Information Governance Incidents closed during 1st October to 31st. December 2017

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Contents

Introduction

This is the 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 2017, following investigation by the local organisation(s) concerned.

Content of the report

The report below consists of **28 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 **98 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.

Next reports

The next closed level 2 IG SIRI report to be published will cover the period 1st January to 31st.March 2018.

[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.

Closed level 2 incidents reported during 1st December to 31st. December 2017

ID	Organisation Name	Date of Closure	Details of Incident	Data
IGI/16203	Bay Medical Group (Y01008)	14-Dec-17	Copies of medical records were requested for patient A pursuing a personal injury claim. The medical records were copied and posted to the firm along with 500 pages of patient B's records which contained patient identifiable data along with sensitive medical information. There is currently a large backlog of medical reports work due to restructuring of reports team following practice merges with 3 other local practices. This incident occurred when a senior member of staff was off sick putting pressure on other team members. The breach was due to human error. Medical records are copied and forwarded to the usual GP for checking prior to sending out. In this case it appears the records were not checked thoroughly.	NHS Patient Data
IGI/15135	BURTON HOSPITALS NHS FOUNDATION TRUST	06-Dec-17	The papers were left on a waste bin within the Costa Coffee lounge within the grounds of the Trust. The incident was reported, and the papers were scanned and sent to the Caldicott Office as evidence.	Report contained key demographic data and detailed clinical information.
IGI/15109	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	29-Dec-17	A request for Patient A's records was received by one of the Data Protection Assistants who recorded it onto the log for access requests relating to deceased patients. The request had not been progressed past the logging stage and had been open for 50 days when the error was noticed by the Information Request Supervisor, who immediately begin to process the request. The Supervisor's search of the electronic patient record system returned two patients both with the same name and date of birth; in haste Patient B was selected rather than Patient A. Patient A is recorded as Miss with no fixed abode and her record did not indicate whether she was deceased. Patient B is recorded as Mrs with an address and her records also did not indicate whether she was	Adult Mental Health records; seven pages of case note summary and fifty pages of care documents.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			deceased. Both patient records have different ID and NHS numbers. Patient B's records were processed in line with the Access to Health Records Act 1990 and disclosed to the requestor, who later contacted the service to advise of the error.	
IGI/15061	BURTON HOSPITALS NHS FOUNDATION TRUST	06-Dec-17	The list contains patient names, medical details and medical plan. Incident was reported, and form was scanned and sent to the Caldicott Office as evidence. The original document has been shredded.	Clinical Handover form contained patient name and age, medical details and care plan.
IGI/15092	PORTSMOUTH HOSPITALS NHS TRUST	27-Dec-17	Patient information of 25 patients found by a local authority in London in a public place. Information includes 15 pages of a mixture of memos, patient letters, photocopies of incident forms, photocopies of patient plaudit, a theatre list and a medical photograph of a wound.	Patient information in the form of memos (names & operation only), operating list (name, DOB, hospital number and procedure), photocopy of incident form (name, DOB, hospital number, limited clinical information), photocopy of thank you letter (name & address of patient), patient letter (name, address, DOB and some clinical information), letter between doctors discussing cases (names of patients x3 only) and x1 photograph of female patient in bra and underwear showing wound on left side (photo, name, DOB, hospital number &

ID	Organisation Name	Date of Closure	Details of Incident	Data
				address)
IGI/15071	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	13-Dec-17	Information relating to a different patient was inappropriately disclosed as part of a Subject Access Request. Document was found within the records disclosed under subject access and reported back to the medical records team by an independent advocate working with the patient.	1 x patient-related document from a mental health service.
IGI/15101	PENNINE CARE NHS FOUNDATION TRUST	15-Dec-17	An envelope sent to Oldham Child Health from Child Health Bury, didn't get franked, but continued to be sent via Royal Mail. Royal mail sent Oldham Child Health a card requesting payment for the postage This postage was never paid, so Royal Mail opened the envelope which contained 7 hospital letters relating to 7 different children. Royal mail sent all 7 letters to one child whose address was on the first letter. Mum received the envelope and took all paperwork to her GP practice. The GP then returned all the paperwork to Child Health Oldham.	Information contained in the letters consisted of names and addresses, DOB, NHS Numbers, details of walk in centre / A & E attendance
IGI/13978	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	04-Dec-17	The recipient of the letters for other patients took the letters to their local Councillor and she reported the incident to the hospital. The IG Manager required more information to ascertain the specialty of the patients involved and the sensitivity of the content also to enable the reporting of the incident both locally and to the ICO.	Personal and sensitive information (health).
IGI/14010	Marie Curie (London)	11-Dec-17	Email addresses for two staff members were not removed from a distribution list resulting in day therapy referrals being sent to two addresses that were not being monitored. This is an incident at the Belfast hospice. The day hospice manager had a call from a GP insisting they had sent through the referral to Day Hospice. A system administrator looked on the system the referrals were set to be received at two previous staff member email addresses. The full referrals contained full patient information, but the information was sent using a secure network. The emails had not been accessed and could not be	56 referrals with full patient details.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			viewed by anyone external.	
IGI/13940	MERSEY CARE NHS FOUNDATION TRUST	23-Nov-17	Senior accountant sent email containing personal identifiable information which should have had personal information removed. Upon realising breach occurred sender contacted recipients and requested immediate deletion and confirmation back that lists deleted, IG Lead notified, and adverse incident completed. SIRO & Caldicott Guardian notified of incident. Email confirmation received from recipients of deletion of original email. New lists sent without personal id contained.	Employee list containing 63 staff names and salaries sent to 3 local CCGs without personal identifiable information being removed and email being encrypted - lists required by CCG for discussion at services TUPE meeting. Recipients contacted and requested to delete email containing Personal ID.
IGI/15018	Central London Community Healthcare NHS Trust	20-Dec-17	Staff member sent a mail to their Director, HR and their own personal email account which included an email enclosed that related to a Subject Access Request with personal data for two patient's including sensitive information regarding one of the individuals.	service user information of a safeguarding nature
IGI/13909	Greenbrook Healthcare	29-Nov-17	The clinical system design had an error in initial set up. Patients that had not consented to their clinical notes being shared were being shared with the GP practice. The clinical system Suppliers (One Advanced) are investigating the issue and have treated it as a serious incident. They will investigate the system and the issue and will feedback their findings into our investigation.	Full notes from the clinical consultation were shared. This will include demographic information, but also clinical case notes.
IGI/15070	PENNINE CARE NHS FOUNDATION TRUST	15-Dec-17	Two letters were accidentally put in one envelope. The second letter was returned to our PO Box number, with a handwritten message from the child's parent explaining that the letter had been contained within the envelope for the wrong child. This letter should have been sent to the GP. There was no clinical risk to the child as the parent had already received a prescription. The parent had also been sent a copy of the	GP details, name, dob, NHS number, address, diagnosis, other issues, medication, care plan, physical measurements and a summary of the latest

ID	Organisation Name	Date of Closure	Details of Incident	Data
			letter to the correct address	appointment
IGI/13857	ADVANCED DIGITAL INNOVATION (UK) LTD	14-Nov-17	NHS numbers being disclosed to third-party subcontractor in error. Contents of database queries being recorded in debug log and sent to third-party logging service used to generate alerts to IT staff regarding system malfunctions. Queries include patient searches by NHS staff, typically by NHS numbers. No further information (other demographics, any health information) or context are being disclosed in error. Debug log levels on live database were set to appropriately low level, which did not ordinarily result in contents of query being logged. However, we have subsequently determined that, where the time taken to execute a query took more than a certain amount of time, details of the query contents were being logged anyway, despite logging levels that should have precluded this. Service went live in Sheffield Teaching Hospitals in April 2017. The issue was not picked-up during initial deployment, and we believe that the inadvertent logging due to excessive query execution time has started and grown in frequency as the number of patient records in our system has increased over time. Log data is retained within third-party service for 30 days to enable us to debug causes of system malfunctions, and then deleted, so we are unable now to look back and determine when the issue first occurred. We are confident that the information is securely held within the servers of the third-party service and has not been subject to unauthorised access.	NHS numbers of patients whose details are recorded within our system and whose record has been searched for by clinical users of our system with Sheffield Teaching Hospitals. Total patient records in our system 58,000, only a small proportion of which will have been searched for by Sheffield Teaching Hospitals staff in our system (as the staff are typically searching for patients at time of first referral, whereas we have data on all musculoskeletal patients who have had any appointments, or appointments booked since April 2017).
IGI/13942	Central London Community Healthcare	20-Dec-17	An email to a parent containing a draft health care plan for their child was sent to the parent's incorrect email address. The wrong domain ending was used, instead of the staff member using .com they used -	care plan had patient's name, address, DOB, mother's name & mobile

ID	Organisation Name	Date of Closure	Details of Incident	Data
	NHS Trust		.co.uk. The email was sent on the 9th October, the member of staff did not realise their mistake as they did not receive a bounce back. They realised that they had used the incorrect email address when the parent told the member of staff that they had not received the email. When the member of staff realised the email was sent to the incorrect email they sent another email asking the recipient to delete the previous email sent on 9th October, but there was no response.	number, school meal plan, treatment plan, challenging behaviour patient was displaying, how to use the EpiPen prescribed, GP details, names of consultant at Royal Free and Dietician, name of nursery patient attends.
IGI/13876	PENNINE CARE NHS FOUNDATION TRUST	20-Nov-17	Lever arch file containing patient details to allocate district nursing visits unable to be located within the office. The lever arch file was last seen on Sunday 8th October. This file does not leave the office and the office is locked when not in use.	The file contained patient names, addresses, dob, NHS number, complaint and key codes for patient accommodation
IGI/13860	Solihull Metropolitan Borough Council	01-Nov-17	Notepad containing hand written notes but no names or addresses or other information that might identify anyone. Also, an Assessment report containing sensitive personal data	Notepad containing hand written notes but no names or addresses or other information that might identify anyone. Also, an Assessment report containing sensitive personal data
IGI/13828	Marie Curie (London)	11-Dec-17	Handover sheets were found in a staff member's locker. This is an incident at the West Midlands hospice. The Hospice Sister found a high number of highly sensitive handover patient notes in female changing room on the 1st floor in an open locker. On review there were 256 handover sheets left in the locker dating back to 22.01.14. The handover sheets confirmed patient diagnosis and treatment - information the nurses would have throughout the day for patient care. The handover sheets were in a staff locker in a staff area and are	256 handover sheets were found in a staff locker that had been left open. The locker is in a staff changing room.

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			unlikely to have been seen by anyone other than staff.	
IGI/16277	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	29-Dec-17	Copy of case note entry sent to wrong patient. Patient A contacted the Community Mental Health Team to report that she had received a letter containing a copy of a case note pertaining to patient B. Patient A was extremely concerned that patient B may also have received a case note about her in error, but this was not the case. It transpired that both patients had attended the same clinic with the same doctor and the medical secretary was meant to send a copy of the relevant case note to patients who had requested it. Patient A had not requested a copy, but patient B had.	Printed copy of Adult Mental Health Community Mental Health Team case notes entry detailing diagnoses, medication, risks, capacity, etc.
IGI/15173	Probus Surgery (L82045)	14-Dec-17	Practice Newsletter was emailed from an NHS email account to our virtual patient group. The email addresses were not sent in 'blind copy format' which meant when the email was received by the recipients that they could see all 185 email addresses.	Patients private email addresses
IGI/15039	Marie Curie (London)	11-Dec-17	Following a previous incident redacted staff were advised of an amnesty and asked to remove and destroy any handover sheets they may have been storing. As part of the sweep of unused and unclaimed lockers another pile of handover sheets was found in a locker. The sheets contained patient identifiable information dating back several years. It was discovered the locker belongs to a member of staff on long term sick leave who was already on sick leave when the first incident occurred so would not have seen the emails and communications about removing and destroying handover sheets.	Handover sheets containing patient identifiable information were left in the locker.
IGI/13995	EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	10-Nov-17	Email containing staff information sent to incorrect email in error. The incorrect nhs.net email address was provided to NHS Shared Business Services by a member of the EMAS Finance Team. As a result, copies of staff payslips were sent from SBS to the incorrect email address. The recipient of the email was an NHS employee at NHS Grampian. This employee has the same name as the EMAS staff member who	Staff names, salary details and job banding. NI numbers. The clear majority did not have home addresses - work addresses are the norm for staff

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			should have received the email. Due to the number of email accounts on the NHS mail system, there are often duplicate names. To allow for this, same names will have a number added to the surname. e.g. John.smith1@nhs.net. This was the case in this matter - the incorrect address did not have a number and the correct one had a 4 after the surname.	payslips. No bank details are recorded on payslips. The email was sent via the NHS secure email system - NHS mail so no additional encryption was required.
IGI/12052	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	09-Oct-17	A potential data breach was reported to the Trust by a patient and is under investigation. The patient alleges that a Trust staff member (A&E Nurse) has verbally disclosed information regarding their recent attendance at A&E to a mutually known 3rd party whom has then shared this with the patient. It is alleged that information (unknown) from the patients' electronic medical record including the reason for attendance (of sensitive nature) was disclosed as part of the discussion with the 3rd party. The staff member works in Children's A&E however as far as can be currently established did not have a legitimate relationship with the patient (Adult) as part of their care to access electronic patient records. Initial investigations though the review of the Electronic Patient Record (EPR) 'audit history' by IG has found that the patients A&E record was accessed on three occasions by the staff member on the evening of the patient's attendance. The Trust needs to discuss with the staff member the circumstances of the staff member accessing the record to establish if this was for a legitimate purpose. Potential data breached - The staff member has had access to demographic data and data in relation to the patient's admittance and discharge from A&E, including reason for attendance. The patients right to confidentially when attending A&E. 14.07.17 - Investigation has found that the audit trail of the Trust EPR	The staff member has had access to demographic data and data in relation to the patient's admittance and discharge from A&E, including reason for attendance. The patients right to confidentially when attending A&E has been verbally breached.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			system (patients electronic records) verifies that the health professional did access records in relation to the patient's attendance at A&E, information included the patient's demographics and the reason for attendance. Investigation has established that the staff member at the time of accessing the information on the EPR did not have a legitimate relationship with the patient which would necessitate them to access the EPR. The staff member works in the department that the patient attended and had initially visually seen the patients name only on the adults admissions list which alerted the staff member to their attendance before then accessing the records in the EPR. As the staff member is part of the care team in the department they were able to access the EPR, but they were not directly caring for this patient so had no legitimate reason to do so in this instance for this patient.	
IGI/14015	East Wing Practice (A88613)	28-Dec-17	Access to medical records received Medical records provided Advised a document had been disclosed in error Document contained personal identifiable information, including a clinical report Document returned (Delay in returning as recipient was away from home) Discussion at Partnership meeting as to actions to take Advice taken from NECS Information Governance team Advice taken from surgery medical indemnity Apology letter sent to patient whose information had been disclosed in error (awaiting to hear from patient - patient no longer registered with practice - no response received) SEA to be undertaken in surgery Protocols reviewed and disseminated to surgery staff	NHS patient data
IGI/13907	SOUTHERN HEALTH NHS	15-Nov-17	The information has been disproportionately shared • The information shared was highly sensitive including health	Patient name, address, date of birth, personal history,

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	FOUNDATION TRUST		information, risk information, and third party information without the third party's consent • The service-user and court case are very high profile (although press restrictions are in place) • Although the service is liaising with the court to retrieve or minimise the distribution of the information, it has already been shared with a number of parties and retrieval is unlikely • The SHFT Staff Member did not use the correct format (it was a GP letter and a copy of assessment, rather than the National HLDS Court report template), the correct format and is designed to provide proportionate and relevant information only	clinical history, current presentation, thoughts to harm self and others, offending behaviours, Police actions, information on family relationships
IGI/13889	Wawn Street Surgery (A88007)	22-Nov-17	Routinely invited eligible patients for 6 month hypertension review. Routine administration task generating NHS letter through Patient Chase (electronic automated system), letters mailed out by the Docmail automated Service. Each single letter was generated as a double-sided letter; the default setting in Docmail was manually changed from 2 to 1 therefore printing only the first page and not the second page. The second setting remained on duplex so page 1 of two patient letters was printed back to back. Subsequently 47 patients received the first page of their letter and on the reverse, the first page of another patient's letter containing name, address, NHS number and reference to the health condition of hypertension.	Name, address, NHS Number and reference to a health condition (hypertension)
IGI/13855	STOKE-ON-TRENT CITY COUNCIL	21-Dec-17	Email was sent to another local authority, with the incorrect adult safeguarding referral attached. It related to two service users and contains sensitive personal data.	Adult safeguarding referral information relating to two service users. Contains sensitive personal data.
IGI/13849	LEEDS AND YORK PARTNERSHIP NHS	23-Nov-17	Mental health service user found information relating to fellow service users in a recreation room and handed this to staff. Paperwork left by staff in recreation room under a box of pool balls. Included information relating to 2 x fellow service users, comprising a mental health care	1 x mental health care plan. 1 x mental health GP summary

ID	Organisation Name	Date of Closure	Details of Incident	Data
	FOUNDATION TRUST		plan & a mental health GP summary for the other. Service user stated "I don't think I should have these" on handing them over and stated they had been found in the room under the box of balls on a side table.	

Appendix A – Incidents closed using the 'auto closure' facility 1st. October to 31st. December 2017.

ID	Organisation Name	Date of Closure	Details of Incident	Data
IGI/13831	Buckinghamshire Healthcare NHS Trust	23-Oct-17	Patient contacted PALS office to report that he had recently attended A&E and his discharge letter had been posted to him. On receipt of his discharge letter he found the envelope to also contain a 'View Dept' list of 26 patients that had recently attended A&E. The identifiable data was limited to first and last name only and age (not DOB) but no other demographics. The list also showed the reason for attendance at A&E. The patient was invited to meet with the A&E Consultant to receive a face to face apology and at which point he returned the list to the Trust.	Patient Name Page Age - not Date of Birth Reason for Admission to A&E
IGI/13759	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	30-Nov-17	Staff information sent from Questback to Survey Co-ordination company in error. Informed by HR. Email deleted immediately by Survey Coordination and data quality control put in place.	All person data. Organisation ID Survey Type Staff ID for survey Full Name

ID	Organisation Name	Date of Closure	Details of Incident	Data
				Gender Title First Name Initials Surname Preferred Name Address Line1 Address Line2 Address Line3 Town or City County Postal Code Email Address Directorate Department Specialty Organisation Ethnic Background Position Title Staff Group Maternity Disability
IGI/13713	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	25-Dec-17	Unsecure Emails - x12 emails have been sent containing sensitive patient information	Patient Name, DOB and some external 3rd party data such as social care information.
IGI/13773	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION	07-Dec-17	A ward handover sheet has been found on the floor in a corridor within the Cheltenham General Hospital site by another member of trust staff. The handover sheet was	Header; Ward name, hospital date time and name of member of staff printing the sheet.

ID	Organisation Name	Date of Closure	Details of Incident	Data
	TRUST		folded so no information was on view and was found and secured by a member of trust staff. The trust is working hard to reduce the risk of these type of breaches occurring following a number of similar incidents which have also been reported via this reporting tool to the DH and the ICO. The most recent being redacted in April 2017. A local action plan is in place and presentation made to the senior management team. Following previous advice specific communication to all trust staff is regularly scheduled the most recent being an article in the September issue of the staff newsletter. An investigation has commenced for this specific incident and will include consideration of current control measures and any further actions possible.	Individual row for each patient including; Bed number, Name, Hospital number, DOB, age, gender, consultant, Abbreviated summary of Diagnosis and History, Patients requirements e.g. IV antibiotics and mobilisation assistance required, Indication of any involvement from multi-disciplinary team; Physiotherapist, Occupational Therapist, Dietician or Speech and language therapist. Dietary needs, expected discharge date and discharge planning
IGI/13772	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	01-Dec-17	Patient assessment sent by fax to number provided by Core Trainee in e-mail. Fax number was wrong, and fax was sent to a private company, not the GP. Inappropriate disclosure of patient data to an uninvolved 3rd party.	1 assessment for a mental health service user.
IGI/13704	NHS England	21-Nov-17	An incorrect complaint document was emailed to another complainant. The complaints team were made aware of this when the individual received the document and realised that this did not relate to their complaint and called the team to advise them. The document contained the complainant's name, address, and their complaint details which included their medical and sensitive clinical data.	Name, address, sensitive medical data
IGI/13711	BERKSHIRE	22-Dec-	42 clients were emailed an invitation from the service to a	e-mail address, condition

ID	Organisation Name	Date of Closure	Details of Incident	Data
	HEALTHCARE NHS FOUNDATION TRUST	17	social anxiety forum, the email was not sent using the BCC field and therefore the email address of all clients was disclosed. The information contained within the invitation highlighted it was also an invitation to a Cognitive Behavioural Therapy (CBT) group to enable clients to manage and reduce anxiety and stress in social and other situations, which disclosed their conditions.	
IGI/13886	Solihull Metropolitan Borough Council	11-Dec-17	It was reported that an agency Social Worker, working on behalf of the council, was discovered reading notes about a patient in the Heart of England Hospital and that they had no legitimate need to access the information. The matter is under investigation.	Medical case notes
IGI/13880	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	14-Nov-17	Medical record containing personal identifiable data transferred from an off-site to main site location via an incorrect transfer route. The medical record described above was transferred unattended from an off-site hospital location to a main-site location using a contracted taxi service. The concerned record was not tamper proof protected, however an unsealed envelope was used to prevent loss of pages. The taxi business partner does not normally transfer documents unattended; however, there was an “in the best interest” of the data subject need to transfer the concerned record urgently. The main site member of staff who received the concerned record realised the process error and attempted to contact the off-site location to address the identified errors. The concerned record was examined against the electronic patient record; This indicated that there was no missing information. The incident was then reported via our incident management reporting tool.	One medical record which contained personal identifiable data and sensitive information for one data subject

ID	Organisation Name	Date of Closure	Details of Incident	Data
IGI/13771	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	01-Dec-17	Member of staff brought husband into office and used their access swipe card to bring him to the non-public side of the building, where he was able to see service user data etc Staff reporting the incident indicate that patient records were on desks in this work area at the time, and service user - related conversations were taking place.	Various service user documentation & telephone calls.
IGI/13769	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	01-Dec-17	E-mail about mental health forensic service user mistakenly copied to his mother. E-mail recalled quickly but we are not aware whether this action has worked. Further investigation revealed the message had been opened and read inappropriately by the service user's mother - inappropriate disclosure of mental health and forensic data as well as inadvertent unsecured e-mail transmission.	1 e-mail relating to forensic services mental health service user.
IGI/13692	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	12-Dec-17	Spread sheet containing names, GMC numbers, working locations, home addresses, home emails and mobile numbers of medical trainees and details about their training supervisor emailed to medical trainees in error. Medical trainees contained within wrongly emailed attachment contacted concerning educational opportunity. Approximately 360 trainees were emailed the spread sheet. All trainees contained within the spread sheet work at the Trust, but some may have now rotated to other organizations. Supervisors work at the Trust and other hospitals in the region.	See description above.
IGI/13705	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	25-Oct-17	Staff member from local acute hospital (St George's) left folder containing pcd about a patient we have in common on car roof and drove off leaving it there. A community midwife employed by St George's, has lost a folder containing an inquiry report relating to a Trust patient, including a considerable quantity of sensitive and confidential	Psychiatric letter, assessment letter, "initials only" report, chronology of events, safeguarding information

ID	Organisation Name	Date of Closure	Details of Incident	Data
			information. This occurred yesterday afternoon and was reported to SGUH that day but was only reported to the Trust this afternoon. This report is used as part of the training for trainee and junior midwives. The report folder was put on the roof of the car, by the community midwife, while preparing to get in. The car was parked at the end of Tooting Grove, close to the entrance to Grosvenor Wing, St George's Hospital, an area frequented by hospital staff. The community midwife drove off without remembering to take the folder off the roof and place it in the car. They realised ten minutes later what had happened, by which time they were in Colliers Wood. They retraced their route, searching for the folder where they had driven and around where they had parked, but could not find it. They reported the loss to SGUH and checked with their Security Department on several occasions whether it had been handed in, but to date it has not. I have discussed this incident with redacted, who knows her well (and to whom she disclosed the incident today), and with IG lead; the Caldicott Guardian is on leave. There is a high risk that patient-identifiable confidential information of a highly sensitive nature (given that the inquiry concerns a patient killing her young children when unwell) has entered the public domain. It would be of considerable media interest: there has been substantial interest around the time of her prosecution and her subsequent release from secure hospital into the community and afterwards, and her name and case history would be very readily recognised by any local journalist. Security to continue to attempt to locate report. Inform IG	

ID	Organisation Name	Date of Closure	Details of Incident	Data
			lead and report incident (both done). IG lead to inform Caldicott Guardian on his return from leave. Trust governance team to liaise with SGUH governance team for joint investigation. I will summarise incident to the patient's clinical team and request their advice on her current condition and whether there would be any clinical objection to this incident being disclosed to her and her husband. Assuming there is not, governance team to contact her to explain the incident under the Trust's duty of candour, and to explain next steps and how she can be involved if she wishes.	
IGI/13758	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	04-Oct-17	Member of public received copy patient records in error. Copy patient records requested via subject access request were posted via recorded delivery to house number 25 instead of 35 due to a typing error. The recipient opened the package but did not read the contents and contacted the relevant office to inform staff of the error. This was immediately escalated to the relevant manager who collected the records in person the same day.	One volume of copied patient records; print out of Mental Health Services for Older People electronic records.
IGI/13669	NHS Sandwell and West Birmingham CCG	13-Oct-17	An unsecured folder/bag within a bag containing x4 patient records was found by a member of the public left outside in a gateway entrance to a utilities service commercial building. Member of the public who found the bag and works for the utilities service contacted the CCG after opening it and noting the information contained was identified as for SWB CCG and contacted the organisation. CCG asked the member of the public to secure the folder/bag and the CCG would have it collected by a Courier service (the documents were found approximately 40 miles	CHC assessment information

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			away from the CCG location). The courier delivered to the CCG the bag containing the information by 2pm the same day of the member of the public contacting the CCG; information contained within were x4 patient records for the purpose of Continuing Health Care assessment.	
IGI/13712	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	25-Dec-17	A Community Midwife has lost a work diary with patient information contained within it and a laptop. The diary contained approximately 50 patient's names and addresses. A member of Trust staff found some documents in the car park of Ormskirk Hospital which contained patient information and also a payslip for a member of staff. The member of staff was contacted whose name was on the payslip advising them that some documents had been found along with her payslip. The incident was reported on the Trusts Incident Management system Datix On the 15th September the Community Midwife was back on duty and noticed she did not have her Laptop or diary. The incident was reported to Senior Managers within the Trust Both incidents were then identified as being connected. CCTV was reviewed and it has been established how the items were lost.	Patient name and address who were receiving home visits. other loose documents that were in the diary on the day it was lost.

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			A number of thorough searches of the car park and adjoining road have taken place over a number of days, however no further items have been recovered. . The incident is being reported as a Steis incident.	
IGI/13674	Rethink Mental Illness	15-Dec-17	A Rethink Mental Illness advocate was at a hospital location in Paddington following a discharge meeting. Whilst walking down the stairs to the platform, where it was extremely crowded due to possible delays, a male passenger rushed past the Advocate and other passengers. The male passenger knocked the Advocate's bag from her shoulder to the floor. A number of items fell out of the bag. The Advocate collated the items and was not aware any items were missing. The Service Manager of the Advocacy service was contacted by the local CMHT Team Manager to inform him that a member of the public had contacted them to advise she had found DoLS forms, medical information and reports at Paddington Station. The paperwork was recovered and will be destroyed by the CMHT as these were copies that had been provided to the Advocate following their visit to the Ward.	The following information was returned to the CMHT: - DoLs form 3 - DoLs form 4 - Paid RPR report - Minutes of ward round and Continuing Care Review meeting - Discharge summary - In-patient letter - Continuing Care Patient Review
IGI/13700	THE WHITTINGTON HOSPITAL NHS	15-Dec-17	A General Surgery nurse handover sheet was found in the Whittington hospital main entrance area by a reception desk staff member. The handover sheet contained the details of	13 individual patients affected. Breached data: patient names, ages, brief descriptions of

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	TRUST		13 individual patients. The sheet contained patient names, ages and brief descriptions of conditions and treatments, plus the accommodation status of patient i.e. “lives with family nil carers”. Whilst not detailed, the clinical information contained is sensitive and 2 cases indicated the mental health condition of patients. The correct protocol for handover sheets involves clinicians writing their name and role at the top of the sheets, keeping them within the wards and not removing them. The sheets must also be placed in the confidential waste bins provided at the location at the end of the shift or before then if no longer needed. The clinician involved did not write their name on the top of this sheet and failed to place it in the confidential waste bin at the end of their shift.	conditions and treatments. Mental health condition of 2 patients indicated.
IGI/13749	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	28-Dec-17	Two copies of the Transfer to Community paperwork were found missing from Obstetrics ward. The paperwork contains the name and the discharge address (Foster Carers) of a baby which the birth parents should not be aware of that followed the discharge home of a baby to Foster Care Placement. Two copies of the E3 (Baby Transfer of Care) Transfer to Community were found to be missing from an obstetrics Ward. These pages contain confidential information to the discharge address of the baby which the birth parents are not to have knowledge of. Both mother and baby were discharged at the same time. Concerns are that the missing pages had been sent home with the birth mother. Social Services did not inform Ward of outcome of court case and baby's Foster Care Placement until late afternoon and did not provide any details for place of discharge until 16:45 and expected immediate discharge	Baby Demographics, Foster Carers name and Address with the baby clinical information.

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			of baby as Foster Carers waiting. There are safeguarding issues involved.	
IGI/13624	THE ROTHERHAM NHS FOUNDATION TRUST	04-Dec-17	Patient names and address details disclosed in error. 3rd party processor uploaded a file to the Survey Co-ordination Centre containing personal identifiable data containing, name, address, DOB. The file itself was encrypted and the password was given over the phone. The file uploaded was the wrong one and had not been cleansed of identifiable data. This was recognised by the receiving party and immediately destroyed.	Name, Address, DOB.
IGI/13618	MARIE STOPES INTERNATIONAL	08-Dec-17	One Call booking centre received a call from a member of the public to advise they had received an email to their personal email address. The reporter advised the email contained appointment details a full client name address and email address, sent to the reporter's correct email address. Reporter has had no contact with MSUK. Full details pending. Full investigation commenced	Name, address, email address, appointment details.
IGI/13657	KINGSTON HOSPITAL NHS TRUST	03-Oct-17	Email sent to South West London Pathology SWLP with PID. Email was sent in error as the sender was not aware PID was included in it.	name, DoB (age), awaiting test results for STIs, dates
IGI/13686	THE QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	19-Dec-17	Patient handed another patient's discharge notification in error (patient had similar name) at point of discharge. (Reported on incident management system 14th September).	Name Address NHS number Diagnosis, treatment and discharge
IGI/13619	Bridgewater	23-Nov-	A Trust District Nurse was subject to a house burglary and	names and addresses of patient

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	Community Healthcare NHS Foundation Trust	17	work items containing PID were stolen. Items stolen: Encrypted work laptop Work diary which contained patient names and address Trust camera with pictures of patient wounds which included names	on caseload - paper Camera with images of wounds which includes names - digital Laptop was encrypted
IGI/13608	Royal Hospital for Neuro-Disability	09-Oct-17	A nursing handover document was found by a visitor to RHN in the hospital car park. The document was handed in to hospital security and recorded on Datix as an incident on redacted. The handover document contained personal and clinical information about 14 patients on redacted Ward, including facial photographs in most cases.	The handover document contained personal and clinical information about 14 patients on redacted Ward, including facial photographs in most cases.
IGI/13601	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	29-Nov-17	In error when issuing notifications to the local Child Health Administration Team in North East Lincolnshire Council for children having attended the A&E department for treatment, details of other patients have been mistakenly enclosed with the notification resulting in personal sensitive and detailed information being disclosed in error to health partners in the council.In error when issuing notifications to the local Child Health Administration Team in North East Lincolnshire Council for children having attended the A&E department for treatment, details of other patients have been mistakenly enclosed with the notification resulting in personal sensitive and detailed information being disclosed in error to health partners in the council. This issue was brought to the Trust's attention following a member of the Child health administration team in North East Lincolnshire Council (NELC) recognising that a couple of A&E notifications contained details of other patients, not known to the team. Following this, a more detailed check of A&E notifications was undertaken, sent from the Trust and then processed by	The data disclosed in error contains patient identifiable information and, in some cases, contains detailed information i.e. extracts of their medical records. The Trust has only been able to confirm 23 of the alleged breaches. The data is shared as part of the Trust's adherence to Safeguarding Children in line with section 11 of the Children's act. If all 115 incidents were confirmed, this would represent a 0.4% error rate given the number of notifications shared by the Trust for Safeguarding

ID	Organisation Name	Date of Closure	Details of Incident	Data
			NELC. From NELC records this has identified 115 cases where information has been thought to have been disclosed in error. However, the Trust from its internal checks have not been able to confirm all these breaches, rather 23 have been confirmed.	purposes.
IGI/13687	THE ROYAL MARSDEN NHS FOUNDATION TRUST	12-Dec-17	On 1st September patient information contained in a monthly finance transaction report which should have been removed before sending was emailed to Boots finance team. The report contained information relating to 4,062 patients. The transaction report contained the patient's hospital number, full name and drugs dispensed. There was no address, Dob or diagnosis. The confidentiality breach occurred on Friday 1st September and involved patient identifiers not being removed from a transaction report sent to Boots for charging purposes. The individual who sent the report in error realised their mistake and re-sent the report 40 minutes later. The issue was picked up on 11th September by a manager reviewing emails on return from annual leave, who immediately responded to the human error. Subsequently an Executive Director led an incident panel. The conclusion was one-off human error. No system failures were identified. • the external Boots staff have confirmed the email containing patient identifiers has been deleted from their generic accounts and was not forwarded. • We are satisfied the incident has been contained and secured and consequences for patients.	report emailed contained patient hospital number, full name, drug prescribed.

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			• The staff member has been offered support and training	
IGI/13683	Marie Curie (London)	11-Dec-17	A member of hospice staff in Edinburgh disclosed to the Evening News that a prisoner was being cared for at the hospice. The Marie Curie Press Officer was contacted by Evening News to confirm that a member of hospice staff had disclosed that a prisoner was being cared for at the hospice, that staff not happy about this and not briefed. (All previous briefings, risk assessments and documentation relating to this admission are available, if required). Evening News confirmed that this was a story of public interest and they would be publishing details, including the patient's name. The patient's name was disclosed and some information about his condition.	Details of a patient being cared for at the Edinburgh hospice were disclosed by a member of the hospice team to the media.
IGI/13578	Nottinghamshire Healthcare NHS Foundation Trust	05-Dec-17	Laptop bag containing laptop, mifi, 1 set of patient nursing records and print-outs from patient information system containing information relating to 3 patients, was left in a car boot. Bag and contents were stolen from the car. Laptop bag was found in an alleyway by a neighbour and all patient information was recovered. Laptop and mifi were gone. Reported on STEIS redacted. Laptop bag contained 1 full set of nursing records and print-outs for 3 more patients that included demographic information and healthcare information. The bag was left in the boot and discovered when nurse was returning to work. Incident reported to police and management within the organisation. Risk that confidential, patient identifiable information relating to 4 patients has been put into the public domain.	NHS patient information including demographics and healthcare information regarding 4 patients
IGI/13684	Marie Curie (London)	06-Nov-17	A handover sheet was printed out onto day therapy unit printer accidentally. The printer stands in an open corridor. Patient names and diagnosis were on hand over sheet.	Handover sheet containing patient names and diagnoses

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			There should be a locked print function on the printer, but two copies were printed and left on the printer overnight and collected early next morning. The day therapy unit is locked overnight so there would have been no one walking through the corridor, reducing the risk of the paper copies having been noticed and seen on the printer.	
IGI/13600	Medway Community Healthcare	04-Dec-17	Member of staff brought in approximately 30 Ages and Stages Questionnaires(ASQ forms) and summary sheets for child health reviews, dating back to January 2017 which had been kept in her home. These forms should be updated on our system daily, however this member of staff had kept them in her home, therefore the outcomes of the visit were not updated on our system and we are unaware how these had been stored whilst in the home, i.e. who else had access to the notes, some included information re safeguarding.	The data included child's name, date of birth, address, development status, parent's comments on the child's development
IGI/13599	POOLE HOSPITALS NHS TRUST	30-Oct-17	A letter that was addressed to the patients GP was cc to the patients Guardian, this letter contained personal/sensitive information relating to a child and the mother. Unfortunately, on dispatching this it has been sent to a neighbouring property, as the wrong property number had been put on the address. The neighbour who received this letter in error admitted opening and when identified this had been sent in error, it was taken to the patients GP, who informed us of the incident. A full investigation is being conducted and appropriate actions being taken. The patients Guardian was informed immediately by phone, and this was followed up by a letter of apology and the offer of a meeting to discuss further was included.	Data included patients name, date of birth and national health number, and description as to the child's condition. It also included names and dates of birth of parents and medical history of mother.

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IGI/13580	VOCARE NLO	28-Nov-17	Assurance emailed Staffordshire Governance and copied in member of staff from Lockton (Vocare Insurers) into the email. Email contained 2 spreadsheets of Serious Incident reports which included patient names. 39 in total. Attempt to recall email, successful with 2 of the 3 Governance staff. Emailed staff at Lockton to delete previous email without reading, from inbox and deleted items. Spreadsheet of 13 names one sheet, 36 names on another detailing various incidents.	spreadsheet of information including patient name/ some summary of clinical condition in some cases.
IGI/13653	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	12-Dec-17	Member of staff accessed the clinical record of a colleague without a legitimate relationship.	Full clinical record
IGI/13652	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	12-Dec-17	Member of staff accessed their own patient record via the clinical system they are given access to for their role. They did not follow appropriate process when acting as a patient.	Full clinical record.
IGI/12558	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	21-Nov-17	A report completed by Complex Assessment Team for Child Care Proceedings contained the address of the foster carer caring for the children subjected to the proceedings. It is known the parent's solicitor has gone through the Complex Assessment Team's report with her. It is not known if the parent was given a copy of the report that contained the foster carer address. Further investigations have commenced	Address of foster carer for two children made subject to Care Orders to the London Borough of Camden.

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IGI/12529	Bay Medical Group (Y01008)	16-Nov-17	Wrong note sent to a solicitor in 2013. The case was closed and then re-opened in June 2017, this is when the solicitors realised that the wrong notes were sent to them. As the case was re-opened the solicitors realised they had received the wrong patients records. They informed their client, they had also sent the client a copy of the records, so they asked for them to be destroyed. The solicitors have destroyed their copy of the records.	Copies of patients records
IGI/12549	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	20-Nov-17	Staff member photographed electronic patient record containing the first name of the service user and highly confidential information including information provided by their sister including her first name. This photograph with a derogatory comment was send via Snapchat to a number of recipients both Trust staff and non-Trust staff resulting in a breach of patient confidentiality.	patient's clinical information contained in progress notes
IGI/12531	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	06-Nov-17	Honorary contract holder for the Trust was sent patient & staff identifying information relating to restraint incidents on wards logged on the Datix incident reporting system. The honorary contract holder was not required to have identifying information as her work was collating statistics from the spreadsheets these should have been redacted for this purpose. The information should also have been sent via encrypted email or password protected but was sent from a trust email account to a private email account. The honorary contact holder was also holding this information on their private computer	Datix incident reports regarding restraints on wards, identifying data was not required for statistical purposes
IGI/12528	Edenbridge Medical Practice (G82019)	16-Nov-17	Non-medical email sent to 398 people: original email addressed to staff member and 398 names thought to be sent BCC but in fact CC in error.	personal email addresses of 398 patients - no other data

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IGI/13649	St Andrew's Healthcare (Original code of NTY85)	12-Dec-17	Staff member was emailing her own scanned personal documentation over to her daughter, however sent incorrect scanned documents which happened to be 3 CPA reports and a medication chart. This occurred because she selected the incorrect scanned items without checking them. STAH has IG policies and procedures in place.	3 x CPA reports 1 x medication chart
IGI/13592	Buckinghamshire Healthcare NHS Trust	06-Oct-17	Bucks CCG contacted the Trust to advise that the CQC had contacted them to alert them to a breach of patient confidentiality. Two referrals that were being rejected back to the GP Practice had inadvertently been faxed to the CQC rather than the GP practice. The responsible member of staff was interviewed by the General Manager for Access and Outpatients to establish how the incident could have occurred. The member of staff reported that she had not been able to find the fax number for the GP practice and Googled it. On further investigation by the General Manager is became apparent that the member of staff had taken the fax number from the CQC link at the bottom of the web page for the GP practice.	NHS patient data
IGI/13693	Thatcham Health Centre (K81073)	18-Oct-17	A list of 45 patient names, printed on 4 sheets of A4 paper were lost. A GP Registrar had taken the list home to complete some audit work, the audit was in regard to the management of urinary tract infections (UTI). The document detailed patient name, date of birth, NHS number and their last consultation with a clinician regarding their UTI. The document also contained details of the surgery name, address and telephone number which was printed on the bottom of each page. A GP Registrar had taken the above document home in a folder to type up. She realised she had lost the folder after several days when she was planning to	Individual patient data for 45 patients, including name, date of birth, NHS number and clinical entry of their last consultation in regards to a UTI. No 3rd party information was released. The practice name, address and telephone number were printed on the bottom of the sheet. The practice has not received any reports of an external agency or

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			type up the findings of the audit. She believes it was accidently put in her recycling bin at home, however the folder may have been lost on her way home on public transport. She has contacted the bus depot on 2 occasions and it has not been handed in, she has also thoroughly searched her home.	person having accessed this report.
IGI/12511	THE WALTON CENTRE NHS FOUNDATION TRUST	14-Nov-17	Health Care Assistant disclosed sensitive information regarding infection status to a patient's daughter without consent from the patient. On entering the side room staff member advised patients daughter to keep her gown and gloves on as her Mother had an infection (and named the infection). Patient concerned was upset with the manner in which this was disclosed. Patient has since confirmed that the daughter already knew the infection status but was concerned that the staff member had not gained clarity of this before disclosure.	NHS patient data relating to infection status was divulged verbally without consent.
IGI/12513	Leeds Community Healthcare NHS Trust	15-Nov-17	As part of a retendering process LCH as the current provider, provided the Commissioner with an anonymised list of LCH staff assigned to the service. This list was uploaded on to a bidding portal by the commissioner with the new specification which potential bidders can use. The information was made 'live' on the portal to potential, registered bidders. The commissioners were contacted by a competitor to confirm they had discovered a 'hidden sheet' on the list which brought up 4000+ lines of LCH staff information including names, DOB, NI Number, salaries, working hours as well as additional coded and non-coded information. Fact Finding investigation currently ongoing.	Excel spreadsheet document of LCH staff information including names, DOB, NI Number, salaries, working hours etc. 4400 lines of information - which included some duplication.
IGI/13606	NHS England	06-Dec-	11 medical records delivered to wrong GP practice.11 Medical records were delivered to the practice, stop ID	Medical records

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		17	redacted , however the records received were labelled for stop ID redacted (redacted) which is a different practice in the same building. All 11 records were opened by the practice.	
IGI/13567	University Hospitals Southampton NHS Foundation Trust	11-Oct-17	7 letters from University Hospital Foundation Trust's Specialist medicine team were sent to a member of the public who had been treated by the team. The letters were intended to go to patients' GP surgery and contained detailed sensitive personal information regarding patient diagnoses, address and NHS number. The letters were sent out using a windowed envelope and the address in the window was not checked prior to sending. The letters comprised 7 routine clinic outcome letters addressed to the patient's GP. The details included recent diagnostic tests carried out, outcomes of these and future follow up plans. The Trust was informed of the error by the member of the public who received the letters and had refused to return them, to the Trust. The member of the public also suggested he had been in contact with the media and asked for a 'finder's fee'. This was declined by the Trust and the patient continued to refuse to return the letters. The Police have since retrieved the letters from the recipient. All patients involved were identified and 6 of them were contacted by telephone. One patient could not be reached by the team. All the patients affected will receive written confirmation of the data breach. The Patient Advice and Liaison Service have been made aware and will provide	The letters comprised 7 routine clinic outcome letters addressed to the patient's GP. The details included recent diagnostic tests carried out, outcomes of these and future follow up plans. The letters all included the patient's name and address, date of birth, hospital number, and NHS number. The majority of letters included a summary of the patients' symptoms and diagnosis and recommendations for treatment or on-going management. The patients affected have requested a copy of the letter be sent to them. The Police have confirmed that they have retrieved all data from the recipient and he has been made aware by Hampshire Police that any attempt to utilise this data would be considered an actionable offence.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			support as required. Immediately following the incident an email was sent to all Patient Pathway Coordinators (PPCs) instructing them to not use windowed envelopes and to ensure they check the address on the envelope is the GPs and not the patient's. The Matron responsible for the area affected is leading the investigation into the incident, together with colleagues from Patient Support Services, Patient Safety and Information Governance.	
IGI/12498	Croydon Health Services NHS Trust	13-Nov-17	Handover notes were put in a waste paper bin rather than a confidential waste bin. A member of staff working in the same building found at the waste paper bin handover notes of 26 patients left in an insecure area. The member of staff informed IG over the weekend and gave the documentation to the IG Team. The IG Team entered the information onto the local system and on review felt it was important to let ICO know.	Bed Number, Patient Details, Problems, BG, Investigations, ABx + Anticoag, Plan and Jobs
IGI/12497	Croydon Health Services NHS Trust	13-Nov-17	A member of staff throwing 9 patient records into a waste bin instead of a confidential bin. Another member of staff working in the building on had noticed that patient letters had been thrown into a waste paper bin. The letters include names, addresses, diagnosis etc.	Name, date of birth, NHS number, Full Address and Telephone Number
IGI/13603	DARTFORD AND GRAVESHAM NHS TRUST	01-Dec-17	An Encounter Report of one patient found on the photocopier on a Trust ward. The document was torn up and disposed of in the confidential waste then retrieved and sent to the IG Manager as evidence. The photocopier is not in a public area and the document was found by a member of staff.	A two-page Encounter Report for one patient detailing demographics, medical history, known allergies, medication, referrals, tests, prevention data

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IGI/12443	DARTFORD AND GRAVESHAM NHS TRUST	13-Oct-17	Ward handover sheet found in hospital grounds by a member of staff. Staff found handover sheet in hospital grounds, realised implications and raised Datix incident.	Ward handover sheet detailing name, age, consultant, diagnosis, treatment plan, social status data
IGI/13565	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	23-Nov-17	Details relating to 21 patients on a ward were found on the printer at a Health Centre having been printed by a member of staff working on the ward. The member of staff had access to the printer at another site and accidentally printed to it from the ward. Details of patient's diagnosis, past medical history, medications and resuscitation status for 21 patients on a community ward were accidentally sent to a printer at a health and social care site. The printer is located in a secure office used by healthcare staff from the same Trust as the ward staff. The member of staff had access to the printer from a previous role.	Patients diagnosis, past medical history, medications and resuscitation status.
IGI/13654	Shiregreen Medical Centre (C88070)	12-Dec-17	Email containing copy letters to 102 patient including name and addresses as well as a spread sheet containing names and unplanned admission details sent to a number of recipients. All email addresses have been redacted.	Name Address Unplanned admission details
IGI/12436	SHEFFIELD CHILDREN'S NHS TRUST	27-Oct-17	3 double sided pages of Ward Handover information - including names, ages, conditions and care plan next actions - found by a member of the public outside the Trust, who then handed them into their local GP Practice, who then notified the Trust. Information relates to up to 74 patients (children). Investigation is being progressed with urgency to ascertain all facts. Patient list on handover documents has been matched with	Handover information - including names, ages, conditions and care plan next actions

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			ward list from same date, and from this validation there is no suggestion that there are further handover sheets that have not been recovered. Member of the public who found the handover information has talked the circumstances through with the Trust's incident manager, and has updated that the handover information was found on 19th July and that he returned this via his local GP surgery at the first opportunity he had, having been away over the weekend following this. He is prepared to give an interview and full statement (which is being organised). Letters were sent out to families on Monday 14th August, with PALS and other support infrastructure in place in the event that families have specific concerns or further questions upon receipt of this notification.	
IGI/13604	NHS England	06-Dec-17	Medical record delivered to dental practice in error. 1 Medical record was delivered to a dental practice due to the similarity of the route I.D's and stops. Medical practice is redacted, and dental practice is redacted.	GP Health Records
IGI/12428	NHS England	02-Nov-17	GP medical records delivered to incorrect surgery. City Sprint incorrectly delivered two sacks of unlabelled Medical records on 26/7 (20 records in total) to redacted. 4 or 5 were opened and checked. Re-bagged and combined into one sack for collection on 02/08	GP medical records
IGI/12455	PENNINE CARE NHS FOUNDATION TRUST	07-Nov-17	Confidential letter to staff member posted to the wrong house number. It became apparent that redacted had not received the letter marked private and confidential. redacted printed a copy off and put it in an envelope for recipient to collect as redacted was at trust headquarters. redacted spoke to redacted where it was clarified that the	Sensitive letter

ID	Organisation Name	Date of Closure	Details of Incident	Data
			letter had been posted to the incorrect house number. the address was double checked on ESR where it was recognised that the house number was wrong on the letter. redacted expressed dissatisfaction that the letter had gone to their neighbour; redacted expressed their sincere apologies and acknowledged the error. Line manager had discussed the incident with redacted; redacted acting CEO emailed redacted to express his apologies for the error and assured that an investigation would take place due to the breach of confidentiality. PA's have also acknowledged that as a lessons learned that all future correspondence to staff would be sent as recorded delivery	
IGI/12477	BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST	10-Nov-17	A locum staff member (Acute Medicine Division - ED) returned 168 original ED cards to the Emergency Department. Upon inspection, the ED card attendances range from 15th, 16th, 18th, 19th and 22nd May 2015 (King George Hospital). It is not yet known how long the records were off site for, however it could be up to 2 years. The number of patients affected is not yet known as it has been identified that there is more than one ED card per patient. The date of the incident is not known (date incident was reported entered instead due to mandatory field above under 'Date of Incident').	Patient identifiable medical records of ED attendance for adult and paediatric patients
IGI/13633	Bristol Community Health	08-Dec-17	Patient received details of two other patient referrals along with her appointment letter. Patient 1 received with her appointment letter the details of the two other patients e.g. the referral for patient 2 and the notes of patient 3. Patient 1 had called Patient 3 to inform her that this had happened, and patient 3 also phoned Physio to report a breach in confidentiality.	The information disclosed contained personal details e.g. Name, address, date of birth and NHS number. The referrals also contained medical information e.g. information regarding their condition and

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				medications taken.
IGI/12512	Bollington Medical Centre (N81022)	15-Nov-17	A patient had given consent for further information about specific elements of medical record to be shared with the insurance company. She indicated that she wanted to see the report before it was sent but, on this occasion, this didn't happen, and the report was sent directly to the insurance company. When the patient was declined insurance, she contacted the practice to ask why her data had been sent directly.	The data was an insurance report and two clinical letters
IGI/12387	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	28-Oct-17	Employee Data disclosed in error - contacted mailto: redacted.	TBC
IGI/13646	HCA HEALTHCARE UK	05-Dec-17	Case manager explained that they had referred a patient for physiotherapy on their company letterhead, which had their business address at the top of the page. The letter specified the address or email address to which correspondence should be sent. The invoice was sent to the company's registered address instead of its business address and the invoice was picked up by the company accountant. The envelope, therefore, contained both the invoice and the patient's referral note which included the patient's confidential information. The invoice was sent in late June, but the patient did not receive it until late July. There was, hence, a delay in processing payment. Data Protection principles 1, 4 and 7 have been breached. Namely, a) the patient was identifiable and confidential information was sent to the wrong person and b) there was a referral sent with an invoice which doesn't appear to be	Patients name, address, telephone number, date of birth.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			standard practice.	
IGI/13617	HEART OF ENGLAND NHS FOUNDATION TRUST	07-Dec-17	A member of staff who works in maternity has accessed records without authorisation, including male patient records.	Patient records
IGI/13562	NHS England	23-Nov-17	A sack of GP medical records was delivered to a GP practice in error. The practice opened one record and verified that the records were not for them. One un-ticketed sack containing approx. 20-30 unlabelled records were delivered to redacted on 27.07.17. One Record was opened – NHS No redacted. Once the surgery realised the records were not for them they contacted PCSE. The NHS number indicates the sack was collected from the previous surgery, redacted – on the designated courier route."	GP medical records
IGI/12431	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	02-Nov-17	3 Domestic Violence "Child Protection, Thames Valley Police - Child Protection Information Sharing Reports" were left in staff room after a team meeting. A member of staff from adult social services, who share the building, found the records on the staff room table and returned them to the Health Visiting Team The reports detail all information regarding a domestic incident by Thames Valley police. It details names, DOBs and addresses of all concerned and details of the incident and investigation such as reports from investigators within Thames Valley Police and the Multi Agency Safeguarding Hub (MASH) and their log entries around each occurrence.	Names, DOBs and addresses of all parties concerned in the cases. Details of the domestic incident and investigation such as reports from investigators within Thames Valley Police and the Multi Agency Safeguarding Hub (MASH) and their log entries around each occurrence.
IGI/12526	OXFORD UNIVERSITY	10-Nov-17	Two paper diaries containing patient information taken and covert recordings made by ex-staff member.	Diaries containing patient some of which could be sensitive

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	HOSPITALS NHS FOUNDATION TRUST		Ex-staff member admitted at meeting taking two diaries and making voice recordings of staff while employed to support claim for constructive dismissal. The ex-staff member then cited details of two patients in witness statement to support employment Claim.	personal information. The number of patients is unknown. Audio files of staff conversations, the scale of these is unknown.
IGI/12542	St Andrew's Healthcare (Original code of NTY85)	18-Nov-17	26 letters were sent to staff members of STAH informing them of changes to pay caps. Unfortunately, these letters were printed double sided so each of the 26 members of staff in question received another member of staff's letter on the back of their own. The letters included name and address of the staff member and informed them of what pay band they were on and point on that band - i.e. band 5 point 2. (no actual salary amount was disclosed).	Name Address Salary banding
IGI/12427	NHS England	02-Nov-17	Sensitive clinical correspondence delivered to incorrect location. A package containing details of a child protection conference relating to 3 children, was delivered via Royal Mail 'Signed For' delivery to a Tesco store in Bury St Edmunds, Suffolk. The package had been posted from an NHSE team processing clinical correspondence, based at the PCSE Offices in Leeds.	Child Protection correspondence
IGI/12356	Marple Medical Practice (P88021)	30-Oct-17	The practice was undertaking a mailing of target patients inviting them to take part in an approved study (Ignite / Sanofi) aiming to reduce their HbA1c. The mailing list was provided to us in line with their protocols (without the study company having patient details unless patients choose to "opt in").	Potential Inference that patient named / potentially identified by Title Initial & Surname (also) suffers from Type 2 Diabetes, is on a range of named medication & has less than optimal HbA1C

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			In the process of hygiening this data to remove patients known to be unsuitable for a variety of reasons, the names on the spreadsheet became mis aligned with the addresses. This meant that the letter went to the correct people but with another patient's title, initial & last name in the address / salutation. The mailing took place on 18/7/2017 with receipt by patients in the mail 21/7/2017 The reason that this happened was human error by the practice manager when manipulating the spreadsheet for uploading to the Docmail bulk mailing facility. There was no specific protocol in place to prevent this happening / provide an additional check which has now been rectified by the immediate instigation of a "Bulk Mailing Protocol" which specifies that final data is to be reviewed by another responsible person for accuracy (specifically in terms of spreadsheet alignment) against patient records before it can be uploaded. The risk is that the Information within the letter about the nature of the study may have led the recipient patient at the address to infer that the person whose initials and surname on the letter also has type 2 Diabetes (with a less than optimal HbA1C). Whilst incorrect information was minimal (Title/Initial/Last Name) It is possible that this could lead the person at the address to be able to identify them. We have deliberately selected High Sensitivity Factors to	control

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			drive to Level 2 as we feel it appropriate that a report is made to the ICO	
IGI/12347	MEDWAY NHS FOUNDATION TRUST	16-Oct-17	Email sent to incorrect recipient with patient identifiable data. The Trust BI team became aware (via a third party) that a team member had been emailing a monthly 'did not attend' report to the wrong email address. The data has remained within the NHS but was sent to another hospital - the recipient's name was identical to the correct sender, but the correct email account should have had a numeric suffix to their email address e.g.xxxx1@nhs.net. It is believed that this has happened each month since at least December 2016 but the team have only just been made aware of the breach. Each report contains 25,000 to 30,000 patient details but the reports often duplicate the previous month with new DNAs added to it. Therefore, it is not a different 25,000 set of patients each month.	NHS number, hospital number, age range, high level description of speciality treatment.
IGI/12469	NHS England	25-Oct-17	Email sent in error containing names of BAME staff and their talent assessment. An email from the Business Office with an attachment BAME Talent Grid regarding all band 7 – 8B staff (including names of BAME staff and their talent assessment) was circulated to all DCO Directors. A further email from the Business Office was then sent to an Associate Director in the Clinical Networks and Clinical Senate team copying in their PA. Another further email from the Associate Director was sent to the Clinical Network and Senate senior team. A member of the senior team who is also named on the talent grid responded back expressing their concern that they have received the email and attachment identifying BAME staff	Staff name, banding and their talent development assessment

ID	Organisation Name	Date of Closure	Details of Incident	Data
			and their assessment.	
IGI/12433	NHS England	11-Oct-17	Correspondence for a complainant was sent to the wrong address. The house number on CRM was different to that on that complainant's letter and due to the details not being checked the incident occurred. A chase letter was sent to the same incorrect address. The matter came to light when the complainant's advocate queried the non-receipt of expected correspondence.	The complainant's name and address were disclosed including details of the complainant's deceased relative and information relating to 'do not resuscitate' and the medical/clinical experiences encountered by the deceased leading up to their death.
IGI/13861	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	18-Oct-17	A letter to the patient's GP from the Community Mental Health Team was copied in to the patient but the wrong house number was typed into the address (51 rather than 15). A member of the public received the letter and took it to his GP surgery who contacted the relevant team manager via phone. The member of staff from the surgery was reluctant to provide any information other than the patient's name and that they would be raising it as an incident within their organisation. We were notified by Commissioning Support.	Letter to patient's GP from Community Mental Health Team detailing patient's presentation, risks, medication, diagnoses, and proposed treatment.
IGI/13583	HEART OF ENGLAND NHS FOUNDATION TRUST	20-Dec-17	Member of staff accessed records of people known to her without a valid reason. This was identified when a member of staff escalated results.	NHS patient information
IGI/12324	LONDON BOROUGH OF ENFIELD	19-Nov-17	As part of a migration to Microsoft Azure, downloads of PCMD, ONS Births, Vital Statistics were moved to a new storage location without prior permission. During the initial investigation, it was revealed that on receipt of the data it was copied and backed up at 2 Serco /	Primary care mortality data base (ONS) ONS Birth Hospital episode statistics Vital statistics service (ONS)

ID	Organisation Name	Date of Closure	Details of Incident	Data
			Sungard AS datacentres in the UK. The backup location was not listed as a storage location in the agreements. LBE has been in receipt of this data since redacted. The Data concerned is: PCMD – 20,274 records of deaths (person identifiable) in Enfield between 2006 and 2015 ONS Births – 21,150 records of births (person identifiable) in Enfield between 2012 and Q1 2016 Vital Statistics – aggregated summary of deaths and birth. Contains records with small numbers (fewer than 5) which are considered person identifiable. All these data were in digital format and role-based access was applied. When was the data moved? 15th of November 2016 initial copy started, data moved to redacted 20-21 May of 2017 - data moved to UK to Microsoft Azure redacted. Where is this data currently physically held? UK - redacted NE - redacted . WE - redacted . In what form?	

ID	Organisation Name	Date of Closure	Details of Incident	Data
			We have live data redacted – this data is backed up within the same data centre only WE has replicated backup copy as storage account used for the backups and is geo-replicated (NE and WE). NE / WE contain data and changes to data to May 2017 - this will be deleted as part of the secure destruction process. Prior to the Azure move data was held in 2 UK data centres managed by Serco - this will be deleted as part of the secure destruction process. Who can access this data? LBE users (maximum of 5 during this time period) have access to the data as per the role based access that they have been assigned. LBE Support staff have access as per role based access that they have been assigned. SunGard AS support staff will have access to the legacy Serco datacentre data and backups as per the role based access that they have been assigned. MS support staff have no access to our data in any of the regions.	

ID	Organisation Name	Date of Closure	Details of Incident	Data
			The data remained under our control, secure and within EU datacentres that are compliant with the DPA EEA processing rules, however handling guidance – and hence our processing agreement –was broken. Appropriate incident management procedures are being followed and documented with a view to applying the learning from this incident to prevent recurrence.	
IGI/12346	Birmingham Women's and Children's NHS Foundation Trust	23-Oct-17	A thief gained entry to a member of staff's home and stole a workbag containing a work phone, diary and patient record sheets. The information is confidential information about all the women booked for homebirth who are currently more than 36 weeks pregnant or who have recently had the baby and are still receiving postnatal care. Approximately 31 patients are involved.	Name, address, phone number, date of birth, GP, due date, parity, haemoglobin level, BMI, and information about the pregnancy. Also, for the postnatal women, the baby's date of birth, type of birth etc
IGI/12328	Frome Medical Practice (L85008)	20-Oct-17	When sending the email, a staff member picked up the name of an external contact at Capita, instead of our safeguarding lead, who has a similar name. The external contact emailed the staff member as soon as they saw the email was not meant for them. The external contact is known to the practice through a company called Capita who come in to do training for the practice. The staff member emailed the external contact back & asked her to delete the email & confirm deletion. The external contact replied that they had deleted the email from their inbox & cleared their deleted folder, so it was no	The attachment contained details of 10 patients between the ages of 4-13, including their names, date of birth, ages, gender, NHS numbers with brief summaries on safeguarding problems on some of them.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			longer on their system.	
IGI/13777	NHS Salford CCG	23-Oct-17	Admin has sent an email using their contact list to a female colleague who is a PM in a Medical Centre however we have been notified it has been sent to a male in the NHS community with a very similar name (e.g. redacted) same surname. Emails contained 4 domestic violence notifications. On checking the sent items, the same thing happened on a number of occasions to the same email address however other emails that have been sent in the same way have gone to the correct recipient. Tried to recall the messages sent but just keep getting a notification that the message cannot be recalled. It may be due to the messages having already been opened. IT were contacted but were unable to offer any assistance with recovery of the email. Incorrect recipient was requested to delete the emails which was confirmed. The incident has been logged with IT 19.07.2017 log number - redacted. IT have made initial checks on the email addresses and neither has the other linked to them. We have checked Admins contact list and it appears to be set up correctly. IT came and checked the computer and can offer no	Surname Address Postcode Date of Birth Gender Ethnic Origin Police history

ID	Organisation Name	Date of Closure	Details of Incident	Data
			explanation as to the occurrence.	
IGI/12398	PENNINE CARE NHS FOUNDATION TRUST	16-Oct-17	Received phone call from redacted support worker regarding letter that was sent to his address but not in his name Letter should have gone to redacted who resides at redacted. The letter was sent out by Rochdale Mental Health Office. The Mental Health Law (MHL) Office at BHH received a phone call from a support worker for a patient (redacted) who is subject to a Community Treatment Order (CTO) under the Mental Health Act (MHA) regarding a letter sent to the address of redacted but not in their name. The letter was intended for patient redacted who is also subject to a CTO. The letter was sent to redacted from the MHL Office at BHH on the 12th July 2017. The MHL Assistant checked the details on Paris for redacted and noted the address for redacted. However, following investigations, it appeared that the address on Paris for redacted was incorrect and was for another patient redacted. The address for redacted had been incorrectly inputted into Paris by a medical secretary based at BHH. HR checked on Paris for address and then sent letter out to redacted Letter went to incorrect patient It did have the correct named patient on letter, but address had been changed Medical secretary changed address for this patient to redacted but the correct address is redacted I've checked this out with care-co yesterday	Letter containing details of a Community Treatment Order renewal under Section 17a of the MHA (1983). Limited confidential information contained within the letter

ID	Organisation Name	Date of Closure	Details of Incident	Data
			New letter now sent out to redacted with correct address regarding his managers renewal meeting	
IGI/13689	Newton Road Surgery (G82039)	20-Dec-17	Patient collected letter from reception and found a letter for another patient in the envelope with it. The letter was a copy of a clinic letter from a hospital. It contained medication details including patient's name, address and date of birth. The letter was included in error when a member of staff unknowingly picked it up attached to the other letter. The letter was given back immediately to the surgery as the other patient opened her envelope upon collection at reception. The risk is another patient's medication details have been seen by her along with their name and address.	Patient data clinical letter including name, address, DOB, NHS number, Hospital number and details of medication and treatment.
IGI/13610	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	07-Dec-17	Following a serious incident involving a KMPT client being reported in the media an audit was conducted on the client record. Within the results it was noted that a member of KMPT staff had accessed the client's record, and there was no legitimate reason for this access to take please. The Caldicott Office then conducted further audits into all client records that had been accessed by this staff member and were provided to the line manager for review. The line manager highlighted a number of other clients that the staff member had no legitimate reason for access. One of these records included the staff members brothers clinical record. Since the investigations the individual has met with their line manager and confirmed that some of the access highlighted was not legitimate and had been accessed because they were being inquisitive. Line manager is currently reviewing	Electronic clinical record

ID	Organisation Name	Date of Closure	Details of Incident	Data
			any further action to take, and the staff member has had all access to clinical information removed whilst this is being decided.	
IGI/12297	Royal Hospital for Neuro-Disability	09-Oct-17	RHN recently introduced a new IT security system which detects and monitors personally identifiable information being sent in emails from RHN.org.uk addresses. The IT department has reported 10 incidents which occurred between 18/05/2017 and 26/06/2017 where PID was not sent securely. All emails were sent to the correct and intended recipient however were not sent via a secure email route. We have no reason to suspect that information was accessible to anyone other than the intended recipients. Most incidents were due to staff not following relevant RHN protocols however one incident involved a typo which prevented the email being sent encrypted.	All incidents involved patient PII, such as names, NHS numbers and DOBs. Most incidents also included patients' clinical information, for example diagnosis, progress notes and treatment plans.
IGI/12388	Leyland Surgery (Y03656)	30-Oct-17	Wise Pharmacy disposed patient identifiable data into general waste. The Practice Manager of Worden Medical Centre was informed who transported the information back to the pharmacy to be disposed of confidentially. All managers of the other surgeries were informed to this effect. Not all information was available to be retrieved from the general waste site.	NHS Numbers, Patient names, DOB, Addresses and medication information.
IGI/12323	NHS South Norfolk CCG	20-Oct-17	A report prepared by a member of staff containing details of an individual patient case was shared with the relevant persons involved in the care but via an unsecured email route.	The report that was attached contained patients first name, initials, place of residence and possible police concern information relating to one individual patient.
IGI/12290	Worden Medical	13-Oct-	I was contacted by redacted from Lancashire County	NHS patient information: Patient

ID	Organisation Name	Date of Closure	Details of Incident	Data
	Centre (P81057)	17	Council. He advised me that paper work had been found with patient details of patients from Worden Medical Centre. I went to the recycling plant to look at the paper work, which the staff had retrieved. They informed me that some remained in the skip which they could not retrieve. It was apparent that the paper work had originated from redacted Pharmacy redacted. The paper work contained prescription information and dispensing labels showing patient personal and medical details from various GP surgeries in the Leyland area. I took the box of paper work and contacted redacted, the Pharmacist/Manager, to advise I was driving to the pharmacy to drop the paper work to them and to discuss the breach. I left the box of paper work with them. I agreed I would report the incident as I was the initial contact. Contact details of other recipients have been redacted.	name, address, NHS number and medication information.
IGI/12295	Dr D E Sousa & Partners (H81007)	16-Oct-17	A fire broke out at Weybridge Hospital resulting in significant damage to the building and contents including patient, HR and financial records in both hard copy and electronic format. At the time of reporting the 12,000 records are believed to have been destroyed. The site currently remains inaccessible to salvage teams meaning any records which may have survived the fire remain at risk of loss and will continue to be a risk until the salvage operation is complete.	Approximately 12,000 are believed to have been affected. Any loss of electronic records continues to be assessed however it is believed electronic records have been unaffected and remain safely stored within the clinical IT system. IT equipment stored on site which may hold local copies of data has yet to be recovered and it is expected that desktop computers have been affected which will not be encrypted. All financial paper and electronic

ID	Organisation Name	Date of Closure	Details of Incident	Data
				data would have been lost.
IGI/12284	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	12-Oct-17	A staff members car was broken into and items were stolen including patient identifiable information. The car was broken into outside home in the forecourt. Police were informed straight away - Crime Reference No; redacted. The work bag taken from boot of car which contained work items including a laptop and lead, a mobile phone, a dairy, a new name badge, a Skype phone, a Dictaphone, blank tapes 2 and a wallet pertaining 6 letters of 6 individual service users which includes their initials, CIS number, address, care plan, diagnosis, medications.	6 letters of 6 individual service users which includes their initials, CIS number, address, care plan, diagnosis, medications.
IGI/13609	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	07-Dec-17	Member of staff accessed clinical system without legitimate relationship with client. Member of staff was mother of client. Concern was raised that the mother of a client who is also a member of staff had accessed the clinical record for her son with no legitimate relationship in order that she could look at whether his treatment could be sped up. Audits were undertaken on the system which showed access had been made on one occasion, but that no other concerns with regards to access had been raised.	Electronic clinical record containing demographics, appointments, documents and progress notes for client's care
IGI/12400	EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	14-Nov-17	Disclosure of employee personal medical data was given by a Trust line manager to the Trust's PAM occupational Health Service contractors. The PAM Occupational Nurse phoned the member of staff to inform him of the information breach. Disclosure of full Employee personal medical information to PAM Occupational Nurse Contractor who was scheduled to conduct an occupational assessment via telephone.	Employee Full Medical Notes
IGI/12348	HAMPSHIRE HOSPITALS NHS	21-Nov-17	A ward handover sheet containing handover information about 20 patients was found by a member of the public on a	A ward handover sheet containing clinical handover

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	FOUNDATION TRUST		road near the hospital. The member of the public contacted the Trust and they returned the information. An initial investigation has found that a member of staff inadvertently took the handover sheet with them when they had finished their shift and dropped it on their way home.	information, names and dates of birth for 20 patients.
IGI/13559	THE ROYAL WOLVERHAMPTON NHS TRUST	22-Nov-17	A photograph was taken of a patient list. The date of the photograph at this stage is unknown. The photograph was then sent to a member of the public (known to the photographer). The member of the public contacted the on-call manager for the Trust to inform them of the photograph. The following week the Group Manager was contacted about this and shown the evidence. The Group Manager suspended the member of staff concerned	Photos taken of screen and lists sent to partner at the time via WhatsApp. Staff member suspended whist we liaise with Police and ICO about how to proceed and obtain devices to examine. Currently exploring possibility of a court order.
IGI/12486	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	13-Oct-17	A parent of a child received a clinic letter for another child that contained very confidential /sensitive information.	NHS patient data.
IGI/12470	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	06-Oct-17	A member of staff accessed and viewed another colleague's personal information (hospital appointments) in Nottingham hospital system.	NHS patient data.
IGI/12426	NHS England	02-Nov-17	City Sprint delivered 2 medical records to redacted. This was incorrect as City Sprint should not deliver medical records to dental surgeries. This resulted in an unauthorised disclosure of 2 patient records.	GP medical records

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IGI/12287	NHS England	12-Oct-17	A medical record was found outside a practice by a member of the public. The record was for a patient who was de-registered. The record was due to be collected on 14 June 2017. The record was handed by a member of the public to the midwife of the practice. The midwife returned the record to the practice and the practice notified the RLM. The record was not opened until it was received back to the practice to ascertain its contents.	Medical records- patient data
IGI/12262	NHS South Tees CCG	20-Oct-17	A document containing NHS numbers, nursing home of residence (and, where applicable, dates of death) was sent via secure email from the North of England Commissioning Support Unit to a member of CCG staff. The information (in a pseudonymised form) was required by the CCG to carry out a piece of work, however, it was not pseudonymised before it was sent to the CCG. The CCG staff member opened the email attachment and, realising it had not been pseudonymised, forwarded it to the Data Management team at the CSU to carry out this work. The DM team notified the information governance team that they had received the information from the CCG (who should not have received it) and the incident was highlighted for investigation. The incident has been contained within the CCG and the CSU - no PID was sent outside of these organisations and was not sent outside of the nhs.net network. The recipient of the information does not have any means of converting the NHS Number or using it to access personal information or records.	1,362 live patient details (NHS numbers, nursing home of residence) were included in a file of 4,144 entries - a number of patients were deceased, and a number were duplicates. Total live patients were 1,362. The incident has been contained within the CCG and the CSU - no PID was sent outside of these organisations and was not sent outside of the nhs.net network.

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IGI/12232	NHS England	20-Nov-17	A spreadsheet containing personal confidential data was disclosed in error via email to external organisations. A spreadsheet containing PCD about 30 prisoners with relation to mental health services was accidentally disclosed to unauthorised (approx. 18) recipients via email. These external recipients work within the health and social care environment or are under contract, however do not all have nhs.net accounts.	Establishment Patient DOB NHS number Remand / Sentence Date of internal assessment Date of referral for mental health screening and to whom How long they have been waiting Where are they located within the prison Outcome of assessment process What is their originating area
IGI/12260	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	11-Oct-17	A staff member took a picture of their computer screen from their desktop and uploaded the picture which contained details of patient information onto Facebook.	18 data subjects included name, surname, date of birth, hospital number, NHS Number, date of delivery, live birth confirmation, the hospital number and names and surnames were not visible for 13 patients.