Information Governance Incidents closed during 1st. October to 31st. December 2016

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Information and technology
for better health and care

Contents

Introduction

This is the fourteenth published report of closed level 2[1] Information Governance Serious Incidents Requiring Investigation (IG SIRIs) recorded on the IG Toolkit Incident Reporting Tool. This type of report will be published on a quarterly basis as specified in the IG SIRI Publication Statement[2]. It covers IG SIRI level 2 incidents closed during the period of 1st.October to 31st. December 2016, following investigation by the local organisation(s) concerned.

Content of the report

The report below consists of **35 closed incidents** reported to the Information Commissioner's Office (ICO), Department of Health (DH) and NHS England (NHSE) by Health or Adult Social Care organisations or suppliers (as advised within the IG SIRI Guidance issued 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[3]. In Appendix A are **87 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 the Health and Social Care Information Centre (HSCIC) but are useful for gathering intelligence, analysing trends and learning from previous occurrences. Details of such incidents are held by the local organisations.

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

Next reports

The next closed level 2 IG SIRI report to be published will cover the period 1st January to 31st.·March 2017.

Closed level 2 incidents reported during 1st. October to 31st. December 2016

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/6731	Marie Curie (London)	13-Dec-16	one	A Marie Curie Nurse A reported that she found another Marie Curie Nurse B's diary with patient details in the patient's home last night. The patient's wife noticed the diary had been left behind and handed it to the nurse the following night. The patient's wife had noticed the diary shortly before arrival of Nurse A and the patient's wife said that she had noticed it was a list of appointments with her husband's name. Nurse A put the diary in her bag and took it home with her, informed her line manager and returned it to her line manager. Nurse B had attended the same patient the night before. The diary left in the patient's home belongs to Nurse B. The diary contains patient identifiable information including the patient names, addresses, telephone numbers, details of NoK, Do Not Attempt Resuscitation (DNAR) status and one key safe code. There were no other visitors to the patient's home before Nurse A's visit when the diary was retrieved.	A paper diary containing patient identifiable information
IGI/6801	EAST LANCASHIRE HOSPITALS NHS TRUST	20-Dec-16	5	ENT handover sheet found on stairwell outside ENT ward. Dropped by doctor and found by a member of staff within 20 minutes of being dropped. Contained 5 patients name, Hosp number, DoB, Diagnosis, limited history, investigation details and brief treatment plans. the sheet was secured and handed to the Assistant Director of Nursing. The handover	Contained 5 patients name, Hosp number, DoB, Diagnosis and limited history, investigation details and brief treatment plans.

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				sheet had the name of the doctor and ward on the sheet. the incident was reported and escalated to the Deputy Director of Nursing, Divisional director of Nursing, Divisional Quality and Safety lead and Information Governance department. Additionally the Caldicott Guardian and Deputy SIRO were informed. Note; there was a local discussion on the extent to which the information was at risk of a information breach. The consensus was that the risk for this incident was minimal as the note was found very soon after being dropped. The Trust decided to report as a level 2 as there had already been an incident of dropped handover sheet within this financial year for the Trust. Also to emphasize how seriously it views information security.	
IGI/6661	LONDON NORTH WEST HEALTHCARE NHS TRUST	07-Dec-16	34	Patient handover sheets found this morning caught in the wooden fence on the path between the hospital and Northwick Park tube station. Unable to identify which specialty this list relates to (since found out - Endocrine) This list contains details for 34 patients (attached to this incident report), including names, hospital numbers, diagnosis and clinical information and jobs to be done / followed up.	Data included: Name, Hospital Numbers, diagnosis and other medical information.
IGI/6670	NATIONAL CENTRE FOR YOUNG PEOPLE	23-Dec-16	27	Instead of downloading only Student A's safeguarding report all reports were downloaded and emailed to Student A's social workers and the Surrey Safeguarding team (our Local Authority).	Safeguarding incident reports:- * 6 concerned medication issues

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	WITH EPILEPSY (NMY)			The reports included references to 27 students either as participants, victims or bystanders/witnesses. Once the error was realised (within 24 hours) the recipients were contacted and asked to delete the email from their systems. All have confirmed that they have done so.	* 6 were written as a result of bruises being found * 10 concerned behaviour that had possible safeguarding implications * 3 resulted from student disclosures
IGI/6655	HINCHINGBROOKE HEALTH CARE NHS TRUST	29-Dec-16	Not Known	A community cancer nurse had parked her car in a GP Surgery car park. She had left a bag containing a Trust-issued laptop, her work diary and some paperwork for new referrals which held patient identifiable information on it under the passenger seat of her car. When she returned to the car she found that the passenger window had been smashed by a concrete block and the bag had been stolen. Nothing else had been taken from the car. The police were called and a crime number issued. There is no CCTV covering the Doctor's surgery or the car park. The patients whose details were contained in the new referral paperwork have been contacted under the Duty of Candour process.	There was identifiable information relating to 8 new patients on paperwork in the bag, this included patient name, DOB and NHS No. As yet, the content of the diary is not known but is likely to have contained some identifiable information but predominantly would be just names of patients and possibly some telephone numbers. The laptop that was taken was encrypted by Trust security and our IT department assure us

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					that the information is not as risk.
IGI/6730	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	22-Dec-16	1 Letter	Neighbour brought letter back to service as appointment was next day. Intended recipient informed and reported to be upset and annoyed by the incident. ICO case reference allocated: redacted	1 patient letter sent from a community mental health service, which would identify the intended recipient as a user of those services.
IGI/6819	Forest Group Practice (D83062)	15-Dec-16	1	Full medical records sent to the incorrect solicitor in error. Records sent by recorded delivery. Solicitor became aware of error when they searched the patients name and couldn't match to any of their clients. They then returned the records to us.	patients full GP medical record
IGI/6644	Marie Curie (London)	17-Nov-16	one email	This is an incident at the Hampstead hospice. Consultation notes for nine patients were dictated by the Medical Director and emailed to an admin assistant to type up. The consultation dictation was sent as an email attachment. It came to light on that the admin assistant had not received the email and on further investigation it was discovered that the email and attachment had been sent to an external recipient.	Personal and sensitive patient information was included as part of the consultation notes.
IGI/6527	CITY OF YORK COUNCIL	23-Nov-16	4	Paper report was found on a printer by staff member. Printer located in one of the office's hubs located within a secure floor level within a secure building. There is no evidence of disclosure within/ outside the Council, therefore, risk is judged to be low.	Person identifiable information relating to the description and opinion of an adult's mental capacity for the purposes of a care needs assessment. The

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					information would be classed as personal data, and sensitive personal data, some of which relates to the person's health and care. It also includes biographical information about the person's daily life and also biographical information about three family members. A charity worker's opinion and the GP's opinion is present also, some of which also relates to one of the family members.
IGI/6547	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	24-Nov-16	1 patient record	Member of staff in the Personality Disorder Care Pathway team admitted to inappropriately accessing her brother's record on the Trust EPR system after being told by him he was entering the service as a patient Manager informed, HR processes started, fact-find done. Disciplinary action to be taken. Duty of Candour to be considered re. informing patient.	Electronic patient record on the Trust EPR system. Patient data is stored on a secure system with users having individual log-on credentials, however this incident constituted an abuse of privilege, with the access outside of a legitimate relationship.

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IGI/6517	Northamptonshire County Council	25-Oct-16	5,207	2 Emails sent with password protected spreadsheets. Passwords sent separately. However, Emails should have been sent encrypted.	Information included names, address and DOB relating to items of equipment (commodes, zimmer frames, pressure care items etc) that customers were in receipt of, or maintenance or servicing of equipment.
IGI/6631	PENNINE CARE NHS FOUNDATION TRUST	02-Dec-16	1	Clinician dictated a child's adhd assessment for typing. Incorrect school address inputted. Child's assessment was sent to the wrong school and opened by the SENCO.	The adhd assessment contained the child's name, address, dob, nhs number, information about the child's current areas of need and plan for input
IGI/6567	Mears Care Limited (part of Mears Group PLC)	01-Nov-16	207	Letters meant for staff members were accidently packaged in envelopes meant for service users. The staffing letter contained names of all carers employed by Mears, pay initiatives for staff who offer to pick up and training dates offered to staff. Staff realised and repackaged the correct envelopes but unfortunately some letters were missed, and these letters were then sent to Service Users. The letters contained 176 staff full names but no other personal data - therefore a low level impact of data. The letters went to 30 Service Users. The letter caused worry and concern to a small number of Service Users.	Staff personal data (full name) - no other identifiers Pay policy information (not specific to individuals) Information sent to Service Users

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IGI/6497	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	03-Nov-16	1	The information was in relation to a Medical staffing hearing. Hearing documentation was sent to the panel members which included an external rep and BMA rep. The documentation sent included an appendix which contained patient identifiable information: first names, NHS number, case notes, mental health status, address and date of birth. Information was sent from NHS trust email to other NHS accounts plus the external rep's personal email account.	An appendix sent via email
IGI/6471	THE ONE HEALTH GROUP LTD	18-Oct-16	Estimated at 200	The shredding bag contained person identifiable data items. Telephone interview undertaken with Royal Mail Sorting Office manager - they confirmed that blue shredding bag had been brought to their attention but declined to comment on how they believed the bag had been arrived at the Sorting Office. The Manager confirmed their actions of opening the bag and forwarding on all contents to Bolton NHS Trust	NHS patient data. Medico legal case notes.
IGI/6465	Sirona Care & Health	21-Nov-16	One	Sirona contacted by Mendip Council stating that a set of health visitor notes from Paulton Hospital had been discovered as part of a fly tipping investigation. Notes have not been returned to Sirona as Mendip Council insisted on retaining them as part of their investigation. Not clear how notes came to be fly tipped but possible that they were in a filing cabinet that was removed by third party organisation. Cabinets were	Set of health visitor notes

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				checked before removal by local staff to ensure they were empty. Service lead to call individual involved tomorrow morning to inform and apologise. IG lead reporting this to meet requirements but currently abroad on leave for another 10 days.	
IGI/6472	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	07-Nov-16	1	The sheet contained details of 12 patients and their current status within the unit. This included any injuries, health issues, medication. It was found by a GP who then returned it to the ICU, it is believed to have been dropped by a Trust Pharmacist.	12 individuals - Current status including other health factors, medication being taken,
IGI/6573	EAST LANCASHIRE HOSPITALS NHS TRUST	26-Oct-16	26 pages	An out of area GP Secretary emailed a referral which had the patient's complete GP history and treatment to the booking office at ELHT. The booking clerk forwarded the email and attachment to 3 mailboxes as they didn't deal with making these appointments. This resulted in around 130 staff members receiving this information when they didn't have the need/ right to see the patient sensitive information. The patient is a senior manager in HR employed by the Trust.	Complete GP history containing personal sensitive information from1984 to 2016
IGI/6416	Long Furlong Medical Centre	27-Oct-16	1	Patient summary sent by Royal Mail to the incorrect address. Additional information e.g. a brief patient medical summary was requested following referral to the Pulmonary Rehab Team and posted. Letter was	NHS patient data including brief medical summary.

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				incorrectly addressed as above. Resident at incorrect address opened letter and reported to the Practice. Risk: patient details and medical summary made available to member of the public. Security measures i.e. NHS mail should have been used to forward information.	
IGI/6446	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	30-Dec-16	6368	Two incidents occurred: Incident 1 - NEW Devon CCG. An email with patient identifiable data in two files was sent to three email accounts when it should have gone to just the secure business intelligence account email. One other recipient was a manager at NEW Devon CCG who informed us of the breach within 20 minutes of the email having been sent. The third recipient shared the same name as another contact at NEW Devon CCG but works at Devon Partnership Trust. The NEW Devon CCG contacts would usually just receive a high level summary contract position without any patient level data. The email should have gone to redacted@nhs.net alone. Incident 2 - North Somerset CCG An email with patient identifiable data in two files was sent to two email accounts when it should have gone to just the secure business intelligence	NHS Patient Data

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				account email. The other email was sent to the main Commissioning Support Unit accountant dealing with our North Somerset contract. The accountant should receive the summary contract information without any patient level data.	
IGI/6400	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	15-Nov-16	18	Hand over list containing the medical summary for 18 patients was found by a patients family member on the bench in the hospital's garden (located outside the hospital wing). The family member handed the information to members of staff. The list was lost and found on the same day.	names and NHS Numbers of patients along with their dates of birth, reasons for admission, relevant past medical history and other clinical information.
IGI/6380	NHS West Cheshire CCG	22-Dec-16	157	An email was sent to Head of Communication and Engagement and Communication and Engagement Manager (from the Engagement and Involvement Manager at a neighbouring Clinical Commissioning group) highlighted that they had reviewed the link and had noticed that the appendix section of the consultation report contained a combination of names, addresses, telephone contact details and email addresses of 157 respondents. Having reviewed email communication with Midlands and Lancashire Commissioning Support Unit regarding the submission of the final report it has been found that the personal details of some of the respondents were added to the appendix of consultation report without request and after final comments had been provided by the Head of	No Sensitive Personal Information, however, the data is personal information: Names, addresses, email address or contact telephone number

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				Communications and Engagement. The assessment of the incident is that personal data has been uploaded to the Clinical Commissioning Group's website in error. The Communication and Engagement team failed to identify that this information had been included in the appendix of the independent consultation outcome report by Midlands and Lancashire Commissioning Support Unit.	
IGI/6368	THE ROTHERHAM NHS FOUNDATION TRUST	05-Dec-16	Approximately 19	A clinician assigned to the Trust left a bag containing personal items (phone/cards) and clinical information, namely ward handover sheets detailing approximately 19 patient on the seat of his car while visiting a relative at another hospital. The car was broken into (crime reference available) and the bag stolen. The handover sheets and other information were found in a street nearby by a nurse on her way to work who recognised the paperwork as being clinical. The nurse and a colleague retrieved as much of the paperwork as they could find and completed an incident report on their own system. They then forwarded the report to ourselves for investigation into the incident.	Paediatric patients named on ward handover sheets detailing first name/surname, age, DOB, local identifier, situation background, assessment/management and recommendations. Internal door codes.
IGI/6386	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	13-Dec-16	12	Patient list print out lost during home and nursing home visit, list contains patients name, address, contact details, NHS no, condition/medication	patients name, address, contact details, NHS no, condition/medication (1 A4 sheet)
IGI/6394	EMIS Care trading as Medical Imaging UK Ltd	27-Dec-16	Between 10 and 100	Mobilisation of new office building - shredex facility on order. Confidential waste kept in cardboard receptacle and	Scrap notes, and also potentially GP referrals to the DESP / opt outs /

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				locked away at night. Staff failed to lock confidential information away. New cleaner emptied a temporary confidential waste container into the general waste and disposed of the general waste in the dumpster. Incident was discovered, however the waste had already been removed by the council and taken to a secure landfill site.	medical exclusions / failsafe information (patient tracking information)
IGI/6384	PORTSMOUTH HOSPITALS NHS TRUST	06-Dec-16	1	Woman attended antenatal clinic for ultrasound. Two sets of notes in the room. Wrong set of notes picked up by sonographer and given to the woman. The woman then took them home. Discovered when second set of notes did not match the other woman. Similar incident recorded in this department in August.	Name Address, DOB NHS number Hospital number Full complete medical record
IGI/6351	CARE UK Ltd	14-Dec-16	43	A file belonging to Doctor who works at the Care UK Suffolk OOH, containing patient identifiable documents was found in the Ipswich Hospital carpark by a member of the public who handed the file to staff members on the oncology ward of the hospital who handed it back to the Care UK Suffolk OOH which is located on the same Ipswich hospital premises. The doctor had finished his shift and the file was found approx. 2.30 hours later. The File contained a mixture of the Doctor's rough notes on several patients, some patients paper records from the Adastra system. The number of instances of patient names counted so far is 43 and	NHS Patient notes (Adastra System patient notes and Doctors own handwritten case notes)

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				investigations are ongoing to determine the type of information that was found for each patient.	
IGI/6310	The Witham Practice (C83652)	09-Dec-16	1	Letter sent as urgent referral by fax from redacted (Witham Practice to redacted (psychiatry) by Administration member. No proof of fax sent. redacted secretary state was marked as received on May 2015. There was a follow up fax in June- marked as received by redacted secretary. Patient's Girlfriend's Mother has managed to get hold of a copy of clinic letter Pt read this letter to me over the phone- word for word correct. Pt states she has never had a copy of clinic letter/referral letter printed out- no chance this was taken from her home. Girlfriend Mother has taken photo of this letter and sent it as a message to her daughter on facebook messenger. She has allegedely taken photo around to neighobours and friends. Pt moved out of area as allegedely being called names. Mother would not disclose where this information was received from.	Data was containing highly sensitive information reagarding patient psychiatry condition. Has resulted in harm as patient is being verbally victiimised as a result- ie being called a 'pscyho Freak'. Moved out of area- currently unstable mental health and unde Crisis team
IGI/6276	YORKSHIRE AMBULANCE	22-Nov-16	1439	1. The incident took place in August 2016. 2. The information affected was a section of the monthly copy payslip (electronic) for August 2016.	The data fields are listed above.

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	SERVICE NHS TRUST			3. It contained these fields: 3.1 Employee name, Work location address and department, Assignment/Employee No, Job Title, Payscale, Salary/wage, Increment date, Hours worked, PT Salary/wage, Tax Code, NI Number. 3.2.1 Pay and allowances: Basic pay (per week), Amount of basic pay per week paid/due, Hourly rate, Amount. 3.2.2 And depending on the individual circumstances of the employee, any of the following data may have appeared: Occupational Sick Pay, Occupational Maternity Pay, Statutory Sick Pay, Statutory Adoption Pay, Paternity Pay, Overtime, Additional hours payment, Annual leave, Mileage, Meal allowance, Unsocial on call, WTD. 3.3 Deductions: PAYE, NI, NHS Pension, Lease Car, Union subs, Car fines, club memberships, court orders, student loan, CSA. 3.4 Year To Date Balances (this employment only): Gross pay (to date), Taxable Pay, NI Letter, Tax paid, NI Pay, NI Contributions, Other NI Pay, Other NI Contributions, Previous Taxable Pay, Previous Tax Paid, Pensionable Pay, Pension Contributions, SD Ref Number (Pension reference), Employee no. 3.5 This period only: Pensionable Pay, Taxable Pay, Tax Paid, Non-Taxable Pay, Frequency (of salary payment), Total payments, Period End date, Total Deductions, Pay Date, Pay method, Net Pay. 4. The security measure in place is a requirement that where an individual who no longer works for the	

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				Yorkshire Ambulance Service, and makes a request for a copy of their pay slip, it is printed and posted to their current home address. 5. The incident occurred because a payroll officer wanted to immediately satisfy a query from a former colleague. The officer thought he was copying a specific copy pay slip, but copied a batch, which he then sent by email. 6. The risk in respect of this incident is interception of unencrypted data, which could be used for identify theft.	
IGI/6255	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	05-Dec-16	4	Upon review, it is has been confirmed that the offending materials had actually been mis-filed in the patient's medical record. Hence, the reason they have been copied as part of processing the SAR.	Data presented in paper form: Patient 1 - Name, DOB and Hospital Number - Fluid Balance Sheets x 2 Patient 1 - Name, DOB and Hospital Number - Observation Sheet x 1 Patient 2 - Name, DOB and Hospital Number - Observation Sheet x 1 Patient 3 - Name, DOB, Address, NHS Number, Hospital Number - Medicine Record Card x 1 Patient 4 - Name, DOB

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					and Hospital Number - Observation Sheet x 1
IGI/6243	7 MANOR BUILDINGS (V07821)	05-Dec-16	not known	member of staff checked garage to ensure locked found it unlocked with patients records inside	patients treatment records x-rays
IGI/6175	North Cumbria University Hospitals NHS Trust	22-Nov-16	47	The SOP contained an appendix with a table containing 47 patient's information, comprising the following data items: • Patient name • Patient Date of Birth • Hospital Number • Imaging Request Date • Histology request reference • Tumour Site • Consultant • 62 Day target date	• Patient name • Patient Date of Birth • Hospital Number • Imaging Request Date • Histology request reference • Tumour Site • Consultant • 62 Day target date
IGI/6257	Rotherham Doncaster and South Humber NHS Foundation Trust	05-Dec-16	1	The Incident was reported by a member of the pharmacy team who whilst undertaking a visit to the building to check on the progression of the building work found the file on the windowsill in the reception area. This file had not been seen on previous visits to the building. The Information Governance Manager was informed immediately and the file recovered. Concern was raised due to the content of the file and that potentially the contents exposed to external contractors. It is Trust protocol that when a building is vacated a data sweep takes place to ensure that nothing is left within the building. The Estates Manager and the Trust Security Advisor undertook the data sweep and confirm that nothing	Name, DOB, NHS Number, Mental Health Inforamtion, Religious information.

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				was left in the building it was completly empty as the builders were going to be knocking walls down. There had been 5 different contactors working on the building and on speaking to them they have all initially stated that they never saw the file apart from the contractor who was in the building when the pharmacy team visited on the 8th. It has been identified that the file was created as part of an investigation and was a copy file produced for reference. This file was last known to be held in a filing room in another building. The IG Manager will be investigating this and will try to acertain how this file ended up in an empty building.	
IGI/6005	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	23-Nov-16	65	A folder of patient information was found in a local park by a member of staff on their way home. The paper was scattered over the road and park as it was not secured in the folder and had not been transported in a Trust approved device. The staff member carried out a search of the park which was repeated by the team in question the following day- some further information was found.	Data was mental health related containing: • Medication (T) Card for 10 patients 'THESE WERE THE ONLY RECORDS THAT SHOULD HAVE BEEN BEING CARRIED. • Case Load Prints dating back to 2015: x2 (approx. 40 patients) • Health & Social Care Assessment for 1 patient • Handwritten notes x3 (re 22 patients) • RiO demographic

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					screen for 1 patient • Ward discharge summary (acute) for 1 patient • PCT MH Comprehensive Care Plan for 2 patients • MIND Referral for 1 patient • RiO Progress Notes for 1 patient • Couple of personal bits for the staff member
IGI/5990	Central London Community Healthcare NHS Trust	23-Nov-16	1	The Nurse was doing a joint visit with the Community Matron to see a patient with complex needs. The Matron and the Nurse agreed that they will assess the patient using his equipment. The Nurse left their work bag in the boot of their car, it was parked on the opposite side of the road from where the patient lived. 45 minutes later when they returned to the car they had noted that the passenger side of the window was smashed and the top cover for the boot of the car was on the floor by the back seat. The work bag was stolen which included 1 patient's referral form, SMART card, equipment, dressings, 2 prescription pads, trust phone and a small book that contained the GP's surgery and District Nurses telephone numbers. An eye witness informed the nurses that 2 men	NHS patient data: name, dob, address, reason for referral

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				broke into her car and took a black bag from the car. Later another eye witness approached the Nurse and the Clinical Lead and confirmed this.	

Appendix A

Incidents closed using the 'auto closure[4]' facility 1st. October to 31st. December 2016

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
IGI/6402	Ramsay Healthcare UK Operations Ltd	05-Dec-16	1	Patient informed us they are in receipt of another patient's MRI images on CD. Patient collected CD from hospital and was provided with password to encrypted CD as it was believed to be their images. Reporting patient intends to return the cd to us ASAP. Patient affected has been notified via telephone conversation that their images have been given to another patient in error. Investigation revealed that the process in place regarding release of medical information was not followed by Radiology staff and the cd was handed to the patient without being checked and signed as released by the staff member - form evidencing this given to Matron. Radiology team informed of the issue and importance of thoroughness. Issue promulgated at staff meetings. Usual process involves request signature from patient, signature from patient to confirm receipt, and signature of releasing staff member. The form has been incorrectly filled in and not signed by the staff member distributing.	Patient identifiable information with radiology image on an encrypted CD, given to incorrect patient with the password

[4] 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	Incident Details	Data
IGI/6375	PENNINE CARE NHS FOUNDATION TRUST	21-Dec-16	5	A letter to the parents of a CAMHs patient was cc'd to the parents of another child. The other child's name and address was included in the cc part of the letter. The letter contained the presenting issues of the child - anxiety, the current functioning, the risk of child self-harming - the school the child attends. The person that received the letter (the parent of another child) opened it and saw the contents.	A letter containing demographic information and clinical information
IGI/6382	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	22-Dec-16	4	We received a phone call from a member of the public saying that they had been called by a member of staff from the hospital (who she believed to be her niece as there are family issues ongoing) asking for the date of births of her children. When questioned on this, the staff member hung up.	Apprentice had access to the Patient Administration System which would have all demographics details, appointment and speciality details, GP details.
IGI/6410	NHS Wokingham CCG	30-Dec-16	1	A nurse assessor from Continuing HealthCare (CHC) was having difficulties accessing email from home. When she went to work the next day the service desk repaired her email which released the waiting emails one of which was sent to all members of staff at the CCG HQ. The email contained : patient name, DoB, address, NHS number, Medical information. This was recalled by the originator but was already seen by other members of staff. Another email was sent out asking users to delete this email. It was reported to IG by both the originator of the breach and another member of staff. The breach was contained within the CCG. A meeting was arranged for Friday between, IG manager,	Name, Date of Birth, Address, NHS number, Medical information

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				CCG Governance, Head of CHC and the nurse assessor. The assessor was not available before then. At the meeting the breach was explained. The patient is non-cognitive so it was agreed to look in to contacting a representative. It was agreed that Access to email lists would be restricted A log of the incident from the Service desk would be obtained. A report would be made to the Service Desk.	
IGI/6374	STOKE-ON-TRENT CITY COUNCIL	12-Oct-16	2	A complaint response relating to home care commissioned by the Council has been posted to the incorrect address. The name on the letter was that of the intended recipient; however the recipient still opened the letter. Sensitive personal information was contained within the complaint letter relating to a relative of the intended recipient. The letter also states where the intended recipient's relative now resides.	A complaint response relating to home care commissioned by the Council has been posted to the incorrect address. The name on the letter was that of the intended recipient; however the recipient still opened the letter. Sensitive personal information was contained within the complaint letter relating to a relative of the intended recipient. The letter also states where the intended

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					recipient's relative now resides.
IGI/6639	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	02-Dec-16	1	Patient A sent an email to the Subject Access Team stating that she had received the incorrect records and upon confirmation would destroy the document. On receipt of the email a staff member confirmed to the patient to destroy the document. The breach was not reported to anyone in the Management Team. Patient A raised a formal complaint to the Trust Complaints office by email and included the Subject Access Team into the email. This was the first time management were made aware of the incident. The member of staff concerned was spoken to and an investigation into the incident was started.	1 neurophysiology EEG report
IGI/6405	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	28-Nov-16	1 Letter	Letter sent to patient following clinic attendance, with detailed clinical history etc., sent to wrong postal address - no. 96 instead of 95.	Post-clinic letter detailing medical history, presenting condition, treatment, progress etc.
IGI/6335	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	13-Dec-16	1	I was on discharge lounge working with staff nurse. When I was printing Patient Discharge medication list called AVS for a patient, staff nurse came and asked me to reprint AVs for another patient so I clicked Print and gave my batch to staff nurse to collect it from the printer, which is based on the other side of the ward. Staff nurse stapled all together and gave it to me I checked the name of the Patient and gave it to his wife who came to collect it	Discharge letter

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IGI/6314	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	09-Dec-16	1	An additional patient's discharge information has been stapled to the back of another patient's notes. Incident only realised once the patient arrived home.	discharge letter
IGI/6364	EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	12-Dec-16	One	Four Emergency Operations Centre staff have unnecessarily accessed patient emergency calls without any cause to do so and have breached patient confidentiality and the confidentiality clause in their employment contract.	Four Emergency Operations Centre staff has unnecessarily accessed the 999 emergency calls of an employee without reason to do so. These calls hold sensitive personal information about the employee which could cause them distress, embarrassment and detriment.
IGI/6274	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	06-Dec-16	625	UCLH has a collaboration agreement and data sharing agreement in place with Google DeepMind for the transfer of anonymised images for research purposes. In this incident an email was sent to Google with a list of 625 patients whose data would be used for the project along with their hospital numbers, initials of the patient's oncologist, date plan needed to be ready by and the initials of staff who planned and checked the radiotherapy plan. The names of the patients should not have been	625 patient names with their hospital numbers, initials of the patient's oncologist, date plan needed to be ready by and the initials of staff who planned and checked the radiotherapy plan.

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				shared. DeepMind identified the error, notified UCLH and deleted the email.	
IGI/6361	LANCASHIRE CARE NHS FOUNDATION TRUST	19-Dec-16	Several pages	The letter relating to redacted that was sent to redacted was regarding her dismissal from the Trust on the grounds of capability due to ill health. Stuck to redacted letter was a sticky note with redacted telephone number, redacted had access to this. This has come to light following an email from redacted to his Manager, redacted. redacted has stated in his email that he has spoken to MW and has informed her of the breach. He also states that he has sent a copy of redacted letter to his 'legal chappie'. redacted has submitted a complaint to the Trust about the data protection breach.	Basic Demographic detail Detailed sensitive and confidential information about the member of staff's dismissal due to grounds of capability and ill health
IGI/6478	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	24-Nov-16	61	Emails contained the following patient data: Name DOB NHS Number Hospital Number Laboratory Results Request to List Patient Notification to add patient to Transplant List The first email was sent in error on, 8 emails in total were sent. The recipient of the emails did not notify the Trust until later in the month. The sender sent the emails to an individual with the same name, they did not realise it was an individual at a GP Surgery in Durham they though the	Emails contained the following patient data: Name DOB NHS Number Hospital Number Laboratory Results Request to List Patient Notification to add patient to Transplant List

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				recipient was a member of staff at LTHTR. The emails were sent from an NHS.Net to another NHS.Net Account.	
IGI/6256	University Hospitals Bristol NHS Foundation Trust	01-Dec-16	1 sheet of paper	A patient was inadvertently handed a copy of a clinic list that had become attached to their appointment letter in error during an administration process.	Clinic list contained: patient names, DOB, NHS numbers, and Trust numbers. There were no clinical details or addresses on the sheet. The document did not contain any clinical details or patient addresses. The exact date fields on the sheet are as follows: Patient Name Date of Birth Hospital ID NHS No Alerts Appointment Time Duration Type Transport
IGI/6251	DENTAL SURGERY (V06737)	07-Dec-16	49 paper records	Patient records of the practice have been found by a member of the public in disused cabinets that had been left outside the practice for removal by local scrap business. Cabinet drawers had been cleared and emptied of all patient records before they were left outside the	Patient records of the practice which includes, medical histories, treatment

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				practice for removal. 6 of the cabinets have been removed by local scrap men and the member of public took the one remaining cabinet for their own personal use after asking the practice for permission to do so. Some weeks later upon dismantling the cabinet so it could be cleaned, patient records have been found in the back of the cabinet. These records had seemingly fallen out of the drawers and had become trapped in the back of the cabinet when in use. Member of the public contacted mydentist to advise of the records they had found. Member of public is stating they have "hundreds" of records. Currently completing an audit of all patient records held at practice to ascertain exact figure missing. Member of the public is currently refusing to return the records she holds to the practice as they feel they should be compensated for the return of the records within their possession, and has also stated that they will report this matter to the press if they are not compensated, and to the Information Commissioner's Office.	consent forms, and x-rays.
IGI/6677	Marie Curie (London)	16-Dec-16	one admin account	A user contacted the IT Service Desk to request a password reset to an NHS.net account. The password was changed. The user is not a member of the team that has authorised access to that account. When authorised users of the account tried to access the account they were unable as the password had been changed. The user who requested the password reset deleted several emails that contained confidential patient information.	The account contains emails about patients and includes confidential and sensitive information.
IGI/6245	NORTHUMBRIA HEALTHCARE NHS	10-Dec-16	1	HV Area Lead notified by Health Visitor that electronic clinical record had been accessed inappropriately	Clinical Record

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
	FOUNDATION TRUST				
IGI/6248	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	21-Oct-16	6	Unauthorised disclosure of six patients.	Waiting for the letters to be sent back to IG Manager from the surgery. Will know the sensitivity factors upon their receipt but likely to be health information
IGI/6273	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	1	Patients mother contacted PALS re a complaint about her daughter's care. As part of this complaint they also returned another patients information that they had been sent with the discharge letter.	Clinical letter
IGI/6228	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	1	Contacted by community midwife from East and North Herts following her visiting a lady who was discharged from Lady Mary ward with hers and another lady's documentation.	Maternity documentation
IGI/6300	Giffords Primary Care Centre (J83011)	08-Dec-16	1	Report requested Completed report posted to employer Report resent due to employer claiming they had not received it despite records being sent signed for. Notified from patient that we had breach confidentiality and data protection as he had not been given the chance to view the report. Informed MDU and asked for legal advice to recall paperwork. Phone call received from MDU advisor informing me that	NHS Patient data from the patients' medical record.

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				she had looked into the Access to medical Records Act and could not see that we had any legal grounds to recall the medical report back from the employer. However, if the employer was to rely on the report the patient Is likely to argue that they should not have had access to the report as it was not obtained by correct process. Phone call to patient's employer. Confirmation received that they will destroy the document and not use any of the information they have had access to when dealing with the patient's case. Meeting with patient at the surgery who read the report and declined for it to be sent.	
IGI/6269	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	10-Dec-16	1	Report from system shows inappropriate access to staff record	Patient Administration Data
IGI/6227	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	1	Patient contacted the ward as they had received another patients discharge letter.	Discharge letter
IGI/6211	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	1	The nurse discharged patient without checking the medication against the discharge letter. The nurse went to print discharge letter, swiped card and the printer said to "load paper." When the paper was loaded the printer started printing. The nurse assumed it was printing the documents that were sent to printer, however the Printer printed a previous job which was a discharge letter of another patient. The nurse assumed the discharge papers were the ones that were sent to printer and	Discharge letter

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				verbally explained the medication with the patient and patients husband, but did not check it against the discharge letter and go through all the discharge papers	
IGI/6306	KIMS Hospital Ltd	28-Nov-16	1	Patient was discharged from day surgery ward on a Friday. He contacted the hospital on the Monday as he had been given discharge paperwork for a different patient and did not have his own. Upon reporting this the governance administrator organised for his correct discharge paperwork to be sent to him by special delivery, so it would arrive on the Tuesday (2 copies of discharge summary and pain relief information). We have been trying to call the other patient to ascertain if she had received her own information but have not been successful to date.	Discharge summary containing patient's details, GP name and address, clinical information about treatment
IGI/6312	Elmtrees Surgery (E85112)	09-Dec-16	1	1. Mother of an adult patient approached the surgery for a private letter which appeared at the time to be from the patient. The letter was given to mother by a staff member. 2. It transpired at a later stage that the information had gone to the wrong hands only after patient denied any knowledge of the request or the letter given. 3. The mother was cross questioned and later admitted to trying to get the information fraudulently. 4. The surgery did investigate the whole process from the time of request to the letter being given and have done a report with recommendations and changes that they have implemented. One of which was to report the incident	letter confirming patient has not health issues
IGI/6194	Millview Surgery (C84106)	05-Dec-16	1	Patient was staying at the local women's refuge. She had moved there from her address due to fleeing an abusive	Confidential patient address

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				relationship. She moved to a permanent address in Mansfield. A letter was sent to the patient from the surgery regarding needing an appointment. The address on the letter was the correct address – redacted, but the receptionist printed a label for the envelope and unfortunately the address on that came up as her previous address. This meant the letter for patient got sent to her ex-partners address (the address she had fled from to the women's refuge). The address showing on our computer system says the new address, but on looking at the administration tree - address node - in system one the address history is showing that the current address is her previous address. Three different surgeries had changed the address on systemone including this surgery to the new address. Our IT co-ordinator has contacted HIS and they have said that the addresses on the PDS and the label trace are not matched on the system and that it might have been because three different surgeries were changing the addresses at the same time could have possibly messed it up.	

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IGI/6258	Prestwich Health Centre Practice No.3 (P83001)	05-Dec-16	189 patients, one detailed record	I (Practice Manager) was contacted by Head of Safeguarding in Bury, to alert us that a bag of paper waste which contained patient identifiable information had been found by the Salvation Army in Openshaw. The GP trainee in question had been having a clear out of paperwork at home, having moved on from our practice. Having found this sensitive information, the Salvation Army contacted Social Services in Bury Council. There was some information relating to a child protection case included and which could be traced back to our practice and this is the reason that the Head of Safeguarding had been contacted initially. I arranged to meet the Head of Safeguarding for a secure handover of the information so that we could investigate further. Having looked at the information contained in the plastic bag it became apparent that it had originated from one of the ex GP trainees who had left our practice. There were various documents with her name and address contained within and she lived in redacted which fit into how the bag had been discovered in that area. We also established that there was some patient identifiable information relating to patients from another surgery, where this doctor had moved on to after having left our practice. The doctor was contacted by her ex-trainer redacted and	Only one detailed record (data items listed below). 4 sheets containing patient names, DOB and NHS numbers. Also, a number of clinic reports and transfer of care reports.

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				she came into the practice on to discuss the incident. (I was on leave at that time, but the meeting was held in attendance with redacted, redacted and redacted). From what we can gather, the information had been at her home address and her husband may have mistakenly taken this to the Salvation Army with clothes in error. We found that 133 patient names were listed on a print out from a computer search (with NHS numbers and DOB) but no other patient details were attached to this list. We also found details from a child protection case conference (in the form of minutes) which contained the child's name and family member details (including address and date of birth). There would have also been details of the child's present and future care plans, as well as the healthcare professionals involved.	
IGI/6250	NHS West Hampshire CCG	05-Dec-16	1	Following on from a Local Appeal Meeting for funded nursing care, the minutes were typed and despatched. The Continuing Health Care team later received a letter from the sender (a solicitor's firm) advising that they had received the information in error. The CHC team checked and reported to the IG manager, confirming that the information had been sent to the wrong solicitor.	Local Appeal Meeting Notes - including some clinical details. 8 pages.
IGI/6311	St Andrew's Healthcare (Original code of NTY85)	09-Dec-16	4	Confidential documentation found loose within a skip on site at St Andrew's Healthcare. The confidential documentation which was found was: -	1. Consent form, handwritten notes, advanced disclosure papers, and GP records in relation to a

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				1. Consent form, handwritten notes, advanced disclosure papers, and GP records in relation to a medico-legal assessment of a patient by a clinician. (These included information such as full name, date of birth, forensic details, and medical details). 2. Medical records in relation to a medico-legal assessment of a patient by a clinician (these included information such as full name, date of birth, and medical details). 3. Handover pack from previous hospital for a patient (this included full name, date of birth, forensic details and medical reports). 4. Doctors' letter in relation to a patient (this included name and date of birth). Following enquiries It has become apparent that a secretary left the organisation at the time the documentation was found. This secretary worked with all the clinicians whose documentation has been found. It is known that the secretary had a clear out of their desk before leaving the organisation. Also known is that the confidential waste bin in the office where the secretary worked was full and a job had been raised with estates and facilities for this to be emptied. St Andrew's has a full suite of information governance	medico-legal assessment of a patient by a clinician. (These included information such as full name, date of birth, forensic details, and medical details). 2. Medical records in relation to a medico-legal assessment of a patient by a clinician (these included information such as full name, date of birth, and medical details). 3. Handover pack from previous hospital for a patient (this included full name, date of birth, forensic details and medical reports). 4. Doctors' letter in relation to a patient (this included name and date of birth).

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				policies which contain details of how information should be handled including disposal of confidential waste. Staff are required to complete mandatory IG training annually which covers all aspects of IG.	
IGI/6252	Solent NHS Trust	05-Dec-16	1	A letter was sent to a patient and enclosed within the envelope was a letter for another patient. It appears that two letters were accidently placed in one envelope, stuck together. The letter contained patient demographics, details of next appointment and summary of previous counselling session. The incident was reported to the Trust the next day and a strategy meeting/investigation commenced. Initial findings indicate that this is human error, but the Trust's investigation is looking if any system/processes played apart and to identify any shared learning from the incident, as this is key, even if human error	The letter contained patient demographics, details of next appointment and summary of previous counselling session.
IGI/6185	MEDWAY NHS FOUNDATION TRUST	23-Nov-16	45	The IG manager was made aware, by HR staff, that 4 sheets of patient details and a summary diagnosis for each patient had been found in the hospital restaurant and handed into the staff working there. The restaurant is open to the public, but it is not clear whether it was a staff member or a member of the public who handed the notes in. The member of staff has been identified through their time sheets which were also with the patient details.	In total there are 45 separate patient details over 4 sheets of paper - name, hospital patient ID number, the DoB for some, their presenting complaint and for some numeric investigatory details - these would only have meaning to clinical staff.

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IGI/6219	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	24-Oct-16	11	Upon investigation 11 patients are listed on the handover sheet which includes the following information. Ward Patient Name Hospital Number Age Clinical Details PMHx Investigations Plan	Ward Patient Name Hospital Number Age Clinical Details PMHx Investigations Plan
IGI/6201	PENNINE CARE NHS FOUNDATION TRUST	02-Dec-16	1	Copy of clinic attendance letter for parent addresses to No 1 instead of No 14.	personal and sensitive data
IGI/6186	Birmingham Women's and Children's NHS Foundation Trust	25-Nov-16	15	A ward handover sheet was found in the street near Trust premises. The handover sheet contained details relating to 15 patients including full name, hospital number, bed space, diagnosis, clinical problems, treatment and procedures. It was printed and found on the same day. The individual who dropped the handover sheet was at the end of the shift on the same day and left the hospital at the same time to go home. Therefore, the handover sheet is likely to have been on ground for a matter of minutes before it was picked up by a member of staff working in the Pharmacy Department and handed to another person in Pharmacy who reported the incident. It is not yet known why the handover sheet was being used by the member of staff who dropped it.	Full name, Bed space, Lead Clinician, Diagnosis, Clinical problems, Treatment, Procedures.
IGI/6182	Bridgewater Community	03-Oct-16	4	Electronic file received from solicitor in relation to an ongoing employment tribunal, containing Legal	Legal Professional Privilege discussion

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	Healthcare NHS Foundation Trust			Professional Privileged (LPP) discussion details, the email was forwarded to the staff member involved in the employment tribunal.	details between the Trust and the Trust solicitor was included in an email file. The file also contained an email which disclosed information on 3 unrelated closed disciplinaries.
IGI/6342	ROYAL UNITED HOSPITAL BATH NHS TRUST	13-Dec-16	1	Patient contacted ward and spoke to Nurse in charge to inform of said incident. Patient was requested to destroy the information.	NHS Patient Data
IGI/6148	PENNINE CARE NHS FOUNDATION TRUST	02-Dec-16	2	A letter was dictated and typed into a letter that included the demographic details of another child seen by the service with the same name.	Letter containing NHS patient confidential information relating to diagnosis and treatment
IGI/6287	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	07-Dec-16	22	An agency nurse left a handover sheet in a visitor's area that contained patient details. Details given below in Data details section	22 patients with sensitive info that included: Patient ID, Surname, Forename, Age, admit date, situation, background, assessment, recommendations, Co-morbidity's. The sheet was traced

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
					back to an agency nurse
IGI/6161	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	14-Nov-16	4955	A member of staff emailed a spread sheet containing sensitive information to another health organisation. The recipients were entitled to the level of information sent and were the correct recipients; however, the email was not encrypted, or password protected.	• Patient name • DOB • Reason of care, which included the following: o Ante-natal booking (Data subjects total = 4248) o Ante-natal miscarriage (Data subjects total = 486) o Ante-natal termination (Data subjects total = 61) o Ante-natal transfer of care (Data subjects total = 160)
IGI/6289	University Hospitals Bristol NHS Foundation Trust	13-Dec-16	1 sheet of paper	Member of the public returned a handover sheet to the Trust. The handover sheet was from a hospital ward at the Trust. The sheet was found on a nearby street. These sheets should be shredded by staff and should not leave the ward.	The data on the handover sheet would typically contain the patient name, DOB, Trust number, ward number, and diagnosis.
IGI/6125	WALSALL HEALTHCARE NHS TRUST	05-Dec-16	41	Physiotherapy records (only regarding physiotherapy care) were left in the boot of a physiotherapists car and then stolen. Along with a Dictaphone which was blank,	patient records for physiotherapy treatment - no other

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				key fobs to offices in two health centres and the staff members hand bag and house keys. Update - the information that was stolen was musculoskeletal clinical assessment service referrals. These would have contained only the clinical detail relating to that referral, no other clinic information. It was not the patients notes.	clinical details. Update - the information that was stolen was musculoskeletal clinical assessment service referrals. These would have contained only the clinical detail relating to that referral, no other clinic information. It was not the patients notes. The patients name, address, NHS number, telephone number and GP details were included.
IGI/6129	WEST MIDLANDS AMBULANCE SERVICE NHS TRUST	05-Dec-16	33	West Midlands Ambulance Service were informed by a paramedic from another ambulance service that when viewing one of our former vehicles' they noticed a blue A3 size zip bag. On examination of the blue bag it contained 7 PRFs. They immediately brought this to WMAS's attention and the bag was handed over. A WMAS team was dispatched to the secure compound. The site contains 57 Double Crewed Ambulances and 25 Rapid Responder Vehicles. The team discovered that a further	Patient Report Forms (Health Records). A3 size paper records capturing health information about the patient at the time of the emergency incident.

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				11 vehicles had a 23 PRFs and 3 Cardiac Forms that had not been removed during decommissioning.	
IGI/6198	NHS South Norfolk CCG	24-Dec-16	1	The CSU as Data Processors for the CCG have received confirmation from a care provider that they received a letter enclosing a care report relating to a patient they did not recognise.	Care report detailing patient care needs and medication.
IGI/6126	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	9	Handover sheet for Coronary Care Unit containing details relating to 9 patients. Investigation underway to establish further details.	Name, DOB, hospital no. some diagnosis, risk assessment and treatment plan information.
IGI/6168	NHS Norwich CCG	10-Nov-16	1	Admin staff member of the CHC team originally sent out a decision letter to the patient but this was incorrect as the decision should have been not eligible. The admin staff member then contacted the next of kin (NOK) to inform them of their error and explained that a new decision letter would be sent. When the correct replacement decision letter was sent it had a different patients DST attached.	The data was a Decision support tool used to assess continuing health care eligibility covering mobility, capacity, general health and wellbeing covering all aspects of their care as part of the assessment.
IGI/6399	SOUTH TEES HOSPITALS NHS TRUST	28-Dec-16	2	Two ex-staff members were sent each other's P45 forms in error.	Demographic data plus national insurance number. Tax code and tax paid.

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IGI/6213	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	1	New address of family was not updated on the system therefore appointment letter was sent to the wrong address	Appointment letter for CAHMS Service
IGI/6133	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	05-Dec-16	1	The Trust received a letter in the A&E Secretary post from a patient who has received another patient discharge summary. Patient had received a large envelope of notes to give to the hospital she was to attend which should have also included her own discharge summary. This was not in the envelope, and instead was another patient discharge summary. The patients discharge summary contained information regarding mental health concerns.	The discharge summary contained the patients name, DOB, address, GP details, NHS number, unit number, admission details including medical details. Includes patient's mental health issues.
IGI/6174	Drayton Surgery (D82029)	16-Nov-16	2	It was reported to the practice that a member of staff had been talking to her friends about information that could only have been discovered from the patient record. The member of staff was suspended whilst an investigation took place. Analysing the audit trail of access to the patient record shows that the member of staff had inappropriately accessed the patient record on a number of occasions. There was a genuine reason on one occasion (booking an appointment) when CG accessed the patients record, and at this point the patient disclosed the reason for the appointment. Subsequent access to the patient record by	Access to the patient's GP electronic record

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				the member of staff was shown to be inappropriate. When questioned, the member of staff admitted accessing the patient record and admitted she knew what she was doing was wrong. She was adamant that she had not disclosed this information to anyone else. The practice was unable to verify if the member of staff had disclosed the information to third parties, but was satisfied that the inappropriate access to the patient record was classed as gross misconduct and that member of staff would be dismissed. In light of this member of staff handed in her resignation Subsequently the practice was contacted by another patient who claims that member of staff had been talking about her medical notes to friends. A further investigation shows that the patients notes HAD been accessed by a member of staff without a legitimate reason to do so. It would appear that all the parties are known to each other.	
IGI/6176	NHS Medway CCG	02-Nov-16	30	A member of staff was asked to send an e-mail with a list of members of a patient group to two recipients. When sending the e-mail, the staff member sent it to two non-secure e-mail addresses and the attachment contained personal and sensitive information on 30 patients. One recipient was a third party company and the other recipient was someone who was due to start employment with the CCG but has since changed their mind.	The following categories of information were sent regarding the thirty patients: Surname, First Name, Title, Category, Sector, Organisation,

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				The patients had not provided consent for their information to be shared with third parties and the following categories of information were shared: Surname, First Name, Title, Category, Sector, Organisation, Age, Gender, Ethnicity, Disability, Interest 1, Interest 2, Interest 3, Interest 4, Interest 5, Interest 8, Interest 9, Interest 7, Pref. Contact, E-mail, Telephone, Address 1, Address 2, Town, County, Post Code, Comments, Twitter	Age, Gender, Ethnicity, Disability, Interest 1, Interest 2, Interest 3, Interest 4, Interest 5, Interest 8, Interest 9, Interest 7, Pref. Contact, E-mail, Telephone, Address 1, Address 2, Town, County, Post Code, Comments, Twitter
IGI/6207	NHS West Kent CCG	05-Dec-16	Approx. 200	Primary Care Quality Assurance Lead at CCG emailed GP Practice on behalf of Child Health asking if they had completed report on child vaccinations as Child Health said they had not received. GP Practice sent to email to Primary Care Quality Assurance Lead with report attached who then forwarded email to PHE. PHE then forwarded to Child Health	Name, address, post code, dob, NHS number, gender, plus vaccination details
IGI/6212	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	05-Dec-16	1	Patient did not attend for appointment, service rang patient who informed they had not received appointment letter	Appointment letter stating CAMHS Service
IGI/6088	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	01-Dec-16	1	Patient contacted secretary to inform her that the letter that had been sent to her GP contained the incorrect GP address and had subsequently been delivered to another person. The person who had received the letter in error had opened it and had taken the letter round to the patients address. Patient telephoned and has written to the Trust regarding this incident. The letter contained	Clinical letter to patient

ID	Organisation Name	Date of Closure	Volume	Incident Details	Data
				name, address, date of birth, NHS number and a brief summary of a recent clinical episode. The breach has been contained and the item recovered. The letter was typed using the Trust electronic letter system Winvoice Pro, initial investigation suggests that an incorrect GP address was selected by the secretary, the address was changed as the GP had retired and the letter was not checked as per the SOP in place before posting (this has been acknowledged by the secretary in her written statement and appropriate disciplinary action will follow where necessary), further investigation is on-going to establish if any other contributing factors led to this incident.	
IGI/6407	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	13-Dec-16	626	This covers services from September 2015 to June 2016, but all invoices were raised in one batch. All invoices are to CCGs (NHS commissioners) who use our same ledger provider, so no postal copies were sent out. Invoices are only available electronically to CCGs on the NHS N3 network, although the ledger provider manages credit control function overseas. Details contained treatment code, DOB, sex, patient #, post code and appointment date. The incident was notified by one commissioner who had received invoices for 3 patients. It would be difficult to identify the patients with the data contained in the invoices.	treatment code, DOB, sex, patient #, post code and appointment date. The description in the invoice was "Hepatitis treatment".
IGI/6172	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	28-Nov-16	1 letter	Letter to patient copied to the daughter of another patient - unrelated and inappropriate disclosure.	1 patient-related letter sent from a community mental health team.

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IGI/6343	ROYAL UNITED HOSPITAL BATH NHS TRUST	13-Dec-16	1	Nurse involved contacted - said they had filled in the form and sent it, then realised that it was sent for an incorrect patient. They then sent the same form for the correct patient after. Social Care called, the incorrect form had been moved to the deleted files and had not been acted upon. Therefore, no member of staff had phoned a member of the public disclosing names. No further action taken. A change to the Millenium forms has already been actioned to help prevent a form been sent for an incorrect patient. The practitioner will have to sign to say they have checked this is the correct patient, before filling in the form. This is due to go live in August.	NHS Patient Data
IGI/6019	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS	05-Dec-16	Twelve	2 double sided sheets of handover patient information for 12 patients was found by a member of public. It was folded and lay in a gutter outside of Walsgrave School.	Patient first name, surname, age, hospital number, ward, consultant name, admission and discharge dates, and description of conditions and symptoms.
IGI/6190	Marie Curie (London)	05-Oct-16	one	A nurse had written patient details in a diary she used to record details of visits to community patients. The nurse had also recorded key safe codes in the diary (nurse stated the codes were encoded). The nurse attended a shift at a patient's home and a number of days later realised she could not locate the diary. The patient had	Sensitive and personal patient information was recorded in the paper diary. Furthermore, key safe codes for

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				died, and it was inappropriate to contact the family to establish if the diary had been left in the home and there was a delay in confirming that the diary was not in the patient's home. The nurse could not find the diary.	two patients had been written (although encoded) down.
IGI/6110	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	24-Nov-16	1	It has been advised that the patient reported the incident to the Access to Medical Records Co-ordinator and this was escalated. Due to annual leave of senior Trust staff, the incident was not highlighted sooner, and therefore not reported until recently. A total of 12 pages from the patient's recent Accident & Emergency attendance was sent to their last known correspondence address via Recorded Delivery, rather than the c/o address stated in the Access to Medical Records application form - as it is understood it is not common practice to send copies of patient medical records to business addresses (in this case the Citizens Advice Bureau) due to the information being of a sensitive personal nature and a judgment call was made not to send this to the business address stated. The patient requested the A&E attendance documents in paper format, rather than on an encrypted compact disc. It is understood the documents were signed for at the correspondence address. From initial investigation, the c/o address is not documented on any Trust system (A&E, Electronic Patient Record, National Summary Care Record, or the patient's Electronic Medical Record). It is understood the patient is a victim of domestic abuse however there are	12 pages of a recent Accident & Emergency attendance

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				no indicators on Trust systems denoting this. The member of staff concerned with this incident has been removed from the Access to Medical Records function pending a conduct & capability investigation, as it transpires it is the same member of staff involved in 2 Access to Medical Records IG incidents reported to the Information Commissioner's Office during the 2015-16 financial year. The member of staff has completed their mandatory annual Information Governance Training and Access to Medical Records training	
IGI/6121	NHS South Norfolk CCG	24-Dec-16	1	A letter and copy of a DST was sent from CSU Community Site to CSU Head Office site via polylope (internal post) which was then sent by CSU Head Office Site via special delivery to the NOK of Patient A to inform them of the outcome of the CHC panel. The DST that was sent with the letter was for the wrong patient	Full CHC Decision Support Tool Assessment Document
IGI/6055	WYE VALLEY NHS TRUST (RLQ)	05-Dec-16	1	report put in the wrong envelope and sent to the wrong practice	standard baby screening report for new borns birth weight head circumference tests
IGI/6086	Solent NHS Trust	05-Dec-16	1	A summary letter of a patient's care was sent to the patients GP. A copy of this letter was then sent to the patient. As the letter was addressed to the GP, when sending to the patient a window envelope could not be used. Therefore, the patient's address was handwritten on to the envelope. The incorrect house number was handwritten, and the letter was in error sent to the next-	Summary letter containing sensitive personal information

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				door neighbour. The letter was opened by the incorrect recipient and then passed to the patient. The letter contained sensitive person information	
IGI/6054	WYE VALLEY NHS TRUST (RLQ)	05-Dec-16	1	family's application support letter to a secondary school sent in error as address was incorrectly addressed on the envelope.	information about a sibling having autistic spectrum disorder
IGI/5989	WALSALL HEALTHCARE NHS TRUST	05-Dec-16	1	Two members of staff had attended two separate disciplinary hearings. The outcome letter for one of the staff members was placed in an envelope with the other staff members name and address on.	The member of staff's address was included in the letter and the outcome of their disciplinary hearing including the allegations made against the member of staff.
IGI/6157	PENNINE CARE NHS FOUNDATION TRUST	05-Dec-16	1	Letter typed by medical secretary without checking EPR for new address- confidential information therefore sent to old address and opened. The client had requested a letter for his solicitor in relation to a court case. The letter was addressed 'to whom it may concern'. The letter indicated that the author was a Consultant Psychiatrist with a recommendation that the client had a forensic psychiatric report to assess the contribution that his mental disorder made towards the offences that he had been charged with to enable the courts to make a fair judgement on how to proceed.	confidential patient letter
IGI/6021	THE CHRISTIE NHS FOUNDATION TRUST	02-Dec-16	2	An HR staff member was preparing 2 final stage sickness packs for meetings taking place the following week. These were sent out via TNT secure postal service to the 2 employees and their respective union representatives.	Personal sensitive information including current stage of the employee illness,

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				Two days later, the HR Manager was notified by a union representative that within one of the packs was also the occupational health report for the incorrect employee. It was confirmed by the union representative that they had already spoken to the employee and that they too had received the incorrect report. The 2 affected employees are from the same department within the Trust. It was established that there was no process in place to check documentation before posting, which lead to human error in sending out the documentation incorrectly.	prognosis and impact on employment as well as identifiable information.
IGI/6199	PENNINE CARE NHS FOUNDATION TRUST	02-Dec-16	1	Service user previous address transcribed on letter. Letter contained sons name and date of birth and was from the Community Mental Health Team inviting to a CAF meeting. The admin worker who typed and posted the letter had not checked the address on the electronic system	personal and sensitive data
IGI/5999	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	12-Oct-16	3	Loss of an unencrypted Dictaphone containing a transcript of a meeting concerning an on-going complaint where clinical details about a service user were discussed; plus, information about the service users mother who was in attendance as she is the complainant. A second service user was also mentioned in the recording, although another service user was mentioned, no name was discussed for this individual. Once the meeting was concluded the Dictaphone was given back to a member of the admin team to download the meeting notes and send them to the Complaints Team to respond to the complainant.	Service users first and last name First and last name of another service user Mental Health History of the Service User whose mother was making the complaint. Service users mental health history and an alleged assault were discussed by Mother in the interview as this

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				The Dictaphone was put into a locked storage cupboard as the staff member was about to go on leave. When the staff member went back to get the device, it was missing. There is currently no formal process for logging devices in/out of the lockable cupboard. There is no way of knowing if the Dictaphone is in the public domain at this time as the team is unaware of its whereabouts, and so this has to be considered a possibility.	forms part of her complaint. The name and ward that the service user is being treated in, and the recovery plans in place
IGI/5974	NHS Surrey Downs CCG	03-Oct-16	2322	Surrey Downs CCG sent 2322 records to Guildford and Waverley CCG by mistake. The records contained DOB, NHS Number, Patient Initials, Diagnosis and Reference ID. The records were sent in a spread sheet. The user was unaware that the spread sheet contained the records. The incident was reported to the IGM at the CCG by the recipient.	The records contained DOB, NHS Number, Patient Initials, Diagnosis and Reference ID.
IGI/6109	Milton Keynes University Hospital NHS Foundation Trust	05-Dec-16	1	Daughter of Patient A requested copies of her father's medical records, both in electronic document management (EDM) format and the working ones on the ward. She completed all the relevant formal documentation to receive this. Records were copied on the ward by the ward clerk but unfortunately, she copied the records of an adjacent patient (Patient B)	One x-ray encrypted disc and 30 accompanying paper reports Name, address, MRN, NHS, Results, Diagnosis DOB

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				The ward Clark sealed the records in two envelopes one volume in each and these were handed to Patient B's daughter Patient B's daughter hadn't requested copies of her father's medical records or completed an access request to receive her father's notes. Included with the notes handed to Patient B was an encrypted image disc with over 30 accompanying paper reports that the Information governance department had provided for the original requester (Patient A). The daughter of Patient A was not due in until the next day, so these had been left with the nurse on the ward to hand to the Patient A's daughter.	
IGI/5982	Sefton Council	05-Dec-16	1	Social worker forwarded an e-mail containing personally identifiable data to an unintended recipient. The incident then came to light when the social worker asked their colleague later that day if they had received the information contained in the e-mail. When the colleague confirmed they had not received an e-mail, the social worker checked the e-mail address they had used to find it incorrect and the e-mail had been sent to an unintended recipient.	The data disclosed was name, date of birth, that the individual had been referred for a substance misuse detoxification and is due to be a witness in a Court case later in the year.
IGI/5970	Care Quality Commission (previously HCC)	05-Dec-16	C. 500	4 lever arch files have been lost during an office refurbishment programme. The files contained up to 500 (tbc) copies of DBS certificates showing details of all convictions for each data subject, this includes spent	Disclosure and Barring Service certificates showing all previous

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				convictions. The files had been stored in a locked cabinet within CQC offices, due to an error made during the refurbishment programme the cabinet appears to have been broken open and removed from the offices by contractors. Some of the contents of the cabinet were very quickly located in the offices but 4 files cannot be found. Extensive searches have been carried out at the CQC offices and at the contractor storage and disposal locations. These searches have, to date, failed to locate the missing documents. As the location of the documents is not known there is an unknown risk that the details of each of the subjects is subject to any wider distribution.	convictions for the data subjects.
IGI/5960	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	05-Dec-16	approximately 31 names addresses and key safe numbers contained in a diary	An on-call nurse visiting a patient at their home had her handbag taken from the lease car she was using; the handbag had been left in the footwell of the car. The handbag contained a diary that had the names, addresses and key safe numbers for patients.	names, addresses and key safe numbers for potentially up to 31 patients
IGI/5954	Care Plus Group	05-Dec-16	1	Whilst investigating a comment on a service user satisfaction questionnaire that was received back to the organisation. A potential complaint was raised by the patient's wife. Upon investigating it was found that Macmillan Nurse went in once and subsequently discharge the patient with rational as the patient had RIP. Chief Nurse investigated this incident and it was identified that the patient had not RIP.	This was two patients in the same nursing home with the same first names

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IGI/5936	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	07-Oct-16	1 page	Ward staff faxed sensitive information related to a service user to a wrong fax number. The recipient alerted the IG department of a neighbouring hospital and the unauthorised disclosure was reported to our IG department. The faxed referral has been securely shredded by the recipient.	The referral of a service user containing confidential sensitive data
IGI/5967	Ramsay Healthcare UK Operations Ltd	12-Dec-16	16	Yorkshire Clinic Hospital Reception received a call from a patient whereby the patient informed them that he had a clinic list, which he advised the consultant had accidentally given to him with his paperwork when in an appointment. The patient asked to speak to the Information Governance lead. The list contained the following information: Names of 16 patients; Date of Birth: Procedure type for 8 patients; Consultants name; Cosmic Patient admin number; Who appointment is funded by e.g. NHS CCG; Time of appointment and if they were a new patient or follow up appt. If new patient breach date for treatment documented. Reception took contact details as the information governance lead was not available and asked if it was ok for the patient to be called back. IG lead contacted patient. Patient advised he had been given list with his paperwork by the consultant and felt his privacy had been breached, he felt the consultation with the consultant had been insensitive, very intrusive, unprofessional and felt he had been treated aggressively by the consultant. IG Lead asked patient to return the patient list in its original format and the patient refused, he then went on to state that he felt there had been a 2nd	Names of 16 patients; Date of Birth: Procedure type for 8 patients; Consultants name; Cosmic Patient admin number; Who appointment is funded by e.g. NHS CCG; Time of appointment and if they were a new patient or follow up appt. If new patient breach date for treatment documented.

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				and 3rd breach. He stated that the letter we had sent to him for his procedure had never arrived, and that the GP had not received the outcome letter. Advised patient that we would investigate this for him. Patient asked to change consultant as he had lost confidence in the consultant. IG Lead discussed options and then asked patient again to return list. Patient advised he would fax list or scan and email. Due to security issues with this and HSCIC briefing not to fax PID IG Lead sent courier taxi to pick up clinic list. Patient agreed to this and taxi was sent. On return it was found that the patient had sent back a list that was photocopied and had kept the original. (Investigations of the allegations for the 2nd/3rd breaches were unfounded. Letter to Patient from Yorkshire Clinic was sent and it was confirmed that the GP had received their letter). IG Lead telephoned patient to liaise over arranging a different consultant appointment and to advise that we were investigating the incident with the clinic list. A call was scheduled with the patient for Wednesday to update on clinical care. IG Lead liaised with Data Protection Officer and Legal team. Legal team drafted a letter asking for return of original patient list and to confirm that information had not been disclosed further. IG Lead and a colleague, hand delivered letter to patient's home address. IG lead spoke to patient and tried to hand over the letter. Patient refused to accept or read the letter. IG Lead explained that it was important that the original list was given back for the investigation and the other patients safety/privacy. Patient	

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				refused to hand back list. Patient was informed that unfortunately the next step was for us to contact the police if he was not prepared to hand back the list and that it was important that a copy of the letter was left with him, even if he did not sign it so that he understood the request. Patient advised he would contact his legal team. IG Lead thanked Patient for his time and left. General Manager informed the Police that a Patient had picked up a clinic list after an appointment and that he was refusing to return it, police advised that this is classed as theft of patient information. Crime reference redacted	
IGI/6244	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	07-Nov-16	1 Letter	A letter was addressed to number 2 instead of number 3 by the admin staff at the Trust. The next-door neighbour opened the letter in error which contained information regarding an outcome of an appointment. The letter was a copy of a letter being sent to the GP. The letter contained sensitive personal data	Information regarding physiotherapy appointment, however contained reference to self-harming
IGI/6138	PENNINE CARE NHS FOUNDATION TRUST	02-Dec-16	1	Patient attended clinic - as consultation started mum advised that Consultant had got the age of the child wrong. Further into the consultation the parent realised the child being referred to by the consultant was not her child. There are two patients with the same name and the consultant had been given the wrong file.	Patient NHS clinical data
IGI/5949	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	05-Dec-16	3	The patient wrote a letter to our complaints department, with the enclosed extra three letters that are addressed to three different GPs, that were all in her envelope. They are all from the Gastroenterology department. One letter is particularly sensitive as gives the patient a suspected diagnosis of cancer. Letters are put into three separate piles depending on whether they are to be sent to the	Three different letters to three different GPs regarding three different patients. Information included name, date of birth, address and clinical

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				patient, GP or other internal. Letters have been being put into envelopes by a volunteer. It appears to be human error that extra letters were put into the envelope at the time.	information. One letter is sensitive due to a suspected diagnosis of cancer.
IGI/5917	IPSWICH HOSPITAL NHS TRUST	28-Dec-16	3	Complaint received re a Consultant as she suspected her records to have been inappropriately accessed. Complaint is upheld, and further investigation found 2x family members of the complainant have also had their records accessed by the Consultant	letters on Evolve
IGI/5955	LANCASHIRE CARE NHS FOUNDATION TRUST	05-Dec-16	190	Greater Manchester West reported that information shared by LCFT, as part of the tender process for prison services, contained an additional worksheet that held person level information. The data set contained the following information for 190 LCFT staff that should not have been included in the data set: Full Name, DOB. It has been confirmed that this information was transferred to other bidders (both non-NHS and NHS organisations). It has been confirmed that the other bidders had not acknowledged the additional worksheet.	Full name & DOB
IGI/6136	PENNINE CARE NHS FOUNDATION TRUST	05-Dec-16	500+	A report being shared with a new provider of NHS Services was being shared with them as part of an SLA. However, the report was emailed to an NHS.UK account rather than a NHS.NET account and it contained patient level information.	Awaiting a copy of the report for the specific data items - but know that it contains patient names etc.
IGI/5915	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	05-Dec-16	estimated 500 records	Missing book has been recovered. The book was returned by a patient to a GP. The initial suspicion that the book had been removed by a patient turned out to be correct In an emergency department ward area a book which is	name, dob, address, sex, code or simplified diagnosis, date of admission, date of discharge, location discharged to

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				used to record admission and discharge information was notified as missing on Sunday 3rd July. The records mostly personal information with an abbreviation or short note of diagnosis which can be considered personal/sensitive. Searches have made for the book; the ward staff are concerned that the book may have been removed by a patient. This has not been substantiated but is being investigated	
IGI/6119	BURTON HOSPITALS NHS FOUNDATION TRUST	02-Dec-16	1930	The file contained PID and the data/email was not encrypted. The member of staff realised their error and recalled the email several hours later. The Virgin Care recipient confirmed they had deleted the email and its content.	A spread sheet containing a Minimum Data Set of patient information, which included Patient Name, Unit Number, Date of Birth, Age, Gender, GP details, Clinic details, Administrative Category, Outpatient Clinic details including Attendance Date, Visit Type.
IGI/6070	Luton and Dunstable University Hospital NHS Foundation Trust	05-Dec-16	278	• The SN finished work and went straight to her Mother's house. She placed the diary and forms in the boot of the car. • SN returned home she parked behind her husband's car which was already on the private driveway. • Later that evening SN was aware that cars still on driveway.	Name, address & telephone number, Name, address, date of birth, gender, NHS Number, Hospital Number & GP Name x 3

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				• Early morning SN opened curtains and noticed her car was not on the driveway. The SN immediately reported the theft of the car to the Police and her Line Manager (LM), however due to SN flying out of the country that morning following a family bereavement the Line Manager was not able to gather any facts until SN's return. The SN highlighted to the Police that she was concerned about the diary. The Police explained to her that in their experience a car of this type and year would have been stolen for parts and that any contents would be burnt to prevent evidence being linked back to them. To date the car has not been found. • Facts gathered, and incident escalated to General Manager and Information Governance Lead. Leaving personal identifiable data in a vehicle overnight is against Trust Policy & Departmental Protocol. Concise investigation underway, including how to prevent this incident from reoccurring.	
IGI/6150	The Stonedean Practice (K82617)	05-Dec-16	not known	A GP has a container in her room with confidential paperwork for shredding. New cleaners mistook this for a rubbish bin and emptied its contents into general waste.	NHS patient data