council. Upon investigation of the fly tip by an Enforcement Officer, a number of documents were recovered which contained personal data belonging to patents. This information was traced to have come from a Trust hospital and to have been taken by a member of staff. The Enforcement Officer spoke to the Head of Nursing and made her aware of the information which had been found. An investigation into the fly tip is currently on going and consideration will be given as to whether the member of staff will be prosecuted or not.	78 handover notes in total which had over 50 entries. 32 patients were affected as a result of the data being disposed of incorrectly. The information within the handover notes include; names, gender, DOB, medical conditions, ceiling of treatment (i.e. not for resuscitation), risks, infection prevention, diagnosis and background, nursing plans, discharge and referral information and other medical information including but not limited to mobility, nutritional and hydration statuses.

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IGI/3188	LANCASHIRE CARE NHS FOUNDATION TRUST	08-Jan-16	1	A family have received an initial assessment letter about a child who is being seen by CAMHS. The letter is not about their child but one with the same name. The address on the letter was incorrect. The letter had been scanned onto the correct child's record on EDMS. It appears that the address the clinician had written had been amended by Admin staff before being sent out.	Name, DOB, NHS number.
IGI/3205	LANCASHIRE CARE NHS FOUNDATION TRUST	08-Jan-16	1	A letter containing clinical detail was sent to the wrong recipient / address. The service concerned is the CAMHS inpatient unit.	Clinical report.
IGI/3206	LANCASHIRE CARE NHS FOUNDATION TRUST	08-Jan-16	1	Clinical report sent to wrong address and so opened by wrong person. Service was CAMHS inpatient unit.	Clinical outcome report.
IGI/3081	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	02-Mar-16	1	Patient contacted the Trust to inform us of this breach. He was aware that his 'story' would be published on the Trust's Public Patient Experience internet page and was fully supportive of this after he had presented this to the Trust Board. At the Board pre-brief it was explained to the patient that his story would be heard in the public domain as Trust board is a public meeting. It was also explained and he gave permission for his story to be used in training and to be posted on our web page in an anonymised and summarised form. The patient's story which was published was the exact story that was read out by the patient detailing his experience when being diagnosed HIV positive. This document was not redacted thoroughly prior to publicising via the internet - it	Disclosure of HIV status. Patient name.

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				still contained his name at the bottom - no other identifiable information published.	
IGI/4385	LANCASHIRE CARE NHS FOUNDATION TRUST	08-Jan-16	1	It was agreed that a father would receive copies of his daughter's clinical correspondence. It transpired that two letters were sent to another address and not to the father. Mr R, father of service user, should receive correspondence regarding daughter but it went to the wrong address. Mr R was not happy and made a complaint. Mr R's letter has been dealt with as a formal complaint and there has also been an investigation. The outcome is pending.	Outcome of a psychiatric assessment appointment - personal and clinical confidential information.