

# Information Governance Incidents closed during 1st. January to 31st. March 2017

Published December 2017

**Information and technology**  
**for better health and care**

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## Introduction

This is the published report of closed level 2<sup>1</sup> 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<sup>2</sup>. It covers IG SIRI level 2 incidents closed during the period of 1<sup>st</sup>.January to 31<sup>st</sup>. March 2017, following investigation by the local organisation(s) concerned.

## Content of the report

The report below consists of **72 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 29<sup>th</sup>. 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<sup>3</sup>. In Appendix A are **82 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 1<sup>st</sup> April to 30<sup>th</sup>. June 2017.

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<sup>1</sup> 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'.

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

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

## Closed level 2 incidents reported during 1<sup>st</sup> January to 31<sup>st</sup>. March 2017

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/10433	Swan Surgery (D83610)	30-Mar-17	1	Full medical record emailed to solicitor. Email address not secure but patient not made aware of this. Record was not checked by a clinician prior to being sent so could have included third party references.	Patients medical record
IGI/9367	Marie Curie (London)	27-Mar-17	fewer than 11	<p>Incident occurred in Belfast hospice.</p> <p>Staff1 contacted Staff2 regarding the fact that she had not had a chance to complete patients records following withdrawal of her contract of employment. Staff1 did not feel able to come back into the place of work and asked whether she could use Staff2 laptop to which she agreed. Staff2 felt that Staff1 was legally bound to complete her notes, as Staff1 was unable to log in under her own name she allowed Staff1 to log in under her name.</p> <p>Staff2 allowed Staff1 to visit her at home and use her laptop to update patients notes. Person fully aware of procedures and policies.</p>	Staff1 accessed and updated patient notes using Staff2 log in details
IGI/10427	NHS City and Hackney CCG	17-Mar-17	31	A document (STP Budget Statement – M9 2016/17) was inappropriately distributed by a third party organisation and sent to 9 NHS organisations via an insecure email account (nhs.uk) that contained person confidential data (initials and surname – although the full names of the individuals appear in documents published by Tower Hamlets CCG by	initials and surname and month and year remuneration of 31 individuals

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				<p>way of a google search) and financial information (month and year to date remuneration) of 31 individuals. The document was circulated in an email containing meeting papers, which were not marked as confidential or not for onwards distribution either on the covering email or papers themselves. The document in question was the only document in the email package containing person confidential information.</p> <p>This document was then distributed onwards in part 1 (publicly available documentation) of the January 2017 NHS City &amp; Hackney CCG Governing Body papers that was published on the City and Hackney CCG website.</p>	
IGI/9348	MARIE STOPES INTERNATIONAL	12-Mar-17	8	<p>An email was received via the MS UK website advising that a client had received a clinic list containing the names of eight clients. The first name and surname were disclosed.</p> <p>Full investigation commenced.</p>	Appointment time, client name, client number, gestation, CCG.
IGI/9339	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	27-Mar-17	114	<p>The School Nursing Service were contacted by Christchurch Infant School, to advise that the NCMP (National Child Measurement Programme) letters, providing details of their child's Height and Weight, were sent to the wrong patient address for all of the Reception Year children who took part in the programme (114 children).</p> <p>The children at Christchurch Infant School were measured on 30th Jan.</p>	114 letters sent with wrong address containing children's name, height, weight

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				<p>The initial error looks to have happened on 2nd Feb. The letters that were produced using the NCMP Tool, and were sent out, were dated 22nd Feb.</p> <p>School Nursing were notified by the school of the breach on the 27th Feb</p> <p>The process that should have been followed is:-</p> <ol style="list-style-type: none"> <li>1. Individual pupil measurements are uploaded onto SystemOne by the School Nurses / Admin.</li> <li>2. Business &amp; Performance extract this information into an Excel spreadsheet.</li> <li>3. This information (by School) is “copy and pasted” into a National NCMP tool by Business &amp; Performance.</li> <li>4. The School Nurses / Admin then use the National HCMP tool to generate individual child letters.</li> <li>5. These letters are printed and posted.</li> </ol> <p>The issue affecting Christchurch Infants School occurred during stage 3. This is usually done by “copy and pasting” the NHS Number, copy and paste Child Name, copy and paste Measurements, copy and paste Address, copy and paste School etc, one spreadsheet column at a time.</p> <p>The pasting of the address information was done incorrectly and instead of pasting into row 1 and down, all data was pasted into row 2 and down. This resulted in each child being registered against the address of the preceding child. Meaning that all 114 children had the wrong address recorded on the National NCMP tool, all other information was</p>	

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				<p>correct. The NCMP Tool is then used to generate letters which were then printed and sent.</p> <p>The addresses are correct on SystmOne, but the addresses are incorrect on the National NCMP tool, and this problem affects 114 children measured at Christchurch Infants School.</p>	
IGI/9356	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	24-Mar-17	1 letter	Service user contacted Psychology and Therapy Team to report they had not received their promised appointment. Partner attended service to collect a copy, when the error was discovered. Service user came into service and raised the issue of miss-delivery, asking the service to attempt to recover the letter.	1 appointment letter for a mental health / Psychology and Therapy service
IGI/8278	MERSEY CARE NHS FOUNDATION TRUST	29-Mar-17	15	Folder containing personal clinical information found in unlocked desk within the family room used by public and service users.	Copies of clinical correspondence relating to 10-15 service users left in folder in unlocked desk drawer in room used by family & service users
IGI/8227	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	27-Feb-17	43	<p>The email was sent in February 2017. The spreadsheet was being used by a member of the clinical staff to track their caseload.</p> <p>The staff member was sending an email to the patient with appointment details at the patient's request. The patient had been warned that email may not be entirely secure and had consented for</p>	Name and other details were listed such as diagnosis, where they were referred on to, the intervention that was offered to them or a

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				<p>email to be used. The attachment was supposed to have been his appointment letter but the spreadsheet was attached instead. Of the 60 patients listed, 17 could not be identified in any way from the data listed it contained only initials. For the other patients: 3 were identified just by their first initial and surname, 9 by their full name, 12 by their name and date of first session. The remaining 19 patients were identified by their name and other details were listed such as diagnosis, where they were referred on to, the intervention that was offered to them or a brief description of their symptoms. The names were the only identifying information included; there were no DOB, NHS no etc and no contacts details for any patient were included.</p>	<p>brief description of their symptoms (this was the case for 19 patients listed on the spreadsheet, not for all of them).</p>
IGI/8223	Asylum Seekers & Homeless (B83657)	14-Feb-17	1	<p>Patient attended surgery with their Support Worker and partner. During the consultation it was necessary for the patient to be examined by the clinician behind the curtain. The partner and Support Worker remained on the opposite side of the curtain. Upon the completion of the examination the clinician found the patient's partner to be looking at their record, as the computer had not been locked.</p>	<p>One patient's SystemOne electronic record</p>
IGI/8258	HCA HEALTHCARE UK	28-Mar-17	3	<p>Received a phone call from a finance company on explaining that they had received 4 emails regarding 3 different patient pathology results. Emails were then forwarded back to secretary to investigate.</p>	<p>HCA pathology reports names, dates of birth and detailed pathology report breakdowns</p>
IGI/8173	PENNINE CARE NHS FOUNDATION TRUST	22-Feb-17	1	<p>Letter inviting CAMHS patient for a QB test was sent to house number 44 instead of 33. Unsure if letter</p>	<p>Appointment letter</p>

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				has been opened by unintended recipient or not as unable to obtain letter.	
IGI/8208	PORTSMOUTH HOSPITALS NHS TRUST	14-Mar-17	230	General information email sent to 230 warfarin clinic patients by administrative staff. Staff sent via nhs.net but failed to use the 'Bcc' function. Personal emails of patients visible to everyone on the email list. Several patients and family phoned the department to alert the Trust of the error.	Name Hospital Number Personal email address
IGI/8125	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	14-Mar-17	1 data subject	The daily Fair Warning report shows unauthorised access to a patient's clinical record by a staff member who is also a relative of the patient. The staff member has no involvement in the care of the patient.	Clinical correspondence Additional details Associated people Personal details Assessments Progress notes summary.
IGI/8188	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	28-Mar-17	33	Nursing handover sheet containing the confidential details of 33 patients was found, by a member of QEH staff, on Winston Churchill Drive, Kings Lynn	Patient name, medical history, diagnosis, wound pressure area, Mobility, discharge planning goals, investigations to do
IGI/8118	MEDWAY NHS FOUNDATION TRUST	06-Feb-17	1251	The Trust IG manager was made aware that the Business Information team had (on 26/1/17 pm) emailed patient identifiable details as an unencrypted attachment to an external third party who perform national patient surveys.  The data should not have been emailed, but uploaded through a secure file transfer protocol to	patient name / home address / month and year of birth - in plain text and identifiable patient gender and ethnicity coded patient dates of admission and

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				<p>the recipient organisation.</p> <p>The file, although now deleted, was opened and read by the receiving organisation.</p> <p>The data contained the patients name and home address, their month and year of birth. Fields such as gender and diagnosis are coded and would not be readily understood outside of NHS coding teams or the receiving organisation.</p> <p>The receiving organisation have confirmed that they are obligated to escalate the breach through their own governance processes.</p>	<p>discharge, and length of stay treating consultant speciality - coded treatment - coded</p>
IGI/8114	EAST LANCASHIRE HOSPITALS NHS TRUST	10-Mar-17	hard to ascertain as the notes were torn but cover a period from june 2016 to jan 2017	<p>Torn handover sheets were found strewn inside and some outside a communal bin enclosure in a housing estate opposite the car park. The handover notes relate to one medical ward and seem to cover period of many months, though not one for every day.</p> <p>The handover notes were torn strips covering a period from june 2016 to jan 2017.</p>	name , dob , hosp number and clinical details
IGI/8219	Marie Curie (London)	27-Mar-17	one diary	<p>A Marie Curie Nurse in Plymouth has lost her workbag whilst on a multi-visit shift. The bag contained her Marie Curie issued tablet device and her work diary. The work diary included her passwords to our systems including Outlook. Also due to technical issues with SystmOne (electronic patient records system) that they use in conjunction with the health service she had written down patient full names for yesterday and their postcode. One of</p>	A paper diary and an encrypted work issued tablet device

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				the patients has a keysafe and number was written down but wasn't identified as a key safe number. There were no other personal patient details written down. There are other dates in January that may have full names and postcodes. There are also days for January only with just patient initials and postcodes. The diary only contained details from the beginning of January.	
IGI/8082	NHS Redditch and Bromsgrove CCG	13-Mar-17	1	A Decision Support Tool (DST) containing highly sensitive patient information was printed 3 times in succession to an un-secure printer in the Finance Office. The Finance Manager was immediately alerted to the volume of printing taking place and these were collected and taken to the CCG IG Lead. An Incident Reporting Form was completed and sent to the IG Team.	Highly sensitive patient information
IGI/8127	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	30-Jan-17	1250	The Audit Department requested that the Information Department forward the survey details to The Patient Survey Co-ordination Centre. A member of the information department followed up this request and submitted a file to The Patient Survey Co-ordination Centre (CQC). However the member of staff selected the wrong file,(which contain 1250 patient demographics, from the two files that were updated, as one contained patient demographics and one didn't. As soon as the file was received by The Patient Survey Co-ordination Centre, they immediately contacted the Information and Audit Department to state that they had been	Patient Data - Name, Address, Age, Gender, Ethnicity, Specialty, Admission and Discharge dates.

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				sent patient details which they did not require and did immediately delete the file sent by Sath.	
IGI/8099	MARIE STOPES INTERNATIONAL	30-Jan-17	1	<p>DH contacted directly redacted to request an investigation to determine why five blank forms had appeared in the HSA4 process.</p> <p>Email sent by MSUK to DH with the intent to resolve issues with the HSA4 process had an attachment of a Word file which contained screen shots of five client records. Four of the client records were redacted leaving one record which was not redacted.</p>	Name, address, treatment type (code), treatment date
IGI/8203	PENNINE CARE NHS FOUNDATION TRUST	22-Feb-17	1	Looked after Child, patient details and address shared with third party (Oldham Looked After Children's Team) via a secure e-mail. Scanned document has been accessed and read – not sure if deleted.	Scanned Child's record uploaded to another child's electronic record in error
IGI/8280	Sussex Community NHS Trust	28-Mar-17	11 patients	<p>This incident involves a sheet of paper from a community nursing SystemOne printout that was found on the street in Hove by a member of the public and taken to a local GP practice. The practice sent a scan of the paper to the redacted and stated that they raised it as a significant event.</p> <p>The printout contained 11 patients home visits details and included the patients demographics, GP surgery and the treatment required plus hand written notes about treatment given. It is not known when the sheet of paper went missing but it could have</p>	Name, address, date of birth, summary of clinical information

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				<p>been anytime between October 2016 to January 2017 - therefore we have no assurances to know how widely this printout has been viewed.</p> <p>There has been a delay in reporting this on Datix due to busy workloads and it was only recorded on <b>redacted</b> February 2017.</p> <p>The information has been recovered. The service manager has spoken to the team to ensure they are aware of their requirements to keep all information secure and to follow the guidance in the Health Record Keeping Policy and Procedure about keeping information safe.</p> <p>It is not common practise to take printouts of patients during visits as staff are provided with encrypted laptops and remote access to the patient system - SystemOne; however, the date of this documents co-insides with the member of staff having recently joined the Trust and therefore did not have access to the patient electronic system.</p> <p>The member of staff had completed the Trust's IG training prior to the date of the home visits.</p>	
IGI/8089	PENNINE CARE NHS FOUNDATION TRUST	27-Jan-17	100 +	A new member of staff sent out an e-mail to 50+ members of the public including their e-mail addresses to invite them to a health and wellbeing college creative arts workshop.	Email inviting members of the general public to a health and wellbeing college creative arts workshop

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IGI/8050	NHS North Somerset CCG	01-Feb-17	103	<p>CCG member of staff received personal identifiable data from an acute trust. CCG member of staff forwarded the email having received it within NHSmail to two senior CCG colleagues to their CCG email account. (for e.g. nhs.net to ccg.nhs.uk - this is believed to be non-secure).</p> <p>The second point to note but only identified after the incident, personal identifiable data was not required and should not have been received by the CCG.</p>	MRN, Name, Age, Admit date, LOS, Ward, Bed number, consultant, admission method, treatment specialty (all say Gen medicine)
IGI/8102	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	06-Feb-17	28	The handover sheet contained details of 28 patients, including Patient name, ULH/NHS number and DOB. Presenting complaint and operation details, current condition, investigation results and plans. This was found in a local supermarket and handed in to the manager who contacted the hospital and returned it to us so we were able to identify the staff member/dept etc.	details of 28 patients, including Patient name, ULH/NHS number and DOB. Presenting complaint and operation details, current condition, investigation results and plans.
IGI/8047	Marie Curie (London)	10-Feb-17	5	A Team leader's folder containing 5 completed direct debit mandate forms has been misplaced. It is believed that the folder was accidentally left on a tram carriage on the Team leader's route home from site.	Paper copy direct debit mandate forms containing personal details including bank details
IGI/8011	MARIE STOPES INTERNATIONAL	27-Jan-17	1	An HSA1 form with completed client details was sent by email to incorrect internal MS UK email distribution list for a second signature. The email contained a PDF attachment which contained client identifiable information. The MS UK recipients were not directly involved in the care of the client.	Name, date of birth, address, gestation.

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IGI/8005	FRIMLEY HEALTH NHS FOUNDATION TRUST	31-Mar-17	1,773	In the second tab of the spreadsheet there were 1,773 patient names documented including hospital number, age and type of illness. This was sent from a non secure email address externally outside of the organisation to non secure emails.	Patient names, hospital numbers, age and type of illness
IGI/8046	Marie Curie (London)	08-Mar-17	6 spreadsheets	Camden CCG contacted Hampstead hospice to advise them that a quarterly activity report had been sent to them and contained the patients' NHS numbers which should have been omitted. The commissioner had not noticed this and embedded the stats into a report she produced. The error was noticed then. On review of the data that was prepared for routine reporting for the different CCGs it came to light that patient names had been included in the individual report for a different CCG - please note the report had been shared with the correct CCG but patient names should not have been included in the report.	Quarterly activity reports were prepared for each CCG. Once Camden CCG had reported the patient identifiable data that was included in their report the other report templates were checked. Information about 474 patients was included in the routine reports.
IGI/7999	Forest Group Practice (D83062)	13-Jan-17	2	Patient's had very similar first names. Letters included patients name and NHS number and details of an appointment at a hospital clinic.	Patient name and NHS number and details of the hospital appointment and clinic
IGI/8176	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	07-Feb-17	1 care plan	A confidential personal identifiable report was posted to the wrong service user. The service user was alerted by the person who received it in error and in turn informed the Trust of the unauthorised disclosure. Apologies issued.	Care plan relating to one service user with some information about the service user's partner
IGI/8021	Turning Point	22-Feb-17	Nine	Licence Agreement – containing client's full name and address Housing Benefit Award Letters – containing client's full name and address and	Clinical/care case notes, social care notes

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				housing benefit. Mental Capacity Act Assessments – containing client’s full name and tick boxes certifying their mental capacity Drug and Alcohol Testing sheets – containing client’s full name and dates/times they were tested for substance use and what substances they were tested for and/or whether the tests were positive or not.	
IGI/8063	YORKSHIRE AMBULANCE SERVICE NHS TRUST	06-Mar-17	1	The recipient opened the letter as it appeared official but did not have a return address, and on establishing the contents returned it to YAS CEO by recorded delivery. Incorrect name and address entered on letter template by Human Resources. Name corrected by Operational Manager signing the report, but address not validated.	Nature of disciplinary offence and outcome of disciplinary investigation.
IGI/8115	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	13-Mar-17	5209	personal sensitive information disclosed to commissioners	personal sensitive and protected characteristics
IGI/8121	PENNINE CARE NHS FOUNDATION TRUST	02-Feb-17	1	The error and subsequent breach of patient confidentiality was brought to the attention of the Trust Solicitor by the non executive board member, who in turn asked someone from the Trust to look into the matter. Checked PARIS and LBs section 2 documentation for the nearest relative address details. On checking it became apparent that the envelope had been addressed to the wrong house number (no. 2 when it should have been no. 3) but the road name	Mental Health Act Letter

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				<p>and postcode was correct. The letter had been delivered to a non-executive Pennine Care Trust Board member resulting in a breach of patient confidentiality.</p> <p>Non executive board member informed by person investigating that they were responsible for the error by writing the wrong house number on the envelope. The individual confirmed that they were aware of standard Mental Health Law team procedures which involves prior to sending out any correspondence to cross check address details on Mental Health Act documentation against those on PARIS. It was also confirmed that they were up to date with the Trust Core online IG training and could offer no explanation as to why the error had occurred and offered their apologies for the error and reassurance that they will be extra vigilant in the future when sending out correspondence.</p> <p>Advised by non executive board member that they need to report the incident and that a breach of patient confidentiality had occurred.</p>	
IGI/7998	Grey Gables Surgery (Y03602)	21-Feb-17	1	To whom it may concern letter' sent to inactive patient's place of work at their request as moving house. Envelope marked 'private & confidential' but patient's name omitted from address. Letter opened by patient's colleague. Letter contained medical information. Patient is understanding of the human error.	NHS patient sensitive information
IGI/8229	Suffolk GP Federation CIC	21-Feb-17	Not known	During a clearance of furniture etc from a common room at a surgery in Felixstowe a filing cabinet was placed in a skip to be disposed of. A member of the	Clinical records, addresses, dates of birth, nhs number,

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				<p>public went into reception and asked if he could take the cabinet from the skip, he was asking permission as it is on private land. He returned later the same day with a folder and said that he had to prise open a locked drawer and that is when he had found a folder that he had not looked in but felt it should be returned. Practice manager checked the folder and it contained documents including: staff details, minutes from meetings, list of new registrations, memos, questionnaires, results from tests.</p>	<p>minutes from meetings, staff details.</p>
IGI/7932	Spiral Health Community Interest Company	17-Jan-17	<p>Maximum 41 patients though it is likely to be fewer. Still under investigation</p>	<p>A cleaning supervisor reported that a waste sack - comprising patient medication boxes, labelled pharmacy bags and photocopies of controlled drug prescriptions - had been handled by a member of their weekend cleaning staff in the main Ward Office.</p> <p>This use of this waste sack, located in the main Ward Office, was intended for a particular type of confidential waste only (as above). Its use had been initiated recently by the Unit Matron as a temporary measure pending the arrival of a larger confidential waste bin which had been ordered following an earlier similar incident where confidential waste had been discovered in clinical waste.</p> <p>It was intended that this temporary arrangement would ensure that these items of confidential waste were disposed of correctly. The waste sack was transparent and suspended on a bin frame with lid. A laminated notice (red print) was placed on the lid indicating that the bin was for the disposal of</p>	<p>Labels from medication boxes, photocopies of controlled drugs prescriptions and pharmacy bags with labels only.</p> <p>1) Patient medication box labels</p> <ul style="list-style-type: none"> <li>- patient name</li> <li>- name of medication (might allow condition of patient to be learned)</li> <li>- number of items (for example, tablets) in the box</li> <li>- dosage and strength of preparation</li> <li>- route (for example,</li> </ul>

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				<p>pharmacy bags, medication boxes and photocopied prescriptions only.</p> <p>The weekend cleaner had taken the waste sack out of the temporary bin for disposal as general waste but the cleaning supervisor discovered the bag before it left the Unit. It was not possible at the time, however, to say how many times this temporary bin might have been emptied (and, therefore, handled as general waste). An investigation reveals that it is likely that this temporary bin was emptied on 4 separate occasions (over 2 weekends).</p>	<p>orally)</p> <ul style="list-style-type: none"> <li>- frequency</li> <li>- cautions or warnings about preparation</li> <li>- date of issue</li> <li>- pharmacist stamp – name, address and telephone number of pharmacist</li> </ul> <p>(There are no patient addresses or NHS numbers on medication box labels)</p> <p>2) labelled pharmacy bags</p> <ul style="list-style-type: none"> <li>- patient name</li> <li>- Spiral Health Address (would indicate that patient has been unwell and treated by us)</li> <li>- name and address of pharmacy</li> <li>- date of issue</li> </ul> <p>3) Copy Controlled Drugs Prescriptions</p> <ul style="list-style-type: none"> <li>- patient's age</li> </ul>

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					<ul style="list-style-type: none"> <li>- patient's dob</li> <li>- patient name</li> <li>- NHS number</li> <li>- Spiral Health address</li> <li>- name of controlled drug to be prescribed (might allow condition of patient to be learned)</li> <li>- dosage and strength of preparation</li> <li>- frequency</li> <li>- quantity to be dispensed</li> <li>- signature of prescriber</li> <li>- date of prescriber signature</li> </ul>
IGI/7880	MARIE STOPES INTERNATIONAL	11-Jan-17	1	<p>Vasectomy client had treatment consented to contact via email and not by post. Procedure was completed. Client contacted MS UK with enquiry which necessitated test kit to be sent to the client.</p> <p>A letter was generated and sent to client advising of test result and advising the client of the need to provide a further sample. Test kit and prepaid return envelope included with the communication to client</p> <p>Client called to make a complaint as he had received a vasectomy letter and vasectomy test kit in the post.</p>	Test Pot, specimen label, condom and prepaid return envelope included with the communication to client

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IGI/7997	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	07-Feb-17	1 individual	Team manager was alerted by Local Authority that an email meant for one of their employees had been sent to multiple employees. Further information provided later by the Local Authority's IG manager confirmed that the email was not sent via an encrypted email system. Included in the email were two supporting letters to housing, one of the letters contained sensitive personal data in relation to health.	NHS patient data
IGI/7966	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	23-Jan-17	1 page	A discharge letter destined to the GP of a service user was inadvertently included with the appointment letter sent to another service user by a clinician. The service user whose information was disclosed brought the issue to the attention of the Trust. It was confirmed that the GP surgery never received the discharge letter.	clinical information and medication as part of a discharge letter addressed to the service user's GP
IGI/7878	Marie Curie (London)	17-Jan-17	one photograph	This incident took place in the Wales nursing region. There is an agreement within the locality (Carmarthenshire) that Marie Curie Nurses are permitted to take a photograph of patient notes so that they can be uploaded to a central patient record. Marie Curie Nurses are issued with devices to enable them to do that. The nurse did not have her issued device with her and took a photo of the notes on her own personal mobile.	A photograph of a single patient's notes were taken on a personal mobile phone. The notes are a record of the care provided overnight - they contain the patient's first name but no other identifiable information.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7915	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	12-Jan-17	A number of pages	Patient removed printouts relating to 2 other patients from printer on ward. Seen reading them and handed over when challenged by ward staff. Staff on the ward had discussion with patient re. confidentiality, IG manager followed up with advice for staff re the printer's use.	Hard copy printouts from the EPR relating to 2 service users
IGI/7914	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	26-Jan-17	1 sheet as above	Agency nurse dropped paper on the ward detailing all patient names, MHA Section, and forensic detail including offences & sexual offences. Found by patient on the ward and handed in to nurses station. The matter has been reported to the Agency.	Paper detailing all patient names, MHA Section, and forensic detail including offences & sexual offences.
IGI/7866	EAST LANCASHIRE HOSPITALS NHS TRUST	16-Jan-17	23 patients	<p>Doctors (orthopaedic)handover (single) sheet found in a hospital entrance mostly used by staff. Dropped at the end of shift and handed in by member of staff arriving for work the following morning the next day. Single sheet with 23 names and hospital number and some clinical information. Contains name, hospital number, diagnosis, clinical notations and treatment plan for the day. the sheet was still folded.</p> <p>Given the above factors the IG department believe that the risk of data breach was not as high as it could have been if dropped in the main entrance and not found by a staff member the next day. It is still considered a serious breach by the Trust.</p> <p>Note, the sheet does not have the name of the doctor concerned.</p>	23 names and hospital number and some clinical information. Contains name, hospital number, diagnosis, clinical notations and treatment plan for the day.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/8202	BEDFORD HOSPITALS NHS TRUST	22-Feb-17	10,675	<p>The IGM sent the details of the breach to the Deputy Director of Finance and Performance and asked her to investigate. The same day the DDoF&amp;P investigated the issue and determined the background to the breach:</p> <p>The contract baseline file for 2017-19 (Excel workbook) was sent to NHS England. The file was based on regrouped patient level activity data. The file contained pivot tables, which covered PLD and PID.</p> <p>The PID included sensitive personal information - NHS number and date of birth. It also included the HRG and diagnosis codes.</p> <p>The contract is for secondary dental services so is for specialties 140 Oral Surgery and 143 Orthodontics primarily.</p> <p>The contract information was being disclosed to the contract lead at NHS England for the dental contract.</p> <p>NHS contracts for 2017-19 were to be agreed. BHT's Head of Contract Management (BHT HoCM) was informed of the breach. He removed the PID from the file but did not refresh the pivots before re-saving. The file was then re-sent to NHS England. Once BHT HoCM was notified again of the breach he removed the PID, refreshed the pivot files and re-saved the file, which was then sent to NHS England again.</p> <p>The breach has occurred as a result of human error in not initially considering that there was PID</p>	<p>NHS number, hospital number and date of birth. It also included the HRG and diagnosis codes. Was sent to another NHS organisation who have confirmed they have deleted the information.</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>accessible through the pivot tables. The second human error was to remove the PID but not refresh the pivot tables. The errors may have been as a result of the time pressure that the HoCM was under because of the compressed contracting timetable for 2017-19.</p>	
IGI/7858	MEDWAY NHS FOUNDATION TRUST	06-Feb-17	2000 plus	<p>Medway NHS Foundation Trust (MFT) were made aware of a fire at Remondis secure hazardous waste destruction site in Merseyside. Remondis company management were alerting all stakeholders of the destruction of the site.</p> <p>The Trust was alerted to 20 cages (approx. 1920 boxes) of Trust Xrays that were in situ at the time of the fire. Although the cages had been in situ for some time their destruction had been deferred as a review was underway to transfer paediatric Xrays back to a secure environment locally, in order to ensure that the Xrays were indeed due for destruction.</p>	20 cages of child and dental records dating from between 2008 to 2013
IGI/7851	SOUTHERN HEALTH NHS FOUNDATION TRUST	20-Jan-17	75	<p>Community home visit by Acute Mental Health (AMH) Nurse.</p> <p>Consultant home visit took place and during the visit the Patient gave the Consultant a notebook which had been unknowingly left by the AMH Nurse the previous day.</p>	<p>Minimal bullet point notes pertaining to Mental Health patients:</p> <ul style="list-style-type: none"> <li>• Patient Names</li> <li>• Addresses</li> <li>• Contact details</li> <li>• RiO numbers</li> <li>• Patients presentation of mental</li> </ul>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					state e.g. suicidal, poor sleep <ul style="list-style-type: none"> <li>Treatment plans</li> <li>Medication</li> </ul>
IGI/8009	St George Healthcare Group	20-Feb-17	1	A staff member was escorting a patient to a GP appointment. The staff member was in possession of a photocopy of the patient's prescription card which contained their name, DOB, NHS number and a list of their medications. When the staff and patient had returned to the hospital the taxi company that had driven them back rang the hospital to inform them that they had found these documents and they would store them safely in the taxi office until we collect them. They were collected by one of our staff members and returned to the ward where the patient resides.	The prescription card indicated which organisation the patient resided in but not the name of the specific hospital. It contained his name, DOB, NHS number and a list of the medications he is prescribed.
IGI/7847	Mears Care Limited (part of Mears Group PLC)	08-Feb-17	42	The rota was disposed by mistake. The care worker went to pick her husband from hospital as he had just had an operation on his leg, and thinking the footwell of the car was full of rubbish, they asked their daughter to put it all in the bin so her husband could be comfortable not realising her rotas were amongst it all .	Employee information (name and employee number) and Service User information (Service User ID, Full name, address, Y/N flag for whether there is a Key Safe)
IGI/7836	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	06-Feb-17	7 pages	Administrator sent correspondence to a carer of a current service user and attached confidential correspondence relating to the clinical input that 7 other service users were receiving.	clinical input, support and medication

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/6802	Marie Curie (London)	17-Jan-17	unknown	<p>This is an incident at the Newcastle hospice. A pile of confidential waste for shredding was left on the floor of an office whilst the individual was on holiday for a week. A new maintenance assistant was on night duty and didn't realise it was confidential waste and placed it in a black bag. Domestic waste was taken by the council and the breach not realised until later that afternoon. The pile of confidential waste included patient identifiable information as the pile of paper was in the Medical Director's office.</p>	<p>Confidential, sensitive patient information for multiple patients</p>
IGI/6813	Rethink Mental Illness	13-Feb-17	2	<p>The MHRW had finished work with a Carers Group and then attended a 1:1 support session with another client. Following this visit the MHRW realised she had misplaced the bag. Previous locations the MHRW had visited that day were checked. The bag was not found and the loss was reported to the Police via an online form.</p> <p>The bag contained the following:</p> <ul style="list-style-type: none"> <li>- Rethink Mental Illness Factsheets (available on the public website)</li> <li>- General leaflets for different agencies (available to the public)</li> <li>- General information for Carers (no personal or sensitive information)</li> <li>- Envelope containing an ID Badge for a volunteer</li> <li>- Rethink Mental Illness forms used for support and safety planning (blank forms)</li> <li>- Personal and sensitive information relating to 2 people using the service.</li> </ul>	<p>The information relating to the 2 people using the service included the following:</p> <p>Name, address and DOB                      Referral Form - fully completed.                      Carers Safety Assessment - completed.                      Contact Sheet - name and session notes.                      Authority to Disclose Information - name and address of carer and name of CMHT.                      Support Plan</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7837	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	06-Feb-17	approximately 18 names, addresses, key codes and clinical information	stolen diary from car contained names and addresses together with key codes and reason for visit. Nurse was not using redbag issued by Trust for transporting Trust Information which should have been locked in the boot, together with personal items.	names and addresses together with key codes and reason for visit.
IGI/6721	HEART OF ENGLAND NHS FOUNDATION TRUST	11-Jan-17	11-50	Agency nurse dropped paper on the ward detailing all patient names, MHA Section, and forensic detail including offences & sexual offences  Patient informed staff that he had been given ward handover document	Patient data including name, PID, age, sex, presenting condition, previous medical history, nursing/MDT notes, including social work notes.
IGI/6710	GATESHEAD HEALTH NHS FOUNDATION TRUST	03-Jan-17	8	A member of staff in the District Nursing Team left the personal data of eight patients at the home of another patient in error. Documents in relation to two of the patients contained further detailed clinical information. The documents were discovered when another member of staff visited the patients home on a routine visit and subsequently returned the information to the Trust.	NHS patient data - including name, address, NHS Number and medical information.
IGI/6725	WYE VALLEY NHS TRUST (RLQ)	25-Jan-17	1	The electronic discharge summary containing detailed clinical information was sent home with the wrong patient. The husband of the wrong patient contact WVT to let us know that the EDS he had was not pertaining to his wife.	Detailed clinical information relating to a hospital episode of care.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/6681	MARIE STOPES INTERNATIONAL	10-Jan-17	1	an attempt to contact patient 'B' has been made but so far has been unsuccessful. Full details are being compiled. But it is possible that both discharge summaries were printed at the same time and were not separated when placed in to a n envelope and posted to the GP's practice.	NHS patient discharge summary data in paper form via courier
IGI/6680	Central London Community Healthcare NHS Trust	06-Feb-17	12	<p>The document is minutes from a Multi-Agency Sexual Exploitation Panel. The document is dated for 2015 so it was initially felt it had been uploaded by LNWHIT prior to CLCH becoming the provider in April 2015. Further investigation indicates that the minutes were uploaded in September 2015 and back dated to March 2015.</p> <p>Minutes from MASE meetings are usually emailed to NHS net account of attendees at meeting which is usually safeguarding team. The MASE minutes should not have been uploaded to the patient's SystemOne record by the administrator. This patient is now 18.</p> <p>CLCH would not have been present at the meeting as CLCH were not the provider.</p>	The document is minutes from a Multi-Agency Sexual Exploitation Panel. The document has the information of 12 patients (inclusive of the patient that has the minutes attached to their record). The document contained the names of patients and sensitive information regarding level of risk of the patients in relation to sexual exploitation - a combination of anecdotal and factual information.
IGI/6726	WYE VALLEY NHS TRUST (RLQ)	25-Jan-17	18	The ward handover sheet contained information relating to 18 patient's symptoms, treatments and were patient identifiable.	clinical information relating to symptoms, treatment and screening

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/6621	Pinnacle Health Partnership	30-Jan-17	308	<p>We were requested by the IOW CCG to send out an invitation to a public meeting regarding the future of WightBread to all the service users. This was being done via NHS Mail and should have been sent using the BCC function following internal procedures.</p> <p>A staff member was tasked with sending the email but copied the email addresses into the 'To' box in error.</p> <p>The invitation was then sent allowing all of the recipients to see all of the Email addresses. This was identified when a patient called to complain.</p> <p>The email was recalled as quickly as possible to ensure that as few people saw the message as possible.</p> <p>The email was initially sent to 308 recipients. It is not possible to identify how many patients received this message before it was recalled.</p> <p>The email contained no sensitive information in the text but did state that it was being sent to WightBread service users.</p>	Email addresses
IGI/6615	MERSEY CARE NHS FOUNDATION TRUST	30-Jan-17	39	A member of staff's home was burgled and her work encrypted laptop stolen - the laptop case contained a printed report detailing 39 deaths from Jan-Oct 2016 of Suicides. The report detailed names, incident dates, type of suicide and place,	Printed report containing details relating to 39 named individuals who had

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				investigation teams and actions. Coroner aware of all cases but some inquests have not yet been held. Incident reported to Police - crime reference no. <b>redacted</b> . Incident reported to Trust Line Manager and IG Lead - Adverse incident completed, Execs and Communications Team notified. Investigation to be undertaken by line manager.	committed suicide stolen.
IGI/6643	PENNINE CARE NHS FOUNDATION TRUST	20-Jan-17	1	A Speech and Language Therapy report was sent in error to client's carer's old address and GP. Client attended a routine medication review appointment accompanied by her grandmother (carer). At there appointment the grandmother mentioned she had not received the Speech and Language Therapy report and so a copy was printed off for her where it became apparent that it had been sent to an old address. This caused her extreme distress as her estranged husband still resides there.	Patient name, dob, NHS number and speech and language assessment
IGI/6614	GATESHEAD HEALTH NHS FOUNDATION TRUST	03-Jan-17	5	<p>The types of records lost were Safeguarding details regarding the parents of two unborn children and medical details concerning the mother of a third child. The information contained sensitive personal data relating to medical conditions and safeguarding concerns.</p> <p>An investigation is underway and the incidents have been recorded on the Trusts risk reporting system. As part of the investigation a root cause analysis will take place along with lessons learnt to reduce the risk of a re-occurrence.</p>	NHS Patient Data Medical Data Safeguarding Data

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7906	University Hospitals Bristol NHS Foundation Trust	18-Jan-17	10 patients	The Trust responded to an FOI request. The requester was not satisfied with the Trust's response and challenged the organisation to provide further details. The Trust agreed to review the response. In early June the Trust sent the requester a refreshed response with more details than previously supplied. The requester was satisfied with the response to his queries. However, he noted there were hidden review cells on the spread sheet in which a series of NHS numbers could be accessed. In addition, the name of the staff member who supplied the NHS numbers could also be seen and three patient DOBs. The requester has subsequently complained to the ICO about this. While the Trust recognises an error has been made, we believe the information itself is of low sensitivity and cannot easily be used to identify any person. However, as a complaint has been made to the ICO the Trust are duty bound to report the matter to the ICO as these circumstances determine that this is a Level 2 IG SIRI.	Excel spreadsheet
IGI/6632	PENNINE CARE NHS FOUNDATION TRUST	20-Jan-17	1	A report for a young person was put in error in the wrong envelope and sent to the wrong parent. The report had the correct name and address on it but had been put in an envelope addressed to another service user.	Child report sent to the wrong parent - level of detail to be confirmed
IGI/6626	TOWER HAMLETS GP CARE GROUP CIC	10-Jan-17	maximum 20	The paper records were being transported by a Health Visitor practitioner. Further details of the purpose of the journey will be explored as part of the investigation. The supervision records contained demographic details and highly sensitive information	Health Visiting Service user information.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				relating to the child and family including the circumstances leading to their having a safeguarding plan in place.	
IGI/6570	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	09-Jan-17	3	Theatre sheet containing the confidential details of 3 patients found by a member of staff on the pavement of the Springwood estate some 100yds from the hospital estate	Hospital number, full name, age, date of birth, sex and surgical procedure
IGI/6654	Urmston Group Practice (P91006)	04-Jan-17	62 names on epilepsy register, 9 clinical summaries and 1 thank you card	9 Patient computer summaries and list of epileptic patients of the Practice in Sept 2013 plus 1 thank you card - had been stored in a locked cabinet in clinician's house prior to destruction, when they were moving house they found it - put it in the car to bring to the practice for destruction and it fell out of the car unnoticed.	Epileptic register contained NHS number, name, sex, age, date of birth and full address. Clinical summaries containing last three consultations, medication, active problems and information re medical investigations. 1 thank you card detailing how the clinician helped her condition.
IGI/6559	IPSWICH HOSPITAL NHS TRUST	11-Jan-17	1	Complaints team posted letter to wrong address due to a typo. Address was entered incorrectly onto Datix and not checked against Lorenzo before sending. Although addressed to patient and marked private and confidential, the wrong recipient opened it and found the patient on Facebook and sent her a Facebook message advising she has received her	clinical information re baby and labour name and address dates of care given

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				letter in error. Letter contained detailed clinical information as the letter was a response to a complaint raised re care provided when complainant gave birth. There have been 2 previous sent in error breaches in the Complaints/PALS team in recent months but these were emailing errors.	
IGI/6545	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	09-Jan-17	12	Doctor's handover sheet containing the confidential details of 12 patients was found, by a member of QEH staff, in the Women's toilets in Pizza Express in King's Lynn	Patient name, date of birth, surgical procedure, blood/investigation results, care plan and notes
IGI/6506	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	03-Jan-17	623 patients	<p>Clinic attendance report email received incorrectly and insecurely from another data controller commissioned by the Trust to provide clinical services. This aspect is considered the other party's responsibility.</p> <p>The Trust recipient then forwarded the email insecurely to another incorrect recipient, a software supplier which has an existing contract with the Trust for support of the system containing this same data.</p>	Name, DOB, address, NHS Number, time of appointment and appointment status (attended/cancelled/failed to attend) for each of 623 patients with scheduled appointments within the reporting period. The reporting period and clinic location were also included for the report.

## Appendix A

### Incidents closed using the 'auto closure'<sup>4</sup> facility 1<sup>st</sup>. January to 31<sup>st</sup>. March 2017

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7968	Rowley Healthcare (M88031)	31-Mar-17	1400	I received a complaint regarding an incident where a Patient had noticed a password which enabled them to gain access to the Practice Website and view emails from other organisations and Patients which contained a variety of information from limited to detailed info regarding external organisations and Patient Medication information. No emails have been forwarded by the Patient to complain. The password was written on a notice board in the Reception Office and a Patient saw and used it from the waiting area. This password has now been removed from view and the password has been changed by Sandwell and West Birmingham CCG IT Department. The Patient has been informed and is happy with the outcome and has no intentions of contacting the press. All staff have been informed. Datix have been alerted, CCG staff and IG staff have also been informed of incident and outcome.	Patient name, address, NHS number, email address, medication and contact details

<sup>4</sup> The organisation is notified by email 10 days in advance giving them time to update or close the incident before the auto closure occurs. If the organisation updates the record, it will not be auto closed. The organisation will also receive an email notification within 24 hours after auto closure, and if necessary can reopen the incident.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7891	Parkgate Surgery (P81041)	21-Mar-17	600	Newsletter sent to all patients personal email addresses. Not blind copied. Unable to recall the message via Outlook. Apology sent along with request to delete email sent. Advice sought from NHS mail and process to recall any unread emails followed- process failed and all email addresses still visible.	Personal email addresses but without other identifiable information
IGI/7901	NHS South Norfolk CCG	29-Mar-17	1	The NOK of a SNCCG patient e-mailed the CSU PHB team informing them an envelope that they had collected from the post office appeared to have been sent unsealed. The envelope was sent special delivery and contained PHB survey and the full and completed care plan. The family noted that there was no covering letter to accompany the care plan and the survey. This letter appears to be missing.	Full Care plan - other evidence being reviewed by the CSU.
IGI/7888	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	21-Mar-17	Approximately 80 patients	Inflammatory Bowel Disease Department sent email to approximately 80 patients informing them of changes to the IBD Helpline service at our Trust. The recipients were not blind copied so all can see each other's email addresses. 3 patients have contacted the department to complain.	Email addresses
IGI/7889	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	21-Mar-17	4	The Trust were notified by a local press firm that they had obtained a copy of a confidential report into whistle blowing allegations that led to the subsequent suspension of and dismissal of the Chief Executive and the suspension of the Director of HR, Director of Operations and the Deputy Director of Performance. The Trust	Report into whistle blowing allegations. Includes identifiers and investigation into staff conduct, performance and behaviour.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>consider this report highly confidential and the publication of information from it would be likely to cause substantial distress to the data subjects. The incident was escalated within the Trust, following the press aim to publish by 21/12/2016.</p> <p>19/12/2016 - The press advised they would publish 20/12/2016 but later retracted whilst they review their options. The Trust still expects this to be published at some point. The Chief Executive had been made aware of the incident by the press and subsequently notified other data subjects, before the Trust had the opportunity to do so. The Trust has requested advance notice of any articles in order to notify and support the data subjects. As the report and its contents is highly confidential, the Trust is unable to confirm with each data subject exactly what information is recorded about them.</p>	
IGI/7887	WALSALL HEALTHCARE NHS TRUST	21-Mar-17	10	<p>We have been contacted by telephone by a parent whose daughter has received 10 letters which although addressed to his daughter contained the clinical details of a different patient. It appears to have been a fault with the Editscript computer system which generates the letters.</p>	<p>Patient name, address, hospital unit number and clinical information regarding their previous appointment</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7929	IPSWICH HOSPITAL NHS TRUST	23-Mar-17	18	Paper ward handover sheet accidentally given to patient with their discharge summary upon their discharge from the ward. A ward handover sheet containing PID relating to 18 patients was printed on ward, picked up by a staff member and given to a patient when handed her own discharge summary. Patient made complaint about clinical care and DPA breach.	Surname, age, bed bay, clinical information e.g. DNAR, medication, details of condition
IGI/7869	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	16-Mar-17	160	A member of staff sent an email to 160 ( approx.) patients ( no clinical details) but inadvertently did it in a way in which all 160 could view each other's email addresses.	email addresses
IGI/7875	WYE VALLEY NHS TRUST (RLQ)	17-Mar-17	1	The circumstances are that a community midwife hand-wrote an envelope (with the in correct address) to a patient. The letter contained the scan results of another patient. Therefore the letter and scan results went to the wrong patient. It was addressed to the wrong street number. The resident opened the letter. They then proceeded to go and visit the patient and congratulate them on their pregnancy, which was not common knowledge.	clinical letter and scan results
IGI/7885	Dr Hart & Partners (P92016)	21-Mar-17	33	Community phlebotomist left an appointment list containing patient details in the disabled toilet. This potentially could have been seen by other patients.	Patient name, DOB and NHS number.
IGI/7863	NHS Bassetlaw CCG	14-Mar-17	2 patients and 2 carers	A patients carer notified the CCG advising them that they had received a letter and associated DST for another patient. The letter and DST were sent to the patients/carers informing them of	Continuing Healthcare Decision Support Tool containing NHS patient data

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>the outcomes from a recent panel meeting whereby the letter and DSTs were enclosed in the incorrect envelopes and sent in error.</p> <p>Upon notification, the CCG arranged with the carer for safe retrieval of the incorrect paperwork. These were hand delivered to the CCG. The CCG has since contacted the other patient and arranged to collect the other incorrectly sent paperwork. The CCG are currently investigating the incident and will review processes.</p>	
IGI/7861	The Linden Medical Centre (K81018)	14-Mar-17	254	A routine email containing a GP practice newsletter was sent to 254 patients without using the correct safeguards (BCC) to ensure that the patient's data was protected. No sensitive personal data was attached, only the email addresses of the patients would be seen, some of which might identify individuals.	Email addresses.
IGI/7862	Barts Health NHS Trust	14-Mar-17	125	<p>A member of the public found a black satchel containing patient level documentation and dictation equipment. The bag was in a consultant's car that was stolen. The following items were in the bag</p> <p>4 letters from professional bodies 1 letter from another Hospital. Stamped private and confidential 2 payslips</p>	The data ranged from clinical letters to referrals to referrals containing clinical notes. All would include name and address. How detailed the clinical information is would vary. There was also a dictation tape that needs a dictation machine to hear.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>None of the above was opened.</p> <p>Altogether there was 125 unique patient records broken down as</p> <p>Referrals containing full notes from the referring organisation – 5                      Service records – 13                      outpatients referral vetting forms – 53                      Outcome sheet – 7                      Referral letter – 1                      Choose &amp; book referral tracker form – 28                      Clinical letter – 17                      Letter from another Health Trust – 1</p> <p>It does not appear that any personal information was disclosed.</p>	
IGI/7843	NHS South Tyneside CCG	09-Mar-17	2000+	<p>Each spread sheet contains the NHS number and condition of the patient (no detailed information on the condition), for example, NHS number – pregnant – smoker/non-smoker – smoking cessation advice given/ not given. From 7 spread sheets (and there were 50+) there were details for 2323 patients.</p>	<p>NHS number and condition of the patient, no detailed information on the condition.                      Included medication and interventions on some but not all data items</p>
IGI/7859	NHS Redditch and Bromsgrove CCG	13-Mar-17	1	<p>A document was found on top of a box of paper by the photocopier that was found to be a staff OH report. Upon checking, the personal file for the individual to which the report related had been signed out of the locked personnel cupboard by a member of staff from HR.</p>	<p>Staff OH report</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7905	St Andrew's Healthcare (Original code of NTY85)	14-Mar-17	1	<p>Safeguarding paperwork was sent to the incorrect commissioner. The commissioner in question was not involved with either patient. The email was sent password protected, however the password was subsequently sent via email to the same incorrect email address.</p> <p>The documentation was an external safeguarding form which detailed an incident which happened on the ward between two patients, one patients name, hospital address and date of birth was included. One of the patients details was redacted.</p> <p>The incorrect commissioner contacted the sender immediately to inform us of the error and deleted the email.</p>	Name, date of birth, hospital address, details of an incident that happened on the ward between two patients resulting in one patient sustaining a bruise
IGI/8101	Sussex Community NHS Trust	28-Mar-17	12500	<p>It was reported that all historic patient record cards from the Bognor Regis War Memorial Hospital (BRWMH) Minor Injuries Unit (MIU) have been destroyed using the Trust's confidential waste management system after 8 years. The records should have had dual retention periods – 8 years for adult records and until the 25th birthday for children (26th birthday if they were 17 years old at the time).</p> <p>Paper records are still available dating back to 2007 and therefore this incident involves historic children's records who attended the MIU</p>	MIU paper record cards prior to 2007 which include patient demographics, illness/injury details, examination and investigation findings, diagnosis, treatment plan and a summary of the treatment given during the visit.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>between 1991 and 2006.</p> <p>It is estimated that 12,500 records were destroyed outside of the correct record retention period.</p> <p>There is no risk to patient care. The records have all been confidentially and securely destroyed and therefore there are no risks to patient confidentiality.</p> <p>The risk is that an MIU record is requested regarding a child seen pre-2006 as part of a subject access request, or similar request from a regulator, and we would not be able to provide this information.</p> <p>The records that had been destroyed included the Minor Injury Unit record card which includes patient demographics, illness/injury details, examination and investigation findings, diagnosis, treatment plan and a summary of the treatment given for each individual episode presented at the MIU.</p> <p>The MIU have ceased destroying records and have written a local health record keeping procedure to covering record management and including record retention. An analysis of the number of records has taken place, reducing the initial estimated number of records destroyed in error from 120,000 to 12,500.</p>	

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IGI/7867	WYE VALLEY NHS TRUST (RLQ)	17-Mar-17	1	The EDS was given to the patient to take home. When they arrived home they found that the EDS was for a different patient.	Clinical data on an EDS summary (electronic discharge summary)
IGI/7868	The Amwell Practice (F83652)	16-Mar-17	1	The breach occurred in November 2016 but we were not made aware until patient (1) advised us in December that there was an erroneous attachment to their OPD referral. The attached document was a 'Send Result Report' generated after faxing blood results to Marie Stopes International for patient (2) and had been left on the printer then inadvertently picked up with the OPD referral and sent to patient (1).	The fax 'Send Result Report' showed the name, date of birth, address and mobile number of patient (2). Apart from disclosure of personal data of patient (2) the document also made reference to a request for termination of pregnancy and therefore sensitive medical information.
IGI/6818	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	03-Mar-17	Approx. 80 patients on a spread sheet	The Caldicott Guardian reported patient names had been included rather than consultant names on the spread sheet sent to NCEPOD for the Young Persons Mental Health study. There were 80 patient names along with sensitive clinical data constituting a breach of confidentiality. The data was password protected and other details will be verified in the investigation.	80 patient names and diagnosis
IGI/6817	Solent NHS Trust	03-Mar-17	1 sheet	Print out of an antenatal scan list containing 16 individual details which included, demographic details and also information shared at midwife liaison, was left in a non-NHS building, however was found by a NHS employee approximately a week later.	Print out of an antenatal scan list containing 16 individual details which included, demographic details and also information shared at midwife liaison

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/7872	General Healthcare Group	16-Mar-17	<p>We estimate that about 2000 individuals have been affected. These are patients of the Consultant and some of the clinical details go back twenty years. About 20% of these individuals are NHS patients while the others</p>	<p>BMI Healthcare Limited is an independent healthcare provider in the UK ("BMI"). BMI operates hospitals throughout the country, including a BMI hospital located in the East Midlands. The Hospital is an 85-bed acute hospital providing inpatient and outpatient care and treatment. Its staff include medical secretaries who are employed to support medical consultants. Consultants are not employed by BMI but independently practise at the Hospital under practising privileges. They are data controllers in their own right, processing their own patient records, and, as well as any statutory obligations to notify the Information Commissioner's Office (ICO), are required under their practising privileges agreement to register with the ICO.</p> <p>Medical secretaries at the Hospital work in an office which has a security lock on the door requiring input of an access code. There are four secretaries who work in the room, supporting various consultants. The area of the Hospital where the secretaries' room is situated is currently undergoing some refurbishment work meaning that contractors are on-site from time to time.</p> <p>A desktop computer drive was removed from the medical secretaries' room after 8pm on 23 November 2016 by someone whom we have not identified. The medical data on the computer</p>	<p>The personal data at risk comprises personal details as part of the management and operation of the Consultant's practice, such as name, address, contact details, date of birth, GP details, and hospital and NHS numbers together with sensitive medical records, detailing clinical conditions, treatments and associated letters, both private and NHS. There is no payment card information belonging to patients stored although there are details of patients' hospital and consultant accounts, invoices and debtor lists. The Consultant's bank account however is also on the computer.</p> <p>We estimate that about 2000 individuals have been affected. These are patients of the Consultant and some of the clinical details go back twenty years. About 20% of these individuals are NHS patients while the others were treated privately. The number of individuals affected who are children or vulnerable persons are extremely low, and the number is likely to be between zero and single figures.</p> <p>Please note we have taken, and</p>

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			<p>were treated privately .</p>	<p>drive belongs to a medical consultant (the "Consultant") and consists of the Consultant's medical records of approximately 2000 patients, of whom, about 80% are private patients with the remainder being NHS patients. The computer however is owned by BMI. The computer operator is employed by BMI but she works for the Consultant as a full time medical secretary. Responsibilities are therefore split, with BMI acting as data controller for some elements of the data on the computer and the Consultant for other elements, such as the medical data, with BMI acting as a data processor in relation to personal data processed by the Consultant.</p> <p>We believe the computer was stolen but we cannot be sure. If the computer was stolen, we believe the theft was random and opportunistic. The missing computer was replaced with a second computer desktop drive, perhaps to hide the fact that the original computer had been removed. This second drive belongs to BMI and was stored in an unused consulting room in the area of the Hospital undergoing refurbishment; the area was unlocked at the time. We have conducted an audit of all PCs on site and there is no evidence that the missing unit is still within the Hospital, which is why we believe it has been stolen. We suspect that the thief had targeted this unit because it was small and therefore assumed to be of a higher</p>	<p>continue to take, our responsibilities as a data controller most seriously, and we are also working with the Consultant in terms of his obligations to patients. We have given serious consideration to whether to contact affected patients, including how this information may impact on them. Taking into account our responsibilities to affected patients, we do not at this stage intend to write to those patients. This is because the records belong to the Consultant and given the security controls on the computer, we consider that informing patients is likely to cause them unnecessary distress. We confirm that we will keep this under review and should anything change we would review our decision in the light of any changes and consider the appropriate action to take, including whether to contact affected patients.</p>

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				<p>specification and easier to conceal. Given access codes are required to the medical secretaries' office, it may be that the removal was carried out by someone with knowledge and access to the Hospital and the medical secretaries' room, in particular.</p>	
IGI/7882	LANCASHIRE CARE NHS FOUNDATION TRUST	21-Mar-17	2-3 sheets of paper	<p>The manager was responsible for preparing a letter advising a staff member that a formal investigation would be commenced into an alleged incident. To expedite the action and facilitate a timely response they used a previous letter sent to another staff member as the template for the letter. Instead of sending the correct version to the admin to post out, the manager inadvertently sent the copy of the letter which was not amended with the staff members correct address. It had the address of the previous staff member (incorrect recipient) still on it. The admin was unaware of the error and proceeded to post the letter to the incorrect address.</p>	<p>The letter contained the following data and information:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Address</li> <li>• Reason for the letter – It advised that a formal Investigation is to be commenced regarding professional conduct and sets out the allegation.</li> <li>• Employment restrictions whilst the investigation is completed e.g. No access to Trust clinical system IPM and restricted front line reception duties</li> </ul>
IGI/6816	Solent NHS Trust	03-Mar-17	1	<p>A DVD containing sensitive images has been lost.                      The DVD and its content are not identifiable                      The DVD was last seen being placed in a safe approximately a month ago.                      A through search has been undertaken of the safe, including double checking all other DVD's in the safe for mis-filing.                      All personal who have access to the safe have</p>	<p>DVD containing sensitive images, that will be required for a court case</p>

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				also been contacted and they have confirmed not held The DVD has now been considered lost Some still images from the DVD are available as a back-up	
IGI/6708	Leeds Community Healthcare NHS Trust	21-Feb-17	1	An Occupational Therapy Report of Child A was included in a letter addressed to Child B.	Occupational Therapy report
IGI/7844	WYE VALLEY NHS TRUST (RLQ)	09-Mar-17	1	Discharge summary containing patient information handed to the wrong patient.	clinical discharge information
IGI/8116	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	13-Mar-17	855	Personal sensitive information disclosed to commissioners	personal sensitive and protected characteristics
IGI/6695	MID ESSEX HOSPITAL SERVICES NHS TRUST	14-Feb-17	32	Criminal and Civil Law Enforcement officer, working for London Borough of Newham, contacted MEHT communications team requesting contact details of senior management to report the discovery of patient handover sheets (8) found in domestic refuse in E15 (Stratford). Communications Team informed redacted Trust Secretary of the incident. Trust Secretary informed CIO, IGM and Head of Communications of incident. CIO informed Trust Secretary that IGM will be contacting Criminal and Civil Law Enforcement Criminal and Civil Law Enforcement officer emailed IGM with 8 scans of handover notes attached (32 Patients), stating that information	Name DoB PAS/NHS Number Limited medical information Discharge plan

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>was found at a fly tipping site and junk mail stated name and address of individual, who they would be interviewing as part of their investigation.</p> <p>IGM discussed incident with Criminal and Civil Law Enforcement officer, stating that information that they hold should be destroyed securely and confirmation email to be sent to IGM.</p> <p>Criminal and Civil Law Enforcement officer emailed IGM stating "All emails deleted and trash box emptied.</p> <p>investigation initiated by Associate Chief Nurse For Medicine to ascertain root cause - investigation on-going.</p>	
IGI/6746	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	25-Feb-17	1 page	Outcome of assessment faxed to a service users GP, call received to say that service user was no longer registered at the surgery as she is now an employee	current mental health status
IGI/6649	Dr Shehadeh E Practice (F81206)	09-Feb-17	Not known.	<p>Today we had a user appear in the SystemOne messaging screen who does not work at the practice. The messaging screen suggested that he was logged on from a laptop. His name is redacted. The profile suggested that his user account had been created on the day that the incident was recorded. The user profile was checked and it had the users phone number on it. He was called and asked what his connection with the surgery was and why he was logged into our system. He said that he worked here once, before the surgery had been taken over,</p>	Our SystemOne will have recorded this.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				but stressed that he had not logged into our system. We would like help in finding out how this user was created with today's date stamp, and also if any information was accessed.	
IGI/6698	Four Seasons Health Care Ltd	23-Feb-17	1	Incident relates to a group of staff and a private Facebook group that was set up by a senior support worker – who then invited a large number of staff to join and some have added comments and some haven't, the organiser of the group mentions a patient by full name and some of the other staff then made comments and some of these comments were less than complimentary. From a company perspective we have taken this very seriously and will be undertaking a full investigation	Patient's full name was written on Facebook
IGI/6648	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	09-Feb-17	1350	As part of the commissioning process Trust commissioners require data on patients related to NHS achievement against wait time targets. This involves sending spreadsheets of anonymised data to the commissioners on a request by request basis. Data is extracted and then manually anonymised before saving in a new spreadsheet before being emailed to the CCG. On this occasion the process was carried out correctly however the wrong spreadsheet was attached to the email meaning the fully identifiable version was sent. The identifiable version contained details of patients not relevant to the request, although part of the same pathway.	The following fields are those which contain person identifiable data in the spreadsheet: Local Patient Identifier Patient Status Tracking Status Person Given Name Person Family Name Date First Seen Corporate Cancer comments Additional Tracking Details Active Specialty

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IGI/6638	Well Street Dental Care	07-Feb-17	not known	<p>Patients records found in shed at rear of building not secured which was discovered during an internal audit visit today revealed that a shed at the rear of the building containing patient record cards. The door was not secured the only access to this shed was through a door which was nailed shut.</p> <p>All records will be moved to a secure room within the practice.</p>	patient clinical records , medical history x-rays
IGI/7921	NHS West Hampshire CCG	25-Mar-17	4	<p>The CCG were informed of a potential information governance breach by a patient's representative. They had received a letter for their sister but it had been addressed to the wrong next of kin and had the wrong patient name on the covering letter. The letter had been sent by CHC Direct (third party provider - Data Processor).</p> <p>The CCG were then notified of another IG breach as three letters were returned to the CCG by Royal Mail. They had been sent to patients/patient representatives by CHC Direct. The letters were not 'signed for' so had been returned to Royal Mail for collection – and no one had requested them from Royal Mail. The letters had no typed address on them, they were not in plastic envelopes as per the CCGs processes and there was no return address on the hand written envelope, therefore they have been opened by Royal Mail to find a return address. The address on the review</p>	<p>1st Incident - name of patient disclosed in covering letter.</p> <p>2nd Incident - 3 x patient review letters sent by CHC Direct were returned to the CCG by Royal Mail as they were not collected by the recipients. Royal Mail had to open the letters as there was no return address.</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>documentation was 'East Hampshire CCG' (not West Hampshire CCG) and therefore had reached the CCG due to the post code.</p> <p>Another letter was returned to the CCG - similar circumstances as above.</p>	
IGI/6645	ROYAL FREE LONDON NHS FOUNDATION TRUST	27-Mar-17	190	Hospital immunology email newsletter (department contact details) was sent to approx. 190 patients with the patients' email addresses visible in the Cc address field. Staff member who sent the email should have used the Bcc address field.	Patients email address
IGI/6668	PENNINE CARE NHS FOUNDATION TRUST	03-Feb-17	2	<p>Mum of patient called to say she was really unhappy that a copy of her child's clinic letter, has gone to her child's previous school. The child is currently educated at home.</p> <p>Mum said she had contacted the office and spoke to somebody previously, as a copy of a letter from a missed appointment, had also been sent to the school when her daughter was no longer attending. She explained that the lady she spoke to on that occasion had apologised and reassured her that it would not happen again. On checking the paper notes, there is a handwritten note on a copy of the DNA letter from Secretary stating 'Not in school, new appointment</p> <p>Another concern was the fact that it was stated in the clinic letter, mum herself has a diagnosis</p>	Appointment letter for NHS patient about a child gone to the wrong school

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				of Autism. Mum says this has now left her feeling unable to attend any further follow up appointments, as she does not trust the service.	
IGI/6619	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	02-Feb-17	1	A patient called to say he was concerned that his ex-wife was looking up his details at her work. An audit trail shows she accessed her ex husbands details on the patient administration system. This would contain information regarding demographics, GP details, appointment details and speciality. Staff member given access to system as part of her role. Patient not under the staff members speciality and therefore no clinical reason to access the details.	Details that could be accessed would include demographic date, GP details, hospital spells including speciality.
IGI/6748	NORTH EAST LONDON NHS FOUNDATION TRUST	25-Feb-17	184	We have a joint service between NELFT and the London Ambulance service, and a joint owned log book was lost when placed on the roof of the ambulance car that contained 184 patient names, NHS number, Age, and Patient issue ( Patient fell, Anxiety etc) No patient address was recorded in the book Staff members re-traced their steps in the car but couldn't find the book.	184 patient names, NHS numbers, Age, patient issue (patient fell, Anxiety etc)
IGI/6630	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	06-Feb-17	116	The email was sent to 116 people (patients, service users, carers & members of the public), as part of engagement and involvement asking if they wished to be contacted about involvement opportunities across the trust. The e-mail went to all of the recipients from the 'To' box and was	116 recipients were e-mailed

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				not sent via BCC, therefore all of the recipients saw each others e-mail addresses.	
IGI/6720	Trust Pharmacy (QMC Campus) - FW548	21-Mar-17	1 case	Staff member became aware of the individual's health status through handling a prescription in the pharmacy. the member of staff then told 3 mutual acquaintances and disclosed the personal sensitive information.	name of medication shared verbally
IGI/6727	Cygnet Health Care Limited	23-Feb-17	Not known	We were informed by another company that a staff member who had previously worked for us at our site was sending sensitive information that included both staff and patient detail to her personal email address. We were then informed by the company that the information had then been placed onto the network of the new company. New company has deleted said information and given us hard copies so we can track when and where the information was sent to. This is an ongoing investigation.	<p>Email regarding a CQC report including information regarding the ward and an investigation into herself as well as including service user initials.</p> <p>Email including an RCA report which contains service user initials, details regarding the incident being investigated, actions taken and recommendations.</p> <p>Email referring to and showing an attachment of a 'Risk and Suitability Assessment Report' for a service user including their initials but do not have access to the attachment</p> <p>Email referring to a serious incident including service user initials and details regarding the incident and referring to an attachment and indicating an attachment was sent regarding the incidents but do not have access to the attachment</p> <p>An email sent to an ex-colleague on a</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					<p>personal email including a reference to an attachment of a CQC action plan for Bierley</p> <p>Email referring to possible serious incidents including service user initials and details regarding the incidents</p> <p>Email regarding a disciplinary including staff initials and information regarding the disciplinary</p> <p>Email regarding a service users care and treatment including service users initials</p> <p>Email regarding service users presentation including service users initials</p> <p>Email regarding a safeguarding issue including service users initials and indication that there is an attachment including information but do not have access to the attachment</p> <p>Email including a service users full name discussing funding</p> <p>Email including a list of instances when service users have attended hospital including information regarding what lead to the attendances and service user initials</p>
IGI/6618	Derbyshire Community Health Services NHS Trust (East Midlands)	06-Feb-17	20	<p>Diary contained patient's names, postcodes and key safe numbers. It also contained some names and addresses, but not with key safe numbers.</p> <p>Approximately 10 patients where nurse has</p>	<p>Approximately 10 patients where nurse has written the name, address and key safe number together in her diary.</p> <p>For approximately 10 more patients,</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>written the name, address and key safe number together in her diary.                      For approximately 10 more patients, nurse has recorded a patient's surname and key safe number in the front of her diary and the same surnames with postcodes for the first couple of visits throughout the diary. There is therefore a risk of this information being linked together.                      Nurse has not recorded DOB or diagnosis, but will have put the task next to patient visit.</p>	<p>nurse has recorded a patient's surname and key safe number in the front of her diary and the same surnames with postcodes for the first couple of visits throughout the diary. There is therefore a risk of this information being linked together.                      Nurse has not recorded DOB or diagnosis, but will have put the task next to patient visit.                      There is therefore no high risk sensitive clinical data involved in this breach, however there is high risk information in terms of patient key safe numbers.</p>
IGI/6611	Yorkshire DSCRO	02-Feb-17	Not Known	<p>Possible inappropriate exposure of NHS Numbers via SQL query following expiry of DSA                      1 member of staff in eMBED executed query and saw NHS Numbers in results</p> <p>Presumed 10,001 – 100,000 records exposed in query</p> <p>Staff member recognised presence of NHS Number, stopped executing query and reported to DSCRO                      Access control applied to prevent all eMBED access to queried objects containing NHS Numbers</p> <p>Staff member has no mechanism to identify</p>	SUS activity data

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				individuals from NHS Number i.e. has no access to other systems like SCR application or Spine.	
IGI/7918	NHS England	24-Mar-17	1	PCSE was notified that a medical record bag was found in the car park of Alexandra Hospital in Cheadle. The hospital was not on the CitySprint route. Following a confirmation of the date of the incident CitySprint confirmed that the Service Centre had requested the courier to visit Alexandra Hospital on their return to the Service Centre. This breach of protocol has been escalated to the CitySprint Management and Compliance teams	GP Health record
IGI/6660	SOUTH TEES HOSPITALS NHS TRUST	11-Feb-17	1 patient	Clinic letter containing health information sent to wrong address due to incorrect house number typed on letter.	NHS patient data
IGI/6599	Lovemead Group Practice (J83008)	31-Jan-17	2	A member of staff has incorrectly forwarded patient identifiable correspondence by email to a third party instead of forwarding the letter to a member of administrative staff in the practice. This was reported to the practice by the third party. We have since found that this also occurred earlier in the month to the same third party.	Emailed patient identifiable correspondence received from Minor Injuries Unit including medical information relating to presenting condition and treatment received.
IGI/6637	Stuart Road (B87015)	07-Feb-17	83	File containing Clinical data of patients in Care homes was lost. This was prepared for nurses to visit and administer influenza vaccination and do care plans. The above file was kept in the reception area and cleaners accidentally put it in the rubbish bin. The file was identified as	Pages with patient demographics and patient summary notes

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				missing the next day, but by then it had been removed by the rubbish collectors.	
IGI/6587	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	10-Mar-17	1	Allegation that a member of staff has disclosed confidential information without authorisation. Due to allegation a formal HR investigation is now underway.	Confidential and sensitive information discussed with a neighbour of a patient
IGI/6728	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	13-Feb-17	To be determined but in region of 301 - 500.	<p>The Trust has purchased FairWarning (Privacy Audit Software) that links the Electronic Patient Record Systems with the Staff Record System creating alerts in terms on suspicious activity. The software showed POTENTIAL suspicious activity against a Minor Injuries Receptionist, namely:</p> <p>The individual is a receptionist in the Minor Injuries Dept and as part of this role requires access to the Adastra system in order to book patients in if they arrive at the Unit. It is believed that this access was used inappropriately as flagged by the controls the Trust has in place (privacy audit software) The individual was suspended and disciplinary investigation commenced. The individual then subsequently resigned and the status of the report is now a Serious Untoward Incident.</p> <p>The Trust invited the individual (receptionist) in for interview in December 2016 to determine what action (if any) she took by accessing the information but as she is no longer an employee whether she decides to turn up will be debatable. The Police have been advised as</p>	<p>Adastra is a system used in the Trust's minor injury units for recording treatment patients receive if they attend the minor injury depts. Access is via smartcard with unique logins. The privacy audit software picked up anomalies against a receptionist in the minor injuries dept which are currently being investigated.</p>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				information relating to high profile case (Murder) as we have identified that this information had been accessed when these individuals attended minor injuries several years ago. The Police are awaiting completion of Trust investigation before taking any action.	
IGI/6617	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	23-Jan-17	unknown	The Fair Warning system reports a member of staff access to a patient with same surname. On investigation the member of staff is related to the patient. The report shows 9 unauthorised access. The member of staff denies unauthorised access when challenged with the Fair Warning report as supporting evidence	one patient care record (Paris clinical system) Update on conclusion of the investigation: progress notes were viewed. In the course of the investigation it became apparent that the staff member had also accessed the record of another family member
IGI/6566	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	15-Mar-17	1	An email containing confidential staff information was sent by email to an unintended recipient. The disciplinary hearing decision of the CEO of Southport and Ormskirk Hospital was released to CEO by email on the 24/10/16. The email was intended for the their personal gmail account but was sent in error to another gmail address of an unknown recipient.	Outcome and considerations of the disciplinary hearing relating to one individual. The report includes reference to other persons but does not relate to other ongoing disciplinary investigations.
IGI/6650	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	11-Feb-17	66	Patient sensitive personal information sent to another NHS organisation via unsecure methods. Under investigation.	<ul style="list-style-type: none"> <li>• Name of patient</li> <li>• Complaint details</li> <li>• Name of complainant (e.g. family members)</li> <li>• Location details (e.g. inpatient)</li> <li>• Service Attended by patient (e.g. Sexual Health, CAMHS,</li> </ul>

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					Inpatient, Eating Disorder, Psychiatric etc)
IGI/6715	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	21-Feb-17	1	Monitoring report shows that a student nurse had access to the case notes of a close family member while on shift. Currently awaiting confirmation of times of bank shifts which the student was also working.	Reports run from the system audit tool show that the student accessed records without a need to know basis and the record is that of a close family member, both being non compliance with Trust policies.
IGI/6805	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	23-Feb-17	1	<p>3 instances of insecure information transfer occurred in one email string concerning the treatment and payment for treatment for a BHFT patient.</p> <p>Email sent by BHFT employee (using @Berkshire email address) to CSU employee (using @NHS.net email) containing patient name and initials. No lawful basis for the CSU employee to have the information and method insecure.</p> <p>Email containing patient information sent by BHFT employee (using @Berkshire email address) to Great Ormond Street Hospital employee (using @GOSH.nhs.uk email address) containing patient name, NHS No &amp; DOB. Email insecure.</p> <p>Email sent by BHFT employee (using @Berkshire email address) to 2 CCG employees (using @NHS.net email addresses) containing patient name, NHS No &amp; DOB - no</p>	Patient name, NHS number & DOB

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				lawful basis for the information to be received and transfer method insecure.	
IGI/6799	MERSEY CARE NHS FOUNDATION TRUST	01-Mar-17	2	Email sent to designated Police Officer in error containing ward round notes for 2 patients. Adverse incident form completed, both patients advised of incident and apology letter issued to both patients.	Clinical Ward round notes relating to 2 service users
IGI/6640	Penrose Surgery (G85084)	08-Feb-17	500-1000	<p>We received 4 large sacks and 4 boxes of medical records from PCSE at our Penrose Surgery SE17 3DW. As each record is individually packed , we had to open every single one to identify which ones belong to us . But unfortunately , out of 2 sacks containing dozens of records checked so far, only 2 patient records belonged to our practice. Rest appears to be for other Practices in different parts of London – W1, Croydon, Villa street practice , Lambeth , Lewisham and more. This is serious breach in patient confidentiality. We are unsure if we should continue checking rest of the sacks and boxes to identify our records because we don't want to spend any more time browsing through other surgery records and then spend more time repacking them individually .</p> <p>We would also like to know the procedure of handling records when they are received at PCSE offices. How the PCSE team members identify which patients records are to forwarded to which Practice because we haven't received</p>	NHS patient data in the form of paper medical records.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				<p>any labels yet to put on plastic bags. We have been asked to seal each record in an opaque plastic bag. So we are correct in assuming that PCSE (or a sub-contractor) is tearing off the plastic bag to check patient record and resealing it in a new bag to forward to the new GP Practice ? If this is the case, then it's not a cost effective , efficient and eco-friendly process.</p>	
IGI/8088	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	31-Mar-17	8	<p>Paperwork containing personal and sensitive information was left in a panier on a bicycle which was stolen. The paperwork was subsequently discarded in a residential street. This was spotted by a member of the public, who collated the information and advised the trust.</p>	NHS patient data
IGI/6798	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	01-Mar-17	672	<p>A folder was created in order to store relevant information with 27 Medical students, however in the creation of this folder access to Medical Education Secure folders was provided in error. Students would therefore have been able to look at or review any number of confidential documents contained within the Medical Educations Teams electronic folders. There is no audit of access to these folders and therefore the Trust is unable to establish if information has been inappropriately accessed/ viewed.</p>	<p>A large number of folders containing confidential information are contained within this secure electronic area including:                      Flu Audit Skills Information - Names and Contact details of 13 students                      Undergraduate Incidents - Number of emails concerning an incident involving a student along with the individual's reflection.                      Medical Students Concerns - List of 74 students with details of concerns made against them and dates for 2013/14</p>

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					<p>Undergraduate concerns - Incident details involving two 4th year students</p> <p>Medical Students Concerns - List of 74 students with details of concerns made against them and dates for 2014/15.</p> <p>Curriculum Vitae - CV of two doctors</p> <p>Honorary Contracts - CV's of seven consultants employed within the Trust</p> <p>Uni Information - Number of spreadsheets containing staff ID numbers and names</p> <p>University Correspondence - Letter 2010</p> <p>University Meetings - Clinical Programme detailed minutes and actions plans for committee members</p> <p>Clinical Skills - Contains detailed minutes and actions plan sent to committee members</p> <p>LOCAS - details of patients used in examination process since 2008 average of 50 individuals details per year includes patient history sheets</p> <p>PMSC and observing students</p>
IGI/6541	Dr S Maharaj's Practice (P81004)	19-Jan-17	2	A clinical letter was received by post today listing the personal contact details for one of our patients, however the letter content was for a totally different patient (unknown to this surgery). Our patient, named on the letter, had also received a copy.	<p>NHS Patient Data (Title, surname) including a full summary of their recent clinical assessment and management plan.</p> <p>Consultant information and Hospital information.</p> <p>Intended recipient and their own</p>

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					practice would not have received copies of this letter.
IGI/6548	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	24-Mar-17	1 patient record	<p>Member of staff in the Bed Management Team observed looking at EPR records of patients not part of workload. When challenged by colleagues replied "I was just being nose y"</p> <p>Manager informed, HR processes started, fact-find done under way. Disciplinary action to be taken. Duty of Candour being considered.</p>	Electronic patient records of mental health service users. Records stored on a secure EPR solution with personal log-on credentials. Inappropriate access to patients not on workload.
IGI/6546	Bollington Medical Centre (N81022)	07-Mar-17	Single address of single patient	<p>Address of child disclosed to caller identifying themselves as the patient's mother with knowledge that they had an appointment booked.</p> <p>Mother not allowed to have child's address, as they live with their father and are in the process of court proceedings for custody.</p>	Address of child disclosed to caller identifying as patient's mother with knowledge that he had an appointment booked. Mother not allowed to have child's address, he lives with father and in process of court proceedings for custody.
IGI/6526	Hampton Surgery (M89608)	18-Jan-17	20 records	As part of the transit of patient records by PCSE and courier City sprint – the practice received 20 sets of patients notes for patients either not registered at the practice or who are deceased and the records have been returned previously. They arrived in a large unmarked hessian bag. Some of the records do not even appear to have a NHS number. Practice has taken list of the NHS numbers and/or name & DOB, Following call to PCSE practice has packaged up records for return on next courier visit and has also emailed the NHS numbers to	patient confidential paper medical record

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				PCSE.enquiries@nhs.net to advise of the breach	
IGI/6550	MID YORKSHIRE HOSPITALS NHS TRUST	19-Jan-17	3 - 5	The Trust received a letter from a member of the public stating that he had been receiving calls on his mobile allegedly for a consultant (Name given) who is employed by Mid Yorks (sample Mid Yorks phone number given). Also messages have been left on his ansaphone which have included personal and sensitive personal data Phone calls have been received by the complainant over a period of time and complainant has contacted the consultant, the main hospital switchboard and the IT service help desk but the phone calls have continued. The claimant has informed the ICO's office in a letter to the Trusts Chief executive and head of IT Services and was received on 14/10. 17/10 the relevant Head of service was asked to investigate and respond by letter to the complainant (sent 18/10). Caldicott Guardian and IG Officer made aware 18/10. Full investigation is ongoing	Ansaphone messages containing personal and sensitive personal data
IGI/6577	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	27-Jan-17	1	A midwife whilst visiting a woman at home after giving birth was alerted to the fact that another woman's notes were within her own notes by the student working with her. This contained demographic data, scan photos, medical details, safeguarding, partners details, previous pregnancies, debit card. All information was removed.	demographic data, scan photos, medical details, safeguarding, partners details, previous pregnancies, debit card

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IGI/6620	LANCASHIRE CARE NHS FOUNDATION TRUST	02-Feb-17	6 patients handover notes	The service user is an in-patient on redacted Ward at the redacted Unit and was receiving treatment in ITU at Blackpool Victoria Hospital. The notes were found by another relative and handed to the complainant. The complainant (parent) initially saw their daughter's name on the documents. At this point they put the notes in the back of their reading book thinking that they were either meant for themselves to read or they were sheets of scrap paper that they could use to make notes on. When the complainant was putting the notes into an envelope for return to the redacted they realised that the papers also referred to five other patients currently being cared for on redacted Ward as well. These papers were clinical notes printed from the Nerve Centre system at the Unit and included clinical detail, actions of care and treatment and personal patient details.	clinical notes printed from nerve centre system and included clinical detail, actions of care and treatment and personal patient details
IGI/6498	Northern Moor Medical Practice (P84651)	19-Jan-17	1	Employee disclosed patient appointment details to a Facebook discussion group with a view of disclosing to the group the whereabouts of the patient. Patient complained to practice and produced evidence of posting and then employee admitted the offence. Practice investigated complaint and member of staff was summarily dismissed and apology sent to patient.	Patient confidential data has been shared with others on social media
IGI/6612	CAMBRIDGE UNIVERSITY	02-Feb-17	1	Call from a patient who had been discharged on 9th Oct from the Ward. When they looked at the	Discharge paperwork

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	HOSPITALS NHS FOUNDATION TRUST			computer printed paper work they noticed that they had paper work for a different patient with their own.	
IGI/6507	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	20-Feb-17	19	ENT inpatient handover sheet left at patient bedside. Handed to nursing staff by patient's Father who may have read it. Sheet contained full names of patients, dates of birth and diagnosis on sheet.	Patient full name / date of birth / hospital number / progress / results / proposed action plan
IGI/6484	Chiltern Vale Health (2012) LLP	09-Jan-17	approx. 240 women	A Senior HCA Lead noticed book no longer in clinic bag. At this point the HCA had yet to check the clinic locations and assumed it was safely held at one of 2 locations. The HCA Lead informed Operations Manager and Manager asked HCA to search all CV Health premises and all Stock bag containers. CV Health only has access to these locations on specific days as utilised by the practices own GPs. Since then the HCAs have checked cars and searched clinic locations. There is still a possibility that the log book and pad will be recovered as they were stored in secure areas away from direct patient access. A more detailed search of Penn and Fairford Leys will be carried out this week by the Operations Manager and the practice manager at each location.	NHS No. Date of Birth Name Address Prescribed medication details.
IGI/6722	HEART OF ENGLAND NHS FOUNDATION TRUST	14-Mar-17	2	A member of staff accessed own and daughter's records	NHS patient data

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IGI/6500	NHS Calderdale CCG	13-Jan-17	17	In checking the existing website content with a view to moving to the new website, our communications manager has identified that a number of individual names have appeared on the spreadsheet relating to financial transactions over £25,000. These are individuals who have received personal health budgets of more than £25k.	Forename and surname of 17 individuals in receipt of personal health budgets.
IGI/6518	Solent NHS Trust	13-Jan-17	1	PID sent to a third party (work address), but was addressed to whom it may concern, rather than an individual  PID was opened and read by someone who was not the intended recipient and therefore disclosed to someone in error.	Theapy / Counselling summary report
IGI/6613	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	02-Feb-17	30	Family of the patient found a nursing handover sheet on the floor. They looked to the data on it and took it to the PALS. PALS rang to say there was breach of confidentiality.	handover sheet
IGI/6691	Kingswood Health Centre (L81063)	25-Mar-17	1	A request was received for full medical records by someone who thought they were a patient at the health centre. The notes were released incorrectly, as it was the wrong patient's notes. The event was notified to us by a third party who destroyed them. Patient contacted and apologised to - no response received from patient following our explanation.	Full Medical Paper Record (copies)

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IGI/6678	LANCASHIRE CARE NHS FOUNDATION TRUST	14-Feb-17	20 patients identified	<p>Patient information is carried in a sealable red bag by all health visitor staff. On this occasion the pad had been removed and not placed back into the bag.</p> <p>When it was realised that the pad had been left in the patients home numerous attempts were made to retrieve it including telephone calls and home visits. The pad was eventually collected by a member of the health visitor team. On retrieval the pad was found to contain 108 patient names written throughout the pad. 20 of the names identified also included the patients address and date of birth. The Pad has been used as a 'to do' reminder. This information had been recorded over several months for home visits but had not been removed from the pad and shredded as per service procedure.</p>	Patient name, address and date of birth
IGI/6524	WYE VALLEY NHS TRUST (RLQ)	25-Jan-17	1	2 clinic letters received by incorrect patient. The clinical letters included, treatment, awaiting results and medication information	clinical information following a clinic appt
IGI/6467	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	05-Jan-17	322	File contained patient details, NHS number, Hospital ID, Forename, Surname, Gender, Date of Birth. Scoring of test results of 322 patients	File contained patient details, NHS number, Hospital ID, Forename, Surname, Gender, Date of Birth. Scoring of test results of 322 patients
IGI/6463	ROYAL FREE LONDON NHS FOUNDATION TRUST	19-Jan-17	4	A patient has handed x5 hospital letters (x4 patients affected) to a local newspaper that had been sent to the patient in error. The x5 letters sent in error were inside an envelope which also had a letter for the intended recipient (patient). There was an envelope packing error	Letters from the Royal Free Hospital NHS Foundation Trust intended for patients and GPs detailing patient conditions. The letters also have patient name, DOB and address.

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				caused by a letter folder inserter machine which was managed by a third party .	
IGI/6509	GATESHEAD HEALTH NHS FOUNDATION TRUST	03-Jan-17	1	A fax notification to a patient of the patient's cancer diagnosis was sent to the wrong surgery and the lady that picked up the faxed information was the patient's daughter who works at that surgery and realised for the first time, by reading the faxed information, that the mother had cancer. This has obviously caused some distress to the patient and her daughter.	Patient's name Patient's address Patient's date of birth Patient's Hospital Number Patient's NHS Number Patient's Clinical Diagnosis
IGI/6435	Heaton Mersey Medical Practice (P88008)	12-Jan-17	658	An email was sent to 658 patients of the practice inviting them to take part in a survey about appointment availability and access. The email contained a link to a survey on Citizen Space. There was no sensitive information in the body of the email. The usual process is to send the email from a generic mailbox, set up specifically for the purposes of communicating with patients, and to place all the recipients email addresses in the 'Bcc' field. This task is completed by the same person each time who is fully aware of the process. On this particular occasion, the staff member had a lapse of concentration and sent the email from her own mailbox and also placed all the recipient's email addresses in the 'To' field, rather than the 'Bcc' field. The error was realised immediately after the email was sent. The staff member contacted NHS CCG IT Service Desk and was advised to 'recall' the email. This was actioned immediately.	Email addresses of 658 patients disclosed to all recipients of an email (same 658 patients).

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				<p>The email was re-sent following the correct process, from a generic email and with all the recipient's email addresses in the 'Bcc' field. Within a few minutes of sending the original email, a patient emailed the staff member to advise of the error. The staff member replied to the patient confirming the practice was aware of the error and was taking steps to correct it. An apology was also sent. The Senior GP Partner was made aware of the error.</p> <p>Approximately 15 patients contacted the practice to advise of the breach of confidentiality. Initially, apologies were sent by email to each patient as they contacted the practice. Two patients telephoned the practice. In all cases, the patients accepted the apology and explanation, however the practice later decided to send an email to all 658 patients apologising for the error and advising them that an investigation would be conducted - the outcome of which would be communicated in due course. The practice felt this would alleviate any further concerns of all 658 patients affected. The practice is aware that patients may choose to contact the media/ICO due to this incident but feel this is unlikely due to the acceptance they have received so far from those affected. The practice chose to select this option in the sensitivity factors below however, due to the large number of patients affected.</p>	

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IGI/6831	DEVON PARTNERSHIP NHS TRUST	06-Mar- 17	4	Patient letter sent to wrong address.	Assessment letters - not full case notes but letters containing sensitive personal information.