Information Governance Incidents closed during 1st. July to 30th September 2016

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Contents

Introduction

This is the thirteenth 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. July to 30th. September March 2016, following investigation by the local organisation(s) concerned.

Content of the report

The report consists of **30 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 29th. 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 **76 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 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 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 **1 October to 31 December 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 1st. July to 30th. September 2016

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/6286	PORTSMOUTH HOSPITALS NHS TRUST	23-Sep-16	97	Handover sheets found by Basingstoke nurse who lives in same lodgings. Sheets identified as belonging to PHT. Chief of Service for AMU notified by Basingstoke Hospital of incident.	Name DOB NHS number Limited Clinical Information - notes on diagnosis and treatment plan.
IGI/6214	NHS BRISTOL CCG	27-Sep-16	1	The Bristol Referral Service received a telephone call from a medical secretary in a GP Practice. The medical secretary advised that a patient had received both their own Patient Choice Letter and a Deferred to Provider letter for another patient. The patient received their letter in a windowed envelope and the next day received the other letter in a hand-written envelope. The majority of Bristol Referral Service letters are generated by an Alternative Patient Choice Letter app. However, this application does not currently generate letters for patients who have been deferred to provider and therefore these letters are formatted in a way which does not enable the use of a windowed envelope. Updates to the app were already being investigated at the time of the incident to resolve this issue. Bristol Referral Service have a Standard Operating Procedure which states that only one case should be process at a time. In this instance	The letter included the patient name, NHS number, UBRN (unique booking reference number) and details of the clinic to which they were being referred.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				two cases were being processed concurrently leading to the wrong address being written on the envelope. These letters were processed by Bristol Referral Service.	
IGI/6162	WOODLANDS DENTAL SURGERY (V07990)	12-Sep-16	not known	Practice was broken into by intruders. Police attended and found no one on site following break in. Alarm activated, and building was securely locked at time of break in. Gained access from back door using a tool to force PVC door open. Intruders have stolen a hard drive which we back up our electronic patient records on. Back up was stored in a fire safe unit which we believe intruders have taken thinking it contained money. Information stored on the hard drive contains a copy of patient's names, DOB, address, phone numbers, email addresses, medical history and dental records. Risks; for someone to access records they would need specific software, licence and password to access records.	A copy of patient's name, address, DOB, telephone numbers, email addresses, medical history, dental records.
IGI/6189	NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	07-Sep-16	72	Following the publication of the Urgent Care procurement for Hartlepool and Stockton Clinical Commissioning Group (the CCG), NECS procurement team were notified by an incumbent provider that Names and Dates of Birth (DoB) of staff had been issued as part of the TUPE information which formed part of the tender documents, resulting in a breach of the Data Protection Act 1998. Immediate action was taken, and the document	Personal information relating to their staff who had been identified as being liable for TUPE. The data was staff data of current employed staff from one provider, which contained, names, job title, date of birth,

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				was removed from the website. A review was then undertaken to establish who else had accessed the documents and downloaded them from the website, and two other providers were identified as having accessed the information. A notice was then sent to those providers highlighting that there was an issue with the information and for it to be destroyed and an amended set of information would be circulated. Following advice from the NECS Information Governance Team a report was issued on NECS risk management system SIRMS where a significant incident was logged. A further message was sent to the other providers who had downloaded the information asking them to confirm that it had been destroyed; they both responded to confirm this had happened.	sex, number of hours employed, hourly rate, pension contribution and annual leave entitlement. The information should have been anonymised but was not.
IGI/6124	TURNING POINT	12-Aug-16	1	Service Manager (Gloucestershire Substance Misuse Service) was sent an email by a Senior Recovery Worker (SRW) who has been signed off sick from work. The email stated that his car had been broken into outside his house and some items stolen that included copies of some parts of two service user's information. Items taken included a supervision case file audit (anonymised) and two care plans and a risk assessment. The documents were recovered. He informed the police.	Care plan with name of client only. A case file audit with no identifiable information. A care plan and a printed electronic risk assessment with full name, DOB, phone number, address and a detailed risk assessment including

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				the documents were retrieved 50 metres away from the car, in a trench dug for cabling, by his father in law and the local baker. The police were contacted by the employee (crime reference number redacted The paperwork was returned to the SRW who then destroyed it.	risk around injecting drug use. There is also reference to the GP surgery of the service user in the body of the risk assessment.
IGI/6112	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	04-Aug-16	9 patients	A member of staff from Corals Bookmakers in Liverpool contacted the Trust to advise that a list of patients had been found on the premises - the document had Informatics at Aintree on it.	The printout contained the following information: - Name - Date of Birth - Complaint/Diagnosis - Past Medical History/Allergies
IGI/6078	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	15-Sep-16	10	The letters were placed into a different style envelope as the standard ones had recently run out. The patient letter which was being copied to their GP was at the top of the pile. As a result, the patient's address showed through the envelope window and the letters were sent there. The letters were all from the Dermatology department and varied in detail. Many of them included information relating to skin cancer. Upon receiving the letters, the patient sent them to all to Gillies Health Centre. The Practice Manager informed the Trust who notified the Information Governance Manager and senior management.	10 letters which were appointment follow up letters intended for the GP. They contained each person's name, full address and NHS number. The sensitive data varied between letters. The information was very limited but contained information relating to cancer.

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IGI/6191	MARIE STOPES INTERNATIONAL	07-Sep-16	1	Client attended for treatment. A 'No Worries' form was completed by HCA. The client declined to be referred, which the HCA circled to highlight this. However, the referral form was sent over to the 'no Worries' team. Client did not sign form.	Client name, client address, date of birth, treatment date, treatment type
IGI/6091	MEDWAY NHS FOUNDATION TRUST	20-Sep-16	70-120	The Trust's IG Manager took a phone call from a member of the public who advised that a number of pieces of paper containing patient details had been found in a black sack in the alley behind a recently vacated property. The member of the public wanted to remain anonymous and did not want to disclose their address for the IG Manager to recover the documents. The member of the public called back and agreed for the IG Manager to recover the records on the understanding that they remained anonymous. The papers were recovered. On reviewing the papers (some of which were torn in half), they are patient handover note summaries i.e. printed copies of patient summary care that are handed over between shifts. The papers show 3 distinct dates of printing and in total there are more than 70 patient summaries. In the main the patient details include: their name, diagnosis, summary medical plan or nursing plan, and physio details. Approx. another 50 patients' details are captured on a table with just their names and key words about diagnosis and treatment.	paper documents (some torn and scribbled over but insufficient to redact information) from 3 dates in 2013 detailing patient information, and summary treatment information.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/6025	MARIE STOPES INTERNATIONAL	18-Aug-16	1	Discharge paperwork for one client given to another client. Client's wife contacted One Call to advise that her husband - AG- was given discharge paperwork for another client.	Name, address, dob, GP information, treatment information
IGI/6102	NHS NEWCASTLE GATESHEAD CLINICAL COMMISSIONING GROUP	02-Sep-16	1	The CSU Continuing Health Care (CHC) team was contacted by a patient's GP to advise that a letter the team had sent out to the patient's family about the CHC panel decision had an attachment that related to another patient. The CCG SIRO and Caldicott Guardian were informed.	The attachment that was sent in error included the name, date of birth, brief medical information and NHS number of patient B (deceased) who had the same name and year of birth as patient A.
IGI/5976	EAST LANCASHIRE HOSPITALS NHS TRUST	22-Jul-16	16 patients, 3 pages	Vascular/theatre hand over sheet showing patient identifiable information found left unsecured on staff car park. The sheets were found early in the morning and must have been dropped the evening before. The sheets were found by a staff member and handed in to their manager who reported the incident on the ELHT Datix incident reporting software.	Hand over notes contained: Ward, type of bed, consultant initials, patient full name, date of birth, hospital number, clinical/examination history, results, key meds and plan for 15 patients. Theatre Vascular List contained full name, hospital number, age,

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					procedure, Anaes, comments, ETT, TCI date, ward and NHS number for 2 further patients
IGI/5945	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	14-Sep-16	27	A member of staff accidentally included a service user as the recipient on an email that was only intended to be sent internally to another member of staff. The email contained two attachments one was a spreadsheet containing the names and NHS numbers of 26 service users along with details of their GP practice, length of time open to service, if they have been assessed, when that assessment last took place, what level of care planning they are on and when the last care plan review was undertaken. The second document was a supervision record and contained the name and some personal/health information about 12 of these same service users. Plus, the name and some health and personal details of the staff member for whom the email was intended. It appears that the manager sending the email had used the cc box to find the email address of a	The email contained two attachments one was a spreadsheet used for operational management containing the names and NHS numbers of 26 service users along with details of their GP practice, length of time open to service, if they have been MANCAS assessed, when that assessment last took place, what level of care planning (CPA) they are on and when

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				service user from the address book. This was then copied into the body of the email for the receiving staff member at their request. Unfortunately, the manager negated to delete the email address of the service user from the cc box prior to sending the email. The receiving staff member realised the next day what had happened and informed the manager who had sent the email. The manager then visited the service user at home that day and the service user allowed the manager to delete the email from their inbox and the deleted items box. The service user told the manager that he realised it had been sent by mistake and did not open the documents. The manager does not recall if the email looked as though it was unread but has stated that they know the service user very well and has no reason to doubt the service users word that they did not see any of the information. The manager has also stated that this service user does not appear to be particularly IT literate and believes thus that the information is unlikely to have been accessed or forwarded to anyone else. The two documents sent had unfortunately not been password protected. It appears that the sending of the email to a service user was a case of human error. The nature of the work in teams which are community based such as this one, require staff to work at different locations. Staff are not always	the last care plan review was undertaken (yes/no columns and dates). It was a caseload report produced by the manager that also had indicators as to if certain data items had been collected e.g. ethnic origin but not the actual data. There was no clinical information on the file but CPA and Mancas are references to Mental Health. The recipient would know this and would thus be able to ascertain that the patients on the list are Mental Health Patients. The second document was a supervision record and contained the name and some personal/health information about 12

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				in the main office and there are some locations and instances where staff are only able to access email thus the most effective way of communicating is via email. Communication by email also provides a record that information has been sent to an individual. Email is the common method for communicating information of this nature internally for the reasons outlined above however staff are advised to password protect documents and where it is appropriate to remove identifiers and/or just use initials.	of these same service users. Plus, the name and some health and personal details of the staff member for whom the email was intended. As the data was intended for internal transmission only it was not encrypted. The second document was a word document which contained the notes from the supervision meeting between the manager who sent the email and a member of their team. Supervision meetings are held in order that a staff member can discuss the status of patients on their caseload and for the manager to provide advice and guidance regarding

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					the care and treatment where needed. The staff member also has the opportunity to discuss their own situation/concerns. The document contained a brief write up about a number of service users including their name. Some of the write ups contained some sensitive information albeit brief such as current mental health status for some of the named individuals, some details of forensic history of one patient.
IGI/5964	MARIE CURIE (LONDON)	01-Aug-16	one sheet	A pack of post was sent to a GP surgery. The envelope included one letter for a patient that belonged to the practice but an additional sheet with details of a different patient that no longer belongs to the practice (but had been a patient at that surgery) was also sent. No notification was received to confirm the patient's practice had change). Correct GP details have now been added to the patient administration system.	The Letter contained the patient's name, address, DOB, NHS number, details of his condition and details of medication prescribed.

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IGI/5934	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	10-Aug-16	8	Letters intended for the GP practice accidently were put in an envelope with a letter addressed to a patient.	The letters about different 5 patients stating the outcomes of their recent tests. All were gynaecological in nature
IGI/5951	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	22-Aug-16	1	Patient contacted department to discuss procedure, Patient then stated that they were unhappy with a previous telephone call in which they advised that previous surgery/implant had been discussed with a relative without permission. The patient advised that the family where unaware of the procedure and that they wished to make a complaint.	Clinical Procedure that was undertaken
IGI/6022	NHS DIGITAL	01-Aug-16	>100000	The CSU has a number of users permitted to access HES data on the HDIS system. Under that arrangement, record level data may not be downloaded (HDIS2), may not be regularly downloaded (HDIS1) and may not be inwardly shared (HDIS1 and HDIS2). Oxford AHSN and NHS South, Central and West CSU have signed an MoU under which the CSU has provided record level HES data to the AHSN. The CSU has stated that HES data was transferred under the MoU (initially Inpatient, Outpatient and A&E data from April 2013 to March 2015). This was transferred. A further extract of data was supplied, which covered the period April-October 2015. All such data related	HES Non-sensitive Pseudonymised data

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				to the Oxford area and was transferred in pseudonymised form. The CSU has stated that no further record level data was supplied to the AHSN, and that record level data has not been supplied to any other third party. The data was shared via secure file transfer, and both the AHSN and CSU have stated that the data is held securely within their own environments. The AHSN has confirmed that all such data is currently held within the AHSN, and that it has no other record level data. The record level data shared was downloaded from HDIS. Following checks on their records, the CSU has confirmed (as noted within our audit trail) that additional record level data has been downloaded from HDIS2 on a number of occasions from February 2016 onwards, by a number of individuals within the CSU. The CSU is continuing to hold the downloaded HES data for its own purposes on a SQL box. Access to that data has been provided to staff within the CSU who have not signed any agreement to use HDIS2. The HSCIC is sharing other record level data with the CSU (e.g.: in relation to SUS).	

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IGI/5944	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	14-Sep-16	1	A member of staff was asked to fax a detailed mental health assessment which contained name address date of birth and sensitive mental health data to a partner NHS organisation. The member of staff unfortunately dialled the wrong number and sent the fax to a firm of solicitors. The solicitors contacted the Trust to inform of the error and they were asked to destroy the faxed document. The Trust removed most of the fax machines during 2015 and replaced them with scanning devices so that documents can be scanned and emailed via secure email instead of being faxed. The Trust has a policy that staff should scan if needed and email documents over secure email to external recipients. The Trust retained a very small number of fax machines in order that faxes can still be received, for instances where it is not possible to email and for business continuity purposes. The member of staff was aware of the policy and would normally use secure email to send such documents. Unfortunately, in this case the member of staff was asked by the recipient to fax the document which they did. The staff member should have informed the recipient they would scan and email the document over secure email. If there were any concerns the staff member should have referred the matter to their manager. The member of staff in this case did not follow process.	Letter containing name address date of birth and sensitive mental health information.

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				Staff members are aware of the policy and we believe this is an isolated incident. The member of staff concerned has been spoken to and is up to date with their IG training. It has been agreed by the manager that the fax machine in the affected area can be removed. The Trust is also reviewing the fax machines that are remaining in the Trust with a view to removing these if possible. The patient is to be made aware of the error at their next appointment.	
IGI/5986	HINCHINGBROOKE HEALTH CARE NHS TRUST	09-Aug-16	16	A member of the public found a loosely folded handover sheet in the corridor and handed it in to a member of pharmacy staff. The member of the pharmacy team bleeped the number that was on the form and a member of staff from the ward came and retrieved the sheet. There are 4 poorly copied sheets stapled together, 3 of which contain patient information. Some of the information is barely legible.	Both medical and personal information pertaining to patients is contained in the sheets, some of the information is barely legible as it's a faint photocopied document.
IGI/5907	SOUTH TYNESIDE FOUNDATION NHS TRUST	09-Aug-16	104	104 pathology report slips dating from September 2007 (7th – 13th) returned to the Trust by a vehicle remarketing company based in Derby. The reports were found in a car that was brought to them for re-sale.	Pathology reports contain full demographic details for the patients, clinical details such as the reason for the

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					request and results. They also contain patients NHS Number, local Hospital identifier and the name of the clinician who made the request.
IGI/5873	WALSALL HEALTHCARE NHS TRUST	18-Jul-16	33	An encrypted laptop, set of babies weighing scales and a Filofax containing the names, dates of birth, NHS number and limited clinical detail of babies seen at Well Baby Clinics was stolen during the night from the boot of a car. It is unknown how many names were included in the Filofax, and it is thought that there may have been a few addresses included (but this is not confirmed). The robbery has been reported to the Police and the Information Commissioner's Office with regards to the stolen Filofax. The member of staff involved does not know the names of the children affected. In order to report the incident, we have assumed there were between 50 - 100 names in the Filofax.	Filofax contained the names, dates of birth, NHS number and limited clinical detail (i.e. weight) of babies seen at Well Baby Clinics was stolen during the night from the boot of a car. It is unknown how many names were included in the Filofax, and it is thought that there may have been a few addresses included (but this is not confirmed).
IGI/5865	NEW HORIZONS CARE	29-Sep-16	1	• Health needs overview • Behaviour • Medication • Nutrition	Care plans relating to • Health needs overview • Behaviour

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				• Hospital Admission • Personal Relationship • Smoking • Skin Integrity	• Medication • Nutrition • Hospital Admission • Personal Relationship • Smoking • Skin Integrity Have been lost by son of client
IGI/5908	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	22-Jul-16	Between 500-1000	Between 500 and 100 patient reports (blood tests, radiology reports and pathology reports) were being stored in black bags within a cage in the admin area of AMU - the reports date up until June 2016. On the 9th June, the cage was moved into a side office within the Admin area for added security through restricted access. The cage was removed and the bags containing the reports consigned to the domestic waste stream and subsequently removed from site for incineration.	The data contained within these reports is comprised of: Patient demographics - Name, DOB, Address, Hospital Unit Number, NHS number Named consultant Ward/Clinic area Investigation/test undertaken and report/results Date of investigation/report

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					Hospital and Speciality Some will include also include the GP Name and Address
IGI/5855	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	05-Aug-16	39	NCMP letters sent to parents with other children's results. – 39 letters to 39 parents all from the same School. Telephone call from parent highlighted the error. Investigation identified human error using cut and paste on a spreadsheet mis-aligning child's name and results with the wrong address for one school. The software that then mass generated the letters had the wrong information. All other spreadsheets for the other schools were checked and found to be correct. Letter of apology for each parent of the school and included in correct result letter and sent out to the parents. Letter of apology and explanation sent to head teacher. Datix completed. Commissioner informed. The service received 6 calls from parents saying they had had wrong letter plus the head teacher advising that the school had received letters back.	The information is the height, weight and BMI of the child with a standard inclusion of whether this means: Underweight/normal weight/overweight or very overweight.

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				Some parents who could see from the window envelopes that they had the wrong child's results have swapped letters without opening them.	
IGI/5834	ROSALIND FRANKLIN HOUSE (D81042)	15-Sep-16	1	A patient needed to be seen at the hospital. Therefore, there was a need for them to be provided with their summary of medical records. One of the admin staff printed out the medical summary of a different patient who has the same name as the intended patient. The summary was put in an envelope and handed over. The mistake was noted by the other patient who informed us early the following day. The Practice Manager went immediately to that patient's house to collect the copy of the records and has since kept it securely at the surgery for investigation purposes.	NHS summary of patient data

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/5845	PENNINE CARE NHS FOUNDATION TRUST	21-Jul-16	2	Mental health worker's car broken into overnight and depot case containing two depot administration cards and depot injection as found near to her car. The contents had been found by a member of the public who telephoned the police.	Depot card containing patient details
IGI/5824	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	20-Sep-16	1 handover sheet	A member of the public found an A4 folded nursing handover sheet in the toilets on a ward. The individual highlighted this to a member of staff. The handover sheet contained the following details - Patient name, bed, clinical treatment being undertaken and handwritten notes to assist nursing staff during the handover. Immediate action was undertaken, discussions took place between the individual/visitor and a senior member of staff. It was highlighted that an investigation was to be undertaken and the individual will be notified of the outcome accordingly.	Patient's name Bed Clinical treatment being undertaken Handwritten notes
IGI/5492	MARIE CURIE (LONDON)	1-July-17	single fax	The ward clerk faxed patient's prescription to the wrong fax number. They rang and spoke to the person who received the fax and asked him to destroy it. The fax had been sent to Lynfield Mount maintenance department instead of the pharmacy.	Patient prescription containing identifiable information

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IGI/5495	MARIE CURIE (LONDON)	1-July-17	one file	The Medical Director was looking through the shared drive files when she found a file about a nurse at the hospice which contained personal confidential information about the staff member including a file note which included very sensitive information.	Sensitive information about a member of staff
IGI/5494	MARIE CURIE (LONDON)	1-July-17	one email with 6 attachments	An administrator emailed a closed group with details of 'return to work' interviews' containing personal and sensitive information relating to six members of staff.	Return to work interviews contained sensitive details about six members of staff

Appendix A

Incidents closed using the 'auto closure[3]' facility 1 July to 30 September 2016

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/5889	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	20-Jul-16	1 page	Correspondence containing detailed assessment was sent to school instead of the GP, GP received the basic report that was intended for the school	letter intended for GP containing sensitive information regarding, diagnosis, ideations and arrests
IGI/5843	PENNINE CARE NHS FOUNDATION TRUST	05-Aug-16	Not known at this stage	Mental health worker's car broken into overnight, work bag was in the foot well and stolen. No patient files in the bag however the work diary was in there with patient names written in	Patient names
IGI/6381	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	22-Sep-16	43	The bag contained an encrypted Dell Venue device, baby weighing scales, keyboard, mouse and a diary which contained two loose sheets of paper. On the sheets of paper there was a case list of 43 children, PID on the sheets included name, address date of birth and identified level of need e.g. Safeguarding status.	Two loose sheets of paper. On the sheets of paper there was a case list of 43 children, PID on the sheets included name, address date of birth and identified level of need e.g. Safeguarding status.

[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
IGI/5745	PULTENEY STREET SURGERY (L81068)	17-Aug-16	16	Patient registered with The Pulteney Practice in Bath. Records were electronically transferred via GP to GP from the patients previous practice in Bournemouth. Paper notes arrived from Bournemouth to The Pulteney Practice but as they had already been transferred electronically, they were filed away as there was no need to review them. Patient moved to a new house again & registered at a Bradford on Avon practice. Paper notes were recalled by the health authority for transfer to the new practice. The CCG were informed by the Bradford on Avon practice that the paper notes contained 18 letters relating to 16 other patients from the Bournemouth area. It appears that the previous Bournemouth practice had closed although this is difficult to confirm as I have no access to the exact details. I presume the letters contained in the patient's paper notes may have included sensitive clinical data, but I am not able to confirm that.	NHS Patient data
IGI/5791	WYE VALLEY NHS TRUST (RLQ)	11-Aug-16	30	30 patients' identifiable clinical data used for ward rounds was picked up off WVT site by a member of WVT staff and returned.	Demographic and clinical information related to all pts on a ward

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IGI/5801	MEDWAY NHS FOUNDATION TRUST	29-Jul-16	50-100	A physiotherapy ward book was taken to the ward, and has not been recovered since. The book contains patient information such as names, dates of birth, and NHS numbers, along with diagnoses. it is believed to have contained details of more than 50 patients but less than 100. These notebooks were retained by staff and carried around internally. The team are peripatetic and use the notebook to record patients currently being treated and as a means of allocating work to team members. Members of the front door therapy team have not been able to locate it, search has included: ED, CDU, and the wards that they covered. The risk to patients is lack of continuity in their care in the context of previous treatment details not readily available to be reviewed. The patients have not been made aware of the incident as it is not possible to identify all those patent details contained in the note book.	Notebook contain two styles of data capture for patient details and are used to allocate work and capture activities: o One captures patients' names, NHS numbers, bed, ward and a summary of treatment. This book averages 20 patients per 2 pages and can contain up to a years (roughly) worth of interaction. o the second contains these plus patients' home addresses and contact details, but less entries per page - 6-7. It is the former style of book that was lost, but it only had a few months' worth of entries, but still possibly up to 100 patient details. The volume of information lost contributes to the assessment level for breach reporting

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/5620	TRENT CBT SERVICES LTD	21-Jul-16	1	Clinician printed discharge letter containing clinical information and it was given out to another client in error in a handout. The client in receipt of the letter in error returned it to us.	paper GP discharge letter
IGI/5603	DERIAN HOUSE CHILDRENS HOSPICE	21-Jul-16	17	We were informed by a family that one of the Derian House digital cameras had accidentally gone home with one of the children discharged from respite care. The camera was found by the family once they were at home which was within their daughter's buggy. Care Team Leader was notified by the child's family that they had found the camera which was labelled as belonging to "The Lodge" (part of Derian House). The family returned the camera to us, they stated that they had not looked at any images on the camera, the last image was one relating to their child, taken during her recent stay. We apologised for the inconvenience caused to the family. An incident form was completed and the Team Leader, Deputy Head of Care (Lodge), Head of Care and Quality Audit Standard Co-coordinator were informed immediately upon discovery of the incident. Clinical Director (Caldicott Guardian) was consequently informed and following further investigation the Chief Executive was notified on her return to work. There are 124 photos in total on the camera with 17	Pictures of Young People and Children enjoying routine activities with the Hospice and outside on a trip.

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				different children. The photos include the following scenarios: • Child in hydrotherapy pool with play worker • Child in messy playroom • Children receiving Music Therapy • Young People cooking • Children and Young People on a trip • Children participating in wheelchair horse-riding All images have been removed from the device. We will be reviewing all our current actions in relation to images taken and when they should be deleted from the camera and control and ownership are being reviewed.	
IGI/5779	MEDWAY NHS FOUNDATION TRUST	15-Jul-16	1500	A contractor has accessed PID relating to 1500 patient discharge summaries. The documents contain full name, hospital number, NHS number, address, telephone number, allergies, MRSA status, admission and discharge date, gender, diagnosis, details of care, medication prescribed and doctor details. The contractor has returned the USB drive to the Trust and no disclosure outside of the contractor has occurred. In relation to the contractor's involvement in reviewing an SI relating to a patient, the contractor believed that they were "acting in good faith" and "in the public interest" "to prevent or detect crime".	The documents on the USB drive contain full name, hospital number, NHS number, address, telephone number, allergies, MRSA status, admission and discharge date, gender, diagnosis, details of care, medication prescribed and doctor details. In relation to the SI the

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				They stated that they acted in the reasonable belief that it was part of their role acting on behalf of the Trust. The Trust disagrees with this position and considers that they acted outside of the scope of their role. As part of their contracted role they should not have accessed any patient identifiable data.	contractor accessed the incident report form which contained patient's name, details of the incident, date of birth etc.
IGI/5518	LOCALA	11-Aug-16	1	Patient had consented to participating in training programme for staff 2 years ago. Article in local newspaper about maximising independence included patient name + patient picture + are in which patient lives + patient medical condition - patient had not consented to this being done	Patient name + patient picture + area in which patient lives + patient's medical conditions
IGI/6067	DR M STACK'S PRACTICE (C82012)	24-Aug-16	22	On investigation, the staff member had printed off prescriptions from 22 patients over a period between 2015 and April 2016. They were always for Co-codamol caplets/tablets 30/500. There had been a number of scripts printed for each patient over the timescale. We think the prescriptions have been fulfilled and we are in the process of getting the prescriptions back from the PPA in Newcastle.	Patient name, address, DOB, age, and NHS number. Possibly other medication that the patient is on, but we don't know until we are able to get the scripts back from the PPA.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/5509	NHS NORTHERN, EASTERN AND WESTERN DEVON CCG	01-Aug-16	One Individual	The Information Governance Team received a call from the Head of Clinical Effectiveness advising that a document on the formulary and referral website contained details that appeared to relate to a patient this included name of patient, date of birth, NHS number and GP, this information had been duplicated on the formulary app. The pages informed GP practices of how they can update their computer files of formulary drugs if they use the EMIS system (Other pages were unaffected by this). The issue affects both the North and East pages and the South and West http://northeast.devonformularyguidance.nhs.uk/ and http://southwest.devonformularyguidance.nhs.uk/. It should be noted that despite that it was uploaded to the Internet site, the documents were so obscure, it would be unlikely to be viewed by a member of the public. Upon receiving the incident, the Information Governance Manager requested that the document was removed immediately and can confirm that this was completed, The Governance Manager was also advised that the detail had been published on an application for handheld devices and removal of the data would not be possible for four days, this will be actively followed up by the Governance Manager and removal confirmed. The Governance Manager sent an E-mail to all Website Administrators requesting that all Administrators review their pages and not to upload any documents unless they had been appropriately reviewed.	The document included the following: One individual's information - Name; - Date of Birth; - Gender; - NHS Number; and - GP Name No other information present

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IGI/5973	HINCHINGBROOKE HEALTH CARE NHS TRUST	30-Aug-16	300+	The Trust's electronic handover tool has been found to be available to all staff via the Trust Intranet. A user can log into the e-handover tool and access information contained in it. This means that they have access to all e-handover sheets for every patient on every ward that contain the patient's personal, confidential and medical information. It is only available to staff through a network login.	Patient's confidential information including medical information.
IGI/5511	NHS BASSETLAW CCG	01-Sep-16	2 patients + 2 carers	, The CCG was notified that a patient's family member had received the incorrect continuing healthcare correspondence in relation to another patient. The correct covering letter was forwarded, however, the incorrect panel outcome letter and Decision Support Tool (DST) related to another patient. The DST contains an assessment of the patient's health status which includes a summary of the individual's health needs, key evidence used, behaviour, cognition, psychological and emotional needs, next of kin name and contact details and other pertinent details. The incident occurred following a Continuing Healthcare panel meeting, whereby the relevant information was sent to the patient/carer notifying them of the outcome of the meeting. The incorrect DST was enclosed into the incorrect envelope and sent in error. The CCG is currently investigating the incident internally including any gaps or processes which may be identified.	NHS patient data - Continuing Healthcare Decision Support tool Assessment
IGI/5557	MARIE CURIE (LONDON)	01-Jul-16	one email	An email containing information about a patient was sent to 3rd party by the Hospice Manager in error The error was identified by the hospice consultant. The Medical Director informed the Hospice Manager	Patient information was accidentally disclosed

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				immediately who contacted the internal IT Helpdesk. Recall of emails carried out immediately and IT Helpdesk member of staff contacted Auditel out of hours IT team (employer of the external individual). They confirmed they would request removal of the email from the individual's email account and confirm the next day. The Hospice Manager also requested confirmation that the individual had not read the email.	
IGI/5533	PENNINE CARE NHS FOUNDATION TRUST	05-Aug-16	1	Staff member left office with care plan for patient, attended various patient visits and when arrived at patient's house realised didn't have the care plan.	sensitive personal data
IGI/5898	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	08-Jul-16	3	Encrypted password protected devices were taken along with hand written notes not containing PID, and an invitation to a Child Protection Conference letter.	One letter inviting clinician to a Child Protection Conference to share and evaluate information regarding the recent child protection enquiry. The letter included name and date of birth of three individuals. This letter did not include the nature of the child protection enquiry.
IGI/5567	MARIE CURIE (LONDON)	01-Jul-16	one email and attachment	The email trail contained a statement that a specific nurse was sick and not to roster another named nurse as she was 'in the hands of H.R'. An attachment contained a 'planner' highlighting when and where specific staff were working on a specific service. No other details were in the email trail.	An email with an attachment containing a staff rota was sent to the wrong external recipient. The body of the email made

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				The error was noticed by a member of staff within 2 minutes and the email was recalled. Confirmation was received that the email was successfully recalled.	reference to a nurse being 'in the hands of HR'.
IGI/5470	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	10-Aug-16	two	Complaints logged separately from different patients. Ex-midwife approaching patients to recruit them into her business, using information she would have obtained while a member of staff. In breach of Trust Policies and Procedures, and Data Protection Act 1998.	Patient name, address and phone number
IGI/5353	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	29-Sep-16	1 patient	A highly confidential clinic letter has been sent to the wrong GP and wrong address - the addressees name is correct. The error was discovered when the GP returned the letter to the service marked as 'not our patient'	Personal information relating to medical status, potential criminal matters and psychological concerns.
IGI/6156	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	09-Aug-16	1	Following an audit trail of the relevant systems (PAS, EDIS, ICE, Healthcare Record tracking, CRIS, PACS), and subsequent HR interviews with staff it was identified that the patient's clinical information had been accessed inappropriately. The member of staff although having appropriate access to systems to fulfil their duties, had accessed the patient's information with no apparent need.	ICE - Patient test results (Full Blood Count, Liver Function test, Antinuclear Antibody test) PAS - Patient address (including demographic details)
IGI/5330	NHS ENGLAND	12-Jul-16	1	Email was sent to a Doctor N by NHS England GP revalidation team. Included in the email trail was highly sensitive information pertaining to a complaint against another Doctor B. Also included were 5 other Doctor's names who were going through revalidation. When Dr N saw the whole email trail he stated he wished to make a complaint because he had access to highly sensitive information pertaining to Dr B.	Personal sensitive data - related to a health condition

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IGI/6253	THE ROYAL WOLVERHAMPTON NHS TRUST	26-Aug-16	265	Member of staff was sending out an email invite to potential fundraisers for the Trust charity. The email accidently contained a database attachment with personal and private data within it; the email had been generated internally and was circulated to an external mailing list in error potentially containing 293 recipients. These recipients were also fundraisers. Immediate corrective action was taken by the sender by recalling the email containing the attachment.	Names, some emails, some telephone numbers and some amounts donated. Limited personal data.
IGI/5270	SELF HELP SERVICES	13-Sep-16	71	Self Help Services use an electronic database to record all contact with its clients. Self Help delivers mental health services. The Self-Help database stopped working but was restored the following day. However, after being restored it was noted that up to 11 hours of data entries had not been restored. The restore was carried by the IT provider, who did not inform us of the impact of this incident The incident was detected, and staff were immediately informed and requested to keep their paper notes of anything recorded on the database on the morning of the 10th. The following day all administrative staff were informed to re-enter the previous morning's referrals and staff members were asked to re-enter any notes. Staff members have been asked to report to their service leads, the number of client records affected. Where they judge that missing data poses a risk to care they have	NHS patient data

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				been instructed to report to their service manager. Investigations revealed that in total, 71 clients' records were affected. Of these, the information for 61 clients was recovered from paper records. Information for the remaining 10 had to be entered from memory (all this information was entered within 72 hours of the original data input). We received the following information from our IT provider as to the cause of the incident and measures they have put in place to prevent a re-occurrence "We have concluded that at the time of the log file corruption a large spike traffic on one of the controllers in the storage area network. This caused the log file drive to disconnect from the Virtual server where your database is hosted on and corrupted the log files. To mitigate the issues in the future we have moved and re-balanced resources to another controller so that traffic can be handled during excessive periods"	
IGI/5767	EAST LANCASHIRE HOSPITALS NHS TRUST	12-Jul-16	three	Break-in occurred over the weekend the police were informed, and an investigation started. It took time to ascertain what was stolen but noticed that three case notes ready for clinic on Monday were no longer in the reception area. The records dept. instigated a thorough search for these records in the hospital, community and all staff involved in the treatment of the patients. Finally concluded that the case notes were missing and presumed stolen. This was reported to the IG department.	three sets of case notes

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IGI/5445	CARE PLUS GROUP	06-Jul-16	1	The Quality & Performance Co-ordinator for Quality & Governance (Q&P Co-ordinator) sent two emails intended for a Rapid Response Practitioner whom had been allocated a Serious Incident to investigate to a member of staff working at Vulnerable Adult Day Services with the same name. The first email contained no patient identifiable information, but it did contain information that a service user in Foundations had died and that interest had been registered with the coroner, although the cause of death was unknown. The second email had patient notes from SystmOne attached to it. The emails when sent had not been responded to and the Q&P Co-ordinator did not realise the error until the Rapid Response Practitioner got in touch with the Q&P Coord asking for an update. When checking the emails that had been sent out, the Q&P Co-ordinator realised that these were sent to the wrong staff member.	Patient records
IGI/5231	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	21-Jul-16	Seven	Currently the Trust has a process in place where private and confidential information is sent via email using the send secure method. A member of staff inadvertently sent an excel spreadsheet containing the details of seven patients to an incorrect email address (one of the patients is referred to in the document) without using the send secure method. Confirmation has been received that the patient who received the email in error has now deleted this.	Patient name, DOB, hospital number, email address, details of surgery patients scheduled to undergo.

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IGI/5285	MARIE CURIE (LONDON)	01-Jul-16	3	A placement student was found to have taken home notes about three patients at the hospice which included social worker assessments with personal and sensitive information. Information included patient's name, address, health and care number, date of birth, next of kin, phone numbers, GP details, medical history, current issues, mobility issues, interests and hobbies, family content, finance details.	Social worker assessments and notes from meetings with three patients including name of patient, name of family, address, GP details, medical history, details of the assessment including diagnosis, issues affecting the patient, coping mechanisms, family issues, finance and benefit details.
IGI/5214	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	10-Aug-16	6	Four sealed bags of patient records were collected by courier to be transported for outreach clinics. On arrival at the clinic location, it became apparent that one of the four bags were missing, containing full medical records for six patients. The courier returned and found the missing bag on the roadside, which was then delivered to the clinic location Six patient records were found but the bag was ripped, the notes were mixed up and parts of the notes were torn, so there is a risk that some parts may have been lost. It is not known what exactly is missing, as not all records would be available electronically for comparison. The relevant consultant was made aware of the incident in advance of the clinics for the affected patients. All electronically-held notes (from EPR)	Full paper health records

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				were emailed to the consultant. No clinical impact occurred.	
IGI/5784	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	07-Jul-16	Approx. 50	The PCHR records for approximately 50 babies were sent to the parent of a baby instead of to the Child Health Department at Sleaford (where they are used to update Systmone.) The mother phoned a Consultants secretary and informed her that she had received the forms and was concerned that they may have gotten into the wrong hands. A member of staff phoned Mum and arranged to go to her home to retrieve the forms and send them on to Child Health. An apology was given to the Mum for any inconvenience caused and explained that this would be investigated thoroughly. The PCHR records includes name, address, DoB, NHS number, ethnic background, weeks' gestation, GP name and the results of hearing screen.	Paper records which included name, address, DoB, NHS number, ethnic background, weeks' gestation, GP name and the results of hearing screen.
IGI/5195	WYE VALLEY NHS TRUST (RLQ)	07-Jul-16	1	Health Visitor written records for a child ere sent via the internal postal mechanism to another Health Visiting team based at a local GP surgery and the records never arrived. the records were sent, recorded as missing on Datix and reported to IG.	Health visitor clinical information - further details to follow
IGI/5190	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION	20-Jul-16	6 pages	Confidential and sensitive information within an assessment summary was sent to an incorrect address, (sent to next door neighbour)	Assessment contained education details, family situation, presenting problems and mental

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
	TRUST				state
IGI/5168	WYE VALLEY NHS TRUST (RLQ)	07-Jul-16	1	Transfer summary document contains PID. Demographics, NOK, triage info, diagnosis, obs, and investigations, and past medical history.	Demographic and Clinical info as above.
IGI/5105	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	20-Jul-16	67	Neighbourhood team patient notes kept at GP surgery in locked filing cabinet, the surgery was broken into and drugs were taken, and rooms were ransacked. Locked Filing cabinets containing patient notes were also opened no records were missing but confidential information including key safe numbers are contained in the file. Police Investigation underway. Patients are elderly and vulnerable and if information has been compromised could be used in a detrimental way.	patient home visit health records
IGI/5111	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	12-Aug-16	1	To be completed following investigation	Social history of a patient
IGI/5444	CARE PLUS GROUP	06-Jul-16	1	Registered Nurse sent referral via email for OT/Physiotherapy, but inadvertently sent this to two wrong email addresses. One was sent to DL-CPG-Collaboratives Volunteers (care plus group) and another to DL-CPG NEL Community therapy (care plus group)	This referral form did contain patient identifiable information.

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IGI/5478	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	18-Aug-16	100+	A member of staff travelling between hospital sites by train left an envelope containing multiple patient documents which included copies of discharge summaries and drug charts on local Train station. It was found under a bench on the platform by the station security staff who contacted the Trust and Trust security staff retrieved the envelope immediately.	Discharge summaries and drug charts include patients name, dob, address, NHS number, details of inpatient stay, diagnosis, treatment and medication
IGI/5544	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	29-Sep-16	1 patient record	Although the complaint was recently received, the incident occurred in January. It is alleged that a theft of property occurred at the patient's home address, as part of an ongoing dispute between the patient and our employee, and that knowledge of the address could only have been obtained by inappropriate records access. Audit of records access proved that the access had taken place in the days immediately before the alleged theft. The access was clearly inappropriate, given that the patient in question was not currently in receipt of services and had been dormant for ~3 years.	Looked up home address of individual.
IGI/5501	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	29-Sep-16	Children's records	HV accessed the records of a service user who was also her daughter in law and mother of her grandchildren. This information was protected as the family were under the care of Council Safeguarding and had a protected address. Son of the Health Visitor and father of the children was subject to court proceedings to restrict access to the family. HV shared the information with her son, who proceeded to wait in a parked car outside of the	SystmOne clinical record

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				family home. Delay in reporting due to wanting to understand whether there was any potential harm as reported by the Clinical team.	
IGI/4825	PENNINE ACUTE HOSPITALS NHS TRUST	29-Jul-16	49	The Trust was made aware that a tender document that had been sent to the CSU contained patient identifiable data for 49 patients in the form of a screenshot from a system being used as part of the new service. The CSU Manager contacted the Divisional Director for Community to ask if the patient details contained in the tender were in fact of real patients. The Trust reported that they were thought to be anonymised patients as requested on completion of the document. Following the query the Trust divisional staff checked the patient NHS numbers to find that the details submitted were of real patients. The Divisional Director for Community notified the Medical Director and Director of Operations so that they were alerted to the breach following the disclosure of the information in error. The anonymised data required for the tender was re-presented to the CSU. The incident has been logged on the Trust's safeguarding system and the division have commenced a full investigation led by the Divisional Director.	Care type, Active Time, Case Number, NHS Number, Forename, Surname, GP

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				The details shown in the report contain First name, surname, NHS Number, Patients' GP for 49 patients. The tender report was viewed by 19 CSU staff outside of the Trust. The documents sent to the CSU were sent via NHS.net. A full investigation continues and a lessons learned will be formulated and embedded.	
IGI/4831	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	22-Aug-16	100 approx.	A member of staff found an envelope in the street. On examination, the envelope was found to contain information relating to people who had been patients within the Trust. The staff member brought the envelope back to the Trust and handed it in to their manager (as instructed in information governance face to face training session which had been attended). The information was passed to the Directorate Manager responsible for the departments where the patients had been seen. The staff member who was believed to have been responsible for the information which had been found was contacted and a meeting was arranged for 7th December to discuss the incident.	30 patient reports following procedure - full demographic details, NHS number, clinical findings, recommendations/suggested actions, medication Approx. 65 patient details - name, dob, clinical details, diagnosis, symptoms, medication, blood results

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IGI/5028	MARIE CURIE (LONDON)	01-Jul-16	9	A member of the public handed in a folder with 9 populated direct debit mandate forms, alerting us to the incident. On receipt, the folder was secured in our office and it was confirmed that it belonged to an agency working on our behalf. The agency was notified, and they conducted an investigation which included interviewing the fundraiser involved. The forms were in a folder and the folder was misplaced on the fundraiser's way home. The fundraiser did not report the folder missing.	Name, address, contact details, date of birth and bank account details for the purposes of setting up a direct debit for 9 individuals.
IGI/5477	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	17-Aug-16	1	A member of the public handed in a set of Hospital Case notes to a GP surgery. They had been found in the road outside the surgery.	Case notes contain detailed patient information
IGI/5029	MARIE CURIE (LONDON)	01-Jul-16	1	A Marie Curie Rapid Response Registered nurse had verified an expected death, unfortunately she put incorrect GP details on the verification document and this was the sent, via NHS.Net email to the wrong GP surgery, by the RRS Coordinator. There was a delay of 48 hours issuing the Death Certificate.	Name, address and date of birth of one person. No sensitive personal data or financial data.
IGI/4720	MARIE CURIE (LONDON)	01-Jul-16	41	An email was sent to the East Dorset and Fast Track Team with a spreadsheet containing Marie Curie contact numbers. The spreadsheet also included a tab that held staff personal contact details and brief notes relating to work patterns, including comments like '20 weeks pregnant'. The email was sent using an internal distribution list and was sent to internal staff only. The information included in the spreadsheet was about the staff the email was circulated to.	The spreadsheet contained personal contact details and brief notes relating to staff work patterns, including comments like '20 weeks pregnant'.

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IGI/5181	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	20-Jul-16	26	Staff member who was also a former service user was found to have accessed the records of 3 former service users that she was friends with and her own records on several occasions. On further investigation staff member had also accessed records of service users in other directorates for no legitimate reason	service users' mental health records
IGI/4509	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	04-Jul-16	1	Inpatient ward staff anonymously wrote a lengthy whistleblowing complaint about a member of their team. They sent the whistleblowing complaint to the CQC and Lambeth CCG. Staff enclosed a fact finder report on a separate incident as evidence to support their allegation, which contained identifiable confidential information about one patient. The Trust was notified by Lambeth CCG as they were concerned about the confidentiality of the patient mentioned in the report. The Trust has reported the incident, escalated internally and has initiated an investigation. The Trust is conscious not to inadvertently have an impact on the investigation of the whistleblowing complaint so decided to handle the data breach investigation with a plan that is sensitive to the requirements of a whistleblowing investigation. Immediate actions were taken to meet the duty of candour.	A scanned pdf copy of a factfinder report on a previous patient safety incident containing personal data about one patient, including their full name, date of birth, mental health diagnosis, brief medical history, medication and treatment plan.
IGI/4441	MARIE CURIE (LONDON)	01-Jul-16	one	External tree cutter approached member of staff to ask if they worked across the road in the hospice. They then handed over a piece of paper that was lying under the branches/leaves that they had cut down. The paper contained personal data regarding a patient. junior doctor at hospice who when shown the paper agrees it was hers.	Patient identifiable and sensitive data

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				Junior doctor had used sheet to draft a discharge letter the previous day and was confident that she had disposed of it, together with her ward patient list, in the iron mountain before leaving work.	
IGI/4357	SCRIVENS	19-Jul-16	5,293	Thieves broke into our Dorchester High Street branch overnight by smashing the front door and stole a fixed computer containing a database of 5,293 optical patient records. These records contain PID information, including optical prescription and dispensing details but no sensitive information and no bank account or payment card details. The database was protected by three layers of password which are unknown to the thieves and who will be unable to access any records and no breach of confidentiality has occurred. The theft was reported to the Police by the store manager and the crime number is <redacted> Several other shops on the same High Street were broken into the same evening and the police are examining CCTV footage.	A database of 5,293 optical patient records containing PID information, including optical prescription and dispensing details but no sensitive information and no bank account or payment card details. The database was protected by three layers of password which are unknown to the thieves and who will be unable to access any records and no breach of confidentiality has occurred.
IGI/4440	MARIE CURIE (LONDON)	01-Jul-16	24	There were a couple of documents for current patients which were filed away-however when RN sorted thought the files they found prescription charts, care plans, hospital documentation and district nursing case notes. In total, there was documentation for 24 patients. The majority of the documentation was relating to deceased patients, some was related to patients currently still inpatients or patients attending Day Therapy and some were	Patient sensitive and identifiable information

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				for discharged patients. Given documentation to Admin Supervisor who will investigate patient status and arrange for documents to be filed away.	
IGI/5399	THE ROYAL WOLVERHAMPTON NHS TRUST	26-Aug-16	1 record	A patient contacted PALS to suggest that a member of staff (who is also a relative of the patient) had accessed her health record. She did not want action to be taken, but that her suspicions were considered. Following an audit, it appeared that the member of staff had accessed the records on a number of occasions over a period.	Relative of the staff member
IGI/4439	MARIE CURIE (LONDON)	01-Jul-16	one	E-mail received from London office informing hospice that notes had been returned to London office that were intended for doctors' surgery. Envelope containing deceased patient records opened by Royal Mail to return them to London office as compliment slip enclosed.	Patient identifiable and sensitive data
IGI/4438	MARIE CURIE (LONDON)	01-Jul-16	one	Patient discharge letter incorrectly faxed to Liverpool Heart & Chest Hospital Pharmacy Department. Spoke to admin staff and pharmacy technician regarding recent faxes sent. Pulled fax report off the machine. Several faxes sent within minutes of each other to various numbers. Report indicates that it was a machine error - machine merged two fax numbers together therefore sending the fax to the pharmacy in error.	Patient identifiable and sensitive data

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IGI/4268	THE WHITTINGTON HOSPITAL NHS TRUST	16-Aug-16	23	Haringey CCG contacted the Trust to say they had been informed via their Twitter feed by a member of the public that he had been receiving confidential faxes for over 2 years. The following weeks the CCG attempted to liaise with this member of the public to ascertain more details about these faxes and if possible obtain copies. On 4th September the CCG contacted the Trust's CEO & Communications department to inform the Trust that the member of the public has sent [the CCG] numerous emails containing copies of the faxes he had received. On 7th September, the CCG forwarded copies of these faxes to the Trust. It was identified that numerous faxes from various Trust departments which were intended for the Trust's Community Referral Team, had been accidentally sent to this member of the public. There were also numerous faxes from other organisations and GP practices.	Not applicable for all due to nature of incident: Forename Surname Address Gender DoB Marital Status NHS No Hospital No Diagnosis Presenting Problem Actions for GP, Hospital Team and Patient Co-morbidities Blood Count Medications GP Details NoK
IGI/4318	WYE VALLEY NHS TRUST (RLQ)	07-Jul-16	2	Patient 1 was given patients 2 prescription. contained within this prescription was the medication, GP letter and a discharge letter. Pts 1's daughter opened the package and has confirmed she did not open the sealed envelope containing the GP letter. After speaking to the discharge lounge, they confirmed the letter was not in an envelope and therefore it was loose in the bag. Therefore, we cannot determine whether the info was breached.	full discharge summary, medication

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/4437	MARIE CURIE (LONDON)	01-Jul-16	one	Marie Curie Nurse left referral paperwork for patient in his home. Family/carer found paperwork and was shocked at what she read, regarding the patient's condition	Patient sensitive information
IGI/4080	THE WHITTINGTON HOSPITAL NHS TRUST	16-Aug-16	Seven	A member of staff has access to digital health records as per her job role. The member of staff has been identified as accessing the digital health records of work colleagues with whom she does not have any clinical involvement or permission from the members of staff to view their personal records	Anglia Ice records - contain various data including pathology results. Dependent on what treatment a patient has had as to what is in their record.
IGI/4436	MARIE CURIE (LONDON)	01-Jul-16	one	"Fax sent using correct speed dial but instead of going to Velindre Pharmacy it went to Taffs Wells Medical Centre Fax sent to Velindre Pharmacy on speed dial 008 when clarification of transmission report received fax has gone to Taffs Well Medical Centre. Both nurses checked together before sending.	Patient sensitive data
IGI/4076	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	16-Sep-16	one filofax containing Trust information but also consultant personal information also	A consultant psychiatrist out of hours was taking her dog a walk around a local beauty spot leaving her handbag and canvas bags in the car. The car was broken into and both bags were stolen. The contents included a lot of personal information relating to the consultant psychiatrist (passwords for Tesco, EasyJet etc) but also a Filofax which included other consultant / staff contact details, to do lists (i.e. phone Doctor x), demographic information for patients when called out of hours to do a mental health act assessment (i.e. name, postcode), notes on any related conversations when out of office. In general demographic information only but with the odd clinical comment.	Paper - demographic information held in a Filofax relating to patients but also personal information associated with consultant (i.e. passwords to Tesco, EasyJet etc)

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IGI/5166	THE ROYAL WOLVERHAMPTON NHS TRUST	26-Aug-16	1	Patient letter (Child Protection report) was sent to school nurses at a GP surgery in West Yorkshire. The GP surgery name was the same as the one that the letter was supposed to have been sent to at West Bromwich. Minimal Information provided about the GP, HV and school nurses leading to the secretary using the internet to find missing details.	1 child protection report for GP - sent to wrong GP
IGI/5165	THE ROYAL WOLVERHAMPTON NHS TRUST	26-Aug-16	12	12 Patient Home Visit proformas were identified as missing in a folder were left in the back of a hire car by a member of staff Car Hire company contacted, who confirmed that the folder was still in the Hire Car and the car was now in Nuneaton, the hire car had not been used by other customers since being returned. The manager of the hire car company placed the black folder containing the home visit proformas into an envelope and sealed this with tape. The 2 patients who had their key code information documented on the proformas were contacted and informed of the incident due to the potential safety risk.	12 Patient Home Visit proformas paper documents

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IGI/3947	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	06-Sep-16	1	The Patient Experience Team at Kings Mill Hospital received a telephone call from a member of the public that had found some papers among other rubbish that had been fly tipped on their allotment. The member of the public had contacted Ashfield District Council to collect the rubbish and papers; they then contacted the Patient Experience Team at Kings Mill Hospital to inform them that some papers were records belonging to Sherwood Forest Hospitals Trust. At this stage, the information Governance Team were informed. The member of the public agreed to contact the Patient Experience Team with the details of the employee who would collect these from him. This was forwarded to the Information Governance Team and contact was made to collect the paper work. These were retrieved from Ashfield District Council by the Information Governance Manager. Ashfield District Council called to identify employee involved. The records retrieved were 6 consultant continuation sheets for one deceased individual, dated from 2010. Paperwork that was found alongside the continuation sheets identifies an employee that no longer works for the Trust. The Enforcement Officer for Ashfield District Council will invite the identified ex-employee to interview under caution. We have asked the Enforcement Officer to relay to the ex-employee that the records have been returned to the Trust and that we will be conducting our own internal investigation.	Photocopies of 6 continuation sheets for a patient with demographic details. These relate to the period in which the patient deceased.

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				The initial risks were assessed as: Deceased individual's confidential information fly tipped in a public area. Could attract media interest. Relatives of the deceased could become distressed when informed of the incident. From initial review of the incident it seems that procedure was not followed by a member of staff with regards to handling and disposal of confidential information.	
IGI/3849	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	22-Jul-16	Approx. 1200	An agency member of staff sent confidential staff information from her nhs.net account to her personal email address on 3 occasions The three emails pertained to establishment data re over 800 staff (staff name, payroll number and overall salary costing); doctor recharges (name, recharge rate); and SLA details re the calculation of University support posts (consultants name and amount of recharge). Precise details are being ascertained as part of the investigation.	Trust financial information - three emails including data re over 800 staff (staff name, payroll number and overall salary costing) from a Clinical Group; doctor recharges (name, recharge rate) for a second Clinical Group; and SLA details re the calculation of University support posts (consultant names and amount of recharge).
IGI/4435	MARIE CURIE (LONDON)	01-Jul-16	one	Member of admin staff forwarded a referral form to a member of staff at Cardiff and the Vale University Health Board palliative care team. Referral form	Sensitive information

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				already contained details of a previous referral. Helper Service Manager made aware by the person who had received the referral form.	
IGI/3816	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	06-Sep-16	21	Ward handover sheet picked up by member of the public (ward visitor) and removed it from Trust premises without authorisation or knowledge of staff before returning it on a different date. The ward handover sheet was accidently dropped by a member of staff. It contained the names, ages and clinical information for 21 patients on the ward. No members of staff were made aware this had been removed until the member of the public spoke to an off-duty employee offsite in a Public House. At this point they were asked to return it and explained the severity of their actions but refused to return it. The member off staff passed this information to the Ward leader who then spoke directly to the member of the public who then returned the sheet and apologised.	Ward handover sheet contained the names, ages and clinical information for 21 patients on the ward.
IGI/3788	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	06-Sep-16	58	Nottinghamshire County Council requested anonymised employment information regarding SFH Sexual Health Services staff to facilitate TUPE bidders from SFH Workforce Information Manager. HR Business Partner advised member of staff, Interim Workforce Manager, the Council were not entitled to detailed information at this stage of the TUPE process as the tender had not gone out for bids; this detail should only be given to the provider who wins the contract. HR Business Partner advised employee to send only the grades of staff employed, FTE numbers,	Staff data, including full name, DOB, address, salary, age, gender

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				total salary costs and current vacancies. Interim Workforce Information Manager sent the Public Health Contract Manager and Performance Officer at Nottinghamshire County Council, a spread sheet which contained the required information, the spreadsheet consisted of 2 worksheets the first with Grades of staff, FTE, total salary costs and vacancies. The second sheet contained staff names, employee number, job title, annual salary, date of birth.	
IGI/3793	PENNINE CARE NHS FOUNDATION TRUST	05-Aug-16	2	Incident reported in relation to a confidential letter (from Healthy Minds counselling service), containing sensitive mental health information in relation to a counselling appointment, being sent to the GP practice where the patient worked - the letter was opened by a colleague and handed to the patient causing distress and embarrassment. The patient's GP is not at the practice where she works but is a practice in the same building. The same patient has since reported another incident with the same service where a text message was received by the patient from the service to attend an appointment with Healthy Minds. On attending the appointment, it was a group session not a 1-1 session that the patient had signed up for. On leaving the session she suffered from anxiety and had a panic attack, she later received a phone call from the service advising that the appointment she had attended was intended for her brother. There was someone she knew at the group session and this added to her distress.	NHS mental health data

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IGI/4434	MARIE CURIE (LONDON)	01-Jul-16	one	GP request for medication sent to wrong fax. Prescription list of meds sent to wrong doctor's surgery. Twice as the address for doctor on referral was wrong. Referral form had the GP address used in the original fax it is presumed information transferred from there to core documentation. Post it note then placed over address for GP on referral with new GP information.	Patient sensitive and identifiable information
IGI/4433	MARIE CURIE (LONDON)	01-Jul-16	16	Accidentally left handover sheet in room of patient whilst doing blood tests. Wife of patient noticed this and alerted ward manager who immediately notified me of incident. Details of up to 16 patients were left unattended.	Handover notes contain patient sensitive and patient identifiable information
IGI/4432	MARIE CURIE (LONDON)	01-Jul-16	one person	Email sent from the Referral Centre to Nursing Healthcare Assistant mailbox from Referral Centre by mistake. The email contained personal details about a Nurse and information relating to her health issues as a result of a visit. User concerned mistakenly selected the incorrect mailbox.	Sensitive data
IGI/4431	MARIE CURIE (LONDON)	01-Jul-16	one	It was been brought to the attention of service manager from outside source that there was information online published by volunteer regarding her client. There has confidential patient information posted on a video clip on YouTube, on twitter, Facebook and personal website; which included patient diagnosis, patient name, patients living situation and clear reference to volunteer being a Marie Curie Helper (volunteer).	Patient sensitive data
IGI/5164	THE ROYAL WOLVERHAMPTON NHS TRUST	26-Aug-16	6 patient's data were accessed	It was alleged that a member of the admin team in the Education Dept. had accessed computerised patient records for another member of staff	An IT audit of the individual's access over the previous 12 months was obtained; this

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				An investigation was made, and audits were requested which showed that other records (including her own family's records) had also been viewed. The information access was mainly around appointment details The audit of the individual's access over the previous 12 months showed that other records of various individuals. An on-going investigation is currently being undertaken in line with the Trust Disciplinary Policy	showed that five other records of various individuals had been accessed (in addition to the records of the original member of staff): 1. The member of staff's partner 2. The member of staff's daughter 3. The member of staff's son 4. A colleague of the member of staff 5. A relative (now deceased) of a different colleague of the member of staff The information access was mainly around appointment details.
IGI/4430	MARIE CURIE (LONDON)	01-Jul-16	3	As part of a disclosure process during an employment tribunal claim, the claimant, an ex-employee of Marie Curie, disclosed papers which she had in her possession and these papers included details of three patients who had previously received care at a Marie Curie Hospice. As part of a disclosure process during an employment tribunal claim, the claimant, an ex-employee of Marie Curie, disclosed papers which she had in her possession and these papers included details of three patients	Patient identifiable information

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				who had previously received care at a Marie Curie Hospice The staff member concerned, an ex-employee, lodged an Employment Tribunal claim and as part of that claim, she disclosed papers containing patient data. It was evident that the claimant had sent some work emails to her personal email account or, had taken these work emails home.	
IGI/4429	MARIE CURIE (LONDON)	01-Jul-16	7 or 8	The printer in question is at the top of the day therapy stairs outside a staff member's office so not a public thoroughfare. There were several documents that could have come from several sources, so we could not identify one person.	Confidential patient information
IGI/4427	MARIE CURIE (LONDON)	01-Jul-16	1	A Marie Curie Nurse kept patient information (records) on her Marie Curie mobile telephone and then printed a copy at home. In the managed care service in Carmarthenshire Marie Curie Nurses and Healthcare Assistants write their patient notes and use their Marie Curie mobile phones to photograph the notes and send to the managed care Senior Nurse who then uses the record to inform her decisions around further patient / staff allocations, actions that need to be taken in relation to the patient. This ensures that prompt action can be taken by the SN (especially relevant for night staff who finish their shift at 0700). There is a patient name on the sheet, hence the process that once the photo is sent it must be deleted from the phone immediately. This process was agreed within Marie Curie when setting up the Managed care service in Neath Port Talbot, therefore with agreement from Carmarthenshire Health Board the same process is	Patient notes

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				used. On this occasion, the nurse concerned raised an incident about a back injury she claims occurred at work. It came to light that she had kept a copy of the report on her phone and printed a copy at home when she submitted it to support the statement that she sent following her back injury. We have no evidence to suggest that this has happened before.	
IGI/5575	UK RENAL REGISTRY	02-Aug-16	55,000	Patient identifiable data, namely date of birth has bee European Renal Association/European Dialysis and T Association (ERA-EDTA) and date of birth and/or pos given to four academic/NHS researchers without a leg doing so. At the time, we believed our s251 approval legal basis for sending the data The UK Renal Registry (UKRR) sends data annually to the ERA-EDTA to enable studies on the epidemiology and demography of renal diseases across Europe as well as studies on renal diseases and their treatment outcomes. The UKRR has also shared PID data on four occasions with	NHS patient data, namely ethnicity, gender, date of birth and/or post code

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				academic/NHS researchers The UKRR believed it had a legal basis for sharing this data with the ERA-EDTA and the researchers at the time. Following an internal review of governance procedures and discussions with the Confidentiality Advisory Group, we revisited in depth our data sharing history and identified these breaches as it became apparent the legal basis for sharing the data was not explicit and therefore did not exist. No patient names, NHS numbers or non-postcode address information has been released. While the released data is classed as patient identifiable it would not be possible to identify the patient from this information alone (date of birth and/or post code).	