Information Governance Incidents closed during 1st. July to 30th. September 2017

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Information and technology
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Contents

Introduction

This is the published report of closed level 2[1] Information Governance Serious Incidents Requiring Investigation (IG SIRIs) recorded on the IG Toolkit Incident Reporting Tool. This type of report will be published on a quarterly basis as specified in the IG SIRI Publication Statement[2]. It covers IG SIRI level 2 incidents closed during the period of 1st. July to 30th. September 2017, following investigation by the local organisation(s) concerned.

Content of the report

The report below consists of **65 closed incidents** reported to the Information Commissioner's Office (ICO), Department of Health (DH) and NHS England (NHSE) by Health or Adult Social Care organisations or suppliers (as advised within the IG SIRI Guidance issued 29th. May 2015).

The report contains the organisation name, date the incident was closed, scale (e.g. the number of data subjects affected presented as a range), a description of the incident and data involved. All information displayed below is as reported by the organisation(s) concerned. Where necessary, personal information included within the incidents has been redacted.

An auto closure feature introduced in June 2015 closes all open incidents that have not been updated by the organisation for 90 days[3]. In Appendix A are **85 incidents** which have been auto-closed by the system.

Please note:

- A 'Closed' incident means that the incident has been investigated by the local organisation and no further action is required unless the ICO make a request.
- Closed incidents may still be under review by the ICO and any actions taken will be published on the ICO website.
- This report does not include level 2 incidents which are still marked as open and therefore are still under investigation by the local organisation.
- Any near misses, Level 0 and 1 incidents voluntarily reported by organisations are also excluded as these incidents are not currently being monitored by the Health and Social Care Information Centre (HSCIC) but are useful for gathering intelligence, analysing trends and learning from previous occurrences. Details of such incidents are held by the local organisations.

Next reports

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

[1] Level 2 IG SIRIs are sufficiently high-profile cases or deemed a breach of the Data Protection Act or Common Law Duty of Confidentiality, and hence reportable to the Department of Health and Information Commissioner's Office. Organisations have used the IG SIRI assessment of severity facility to determine this level and report the incident. Further information on this can be found in the 'Checklist Guidance for Reporting, Managing and Investigating IG SIRIs'.
[2] https://www.igt.hscic.gov.uk/resources/IGIncidentsPublicationStatement.pdf.
[3] The organisation is notified by email 10 days in advance giving them time to update or close the incident before the auto closure occurs. If the organisation updates the record, it will not be auto closed. The organisation will also receive an email notification within 24 hours after auto closure, and if necessary can reopen the incident.

Closed level 2 incidents reported during 1st July to 30th. September 2017

ID	Organisation Name	Date of Closure	Details of Incident	Data
IGI/13605	Mears Care Limited (part of Mears Group PLC)	12-Sep-17	A care worker collected their 10-page rota from the branch as per procedure. They inadvertently lost the rota in the street before going home. Care workers retrieved the majority of pages, but 4 pages are still unaccounted for.	Names, address, telephone number, care plan summary update 14 subjects affected. Of these 14 subjects the following data was disclosed 14 x names 7 x address 7 x telephone number 7 x care plan summary update
IGI/13598	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	18-Sep-17	Request for Caldicott approval sent to Caldicott Guardian by data quality staff member through Trust email. Copied in was CG's PA and IG Manager. Contained excessive information (see list provided) for the purpose (to explain what sort of data was to be shared and approved for sharing) resulting in a confidentiality breach. Data on the excel spreadsheet included for 1250 patients: Hospital number Pt Name (Title, First and Surname) Gender Full address and postcode, Date of birth Ethnic Code (can be interpreted by looking up on internet) Date of Admission Date of Discharge Length of stay	Data on the excel spreadsheet included for 1250 patients: Hospital number Pt Name (Title, First and Surname) Gender Full address and postcode, Date of birth Ethnic Code (can be interpreted by looking up on internet) Date of Admission Date of Discharge Length of stay Treatment code (identifying treatment received e.g. General Medicine, Stroke Medicine, Cardiology, Respiratory, Gynaecology, Breast surgery, urology, etc). ICD10 Chapter code (identifying category of illness e.g. infectious diseases, neoplasms, blood diseases,

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			Treatment code (identifying treatment received e.g. General Medicine, Stroke Medicine, Cardiology, Respiratory, Gynaecology, Breast surgery, urology, etc). ICD10 Chapter code (identifying category of illness e.g. infectious diseases, neoplasms, blood diseases, mental &behavioural disorders, endocrine and nutrition, etc Admission method code, Management information such as CCG code, and other non-personal data.	mental &behavioural disorders, endocrine and nutrition, etc Admission method code, Management information such as CCG code, and other non-personal data.
IGI/13638	WYE VALLEY NHS TRUST (RLQ)	20-Sep-17	Radiology referral letters sent incorrectly to a patient instead of being send to the radiology department at WVT	patient demographics, reason for referral
IGI/13634	WYE VALLEY NHS TRUST (RLQ)	20-Sep-17	patient 1 received a letter containing a clinic letter relating to patient 2, the letter contained patient demographics, and dictated notes including diagnosis, treatment and medication.	diagnosis, treatment and medication
IGI/13577	EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	22-Sep-17	A spreadsheet containing details of violence and abuse incidents between 1 April - 23 August 2017 was accidentally released to local media. There are approximately 600 records. However, not all will contain personal and/or sensitive information. Work is ongoing to establish the total number affected.	Affected person's name and address, perpetrators name and address, details of incident e.g. assault, criminal action taken
IGI/13564	WYE VALLEY NHS TRUST (RLQ)	08-Sep-17	A patient submitted a legitimate SAR, requesting both their main and maternity notes. During the process of photocopying both sets of notes the wrong file was photocopied and therefore half of the information sent to the requestee related to another patient.	Full clinical information relating to maternity.

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IGI/12540	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	15-Sep-17	Assessment letter sent to the wrong address. It would appear that a typing mistake was made with the house number	one assessment letter but containing mental health medical information
IGI/12516	MERSEY CARE NHS FOUNDATION TRUST	04-Sep-17	Service users nursing observation sheets disclosed in error to another service user.	A service user received copies of her records following Subject Access Request and discovered 8 nursing obs sheets belonging to another service user. Both current patients on same ward. Service user that the 8 documents related to advised of incident. Investigation underway.
IGI/12554	NHS Bedfordshire CCG	25-Sep-17	CCG Mental Health team member forwarded an email containing details of patient's assessment, name, address, DOB, nhs number and contact details to another member of CCG staff who should not have had access to patient level data.	Email containing patient identifiable data forwarded inappropriately internally
IGI/12474	PORTSMOUTH HOSPITALS NHS TRUST	04-Sep-17	Delivery summary found in patient's hand-held notes for another patient, returned to ward staff by patient's husband.	Name Address, DOB, NHS number, Hospital Number Clinical information of recent birth
IGI/12452	MARIE STOPES INTERNATIONAL	03-Sep-17	Email sent in error to incorrect recipient containing personal information for 11 MSUK clients Initial details of incident available - Full investigation commenced	Name, address, treatment type

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IGI/12515	MERSEY CARE NHS FOUNDATION TRUST	26-Sep-17	A list of patients to be discussed at the Virtual Ward MDT on 02/08/2017 sent to incorrect recipient unsecured. Total number on list = 19 patients. The Company Secretary of Urgent Care 24 contacted Trust SIRO to report incident. IG Lead for the Trust contacted Company Secretary for further details. South Sefton Community Division circulated the email and attached list. Senior Manager in South Sefton Community Division notified of the incident and investigating numbers involved. The list contained patient's names, NHS numbers, Dates of Birth and reason for MDT review.	Patient list due for discussion at MDT which contained patient names, NHS Numbers, Dates of Birth and reason for MDT review. Total number on list = 19
IGI/12415	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	15-Aug-17	Documents containing personal identifiable information sent to business partner in error by a secure email transfer route. The four documents described within the data section were sent to an external health business partner, the documents were not password protected; however a secure e-mail transfer route was used. The health business partner was not entitled to receive the documents; however, they are entitled to receive similar information to carry out contractual obligations. The level of personal identifiable information included within the documents was excessive and the concerned member responsible for the incident understood that pseudonymisation reduces the level of risk for processing data and had redacted the documents; however, the member of staff mistakenly submitted the incorrect documents to the incorrect	Four documents which contained personal identifiable information for a total number of 56764 data subjects. Data entries included full name, DOB, postcode, NHS Number. Out of the 56764 data entries, 1100 of those contained personal sensitive data such as health diagnosis and gender.

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			external health business partner. The concerned member responsible for the incident realised the error, attempted to re-call the e-mails and further requested for the health business partner to not open the documents, and also requested them to delete and provide confirmation of these actions. The incident was then reported via our incident management reporting tool.	
IGI/12430	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	18-Sep-17	Staff member self-reported they had accidentally emailed the wrong email address. Recognised immediately and took action to ensure it was deleted which was confirmed by the recipient. Information consisted of: Name, DOB, NHS number and TYPE of record held (e.g. health visitor or school nurse record) for 302 patients. Sent to a known recipient in Local authority with the same first name as the intended recipient who was internal to the organisation. It happened because the system auto suggested the recipient from a "remembered email recipient" and in haste the sender hit the confirm button. Email sent was not encrypted.	Name, DOB, NHS number and TYPE of record held (e.g. health visitor or school nurse record) for 302 patients. Personal data which refers to information about health but is not health data and therefore not deemed as particularly sensitive personal data.
IGI/12379	Marie Curie (London)	16-Aug-17	This is an incident in Wales where a Clinical Nurse Manager used a distribution group email address to contact 40 members of staff. The email contained an attachment that included personal contact details of all 40 members of staff. Consent had not been sought for this information to be shared.	A spreadsheet containing all staff personal contact details were circulated via email.

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IGI/12333	Mears Care Limited (part of Mears Group PLC)	11-Aug-17	The Manager and Deputy Manager were dismissed in late 2016 when it was discovered they had set up a rival company. During the suspension meeting, devices and access to systems were revoked. Yesterday we discovered that Service Users of the Laindon Care Branch were being contacted via a marketing letter from Together Care, and it later transpired that Together Care had contacted via other channels and to Service User's Next of Kins. There is concern as to how this data was obtained with it potentially being from Mears Care, and Service Users have voiced this concern. We wanted to inform the DoH and ICO at the earliest opportunity whilst we investigate the matter further.	Service Users have reported that they have received mail, phone calls and also phone calls to their next of kins. This suggests name, address and contact details.
IGI/13590	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	31-Aug-17	Telephone call received by Staff A, from Patient A, who advised she had received an appointment letter which contained a copy of the assessment letter of a Patient B. Patient B to explain the situation and ascertain if she had received the assessment letter of Patient A - patient had not noticed when opening the letter and was not home so advised would check and call back. Staff C collected the Letter from Patient A. Whilst out, Patient B rang and advised she had received Patient A's letter, staff C advised via mobile and collected letter from Patient B. Apologies given to both patients who appeared understanding of the situation.	Assessments letters to GP had been copied to the patients; these were sent out accompanying an appointment letter but unfortunately, the incorrect assessments were allocated to the recipients.
IGI/12315	THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST	21-Aug-17	A member of the Human Resources Team emailed information to internal managers and copied in an external address (Hotmail) for a NHS bank doctor. The	Division, Name of Agency Supplier, Sub Agency, Name of Agency Worker, Start Date, Planned End Date, Grade/Band, Department, Number of

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			information on the spreadsheet included sensitive information regarding 65 locum doctors.	hours per week, Core or Unsocial, Number of Shifts Worked after 00.00 10th July to 23.59 16th July, Number of working hours 10th July to 16th July, Overall cost per hour excluding VAT, 1 April 2016 Price Cap Rates, Deficit from Monitor Price Caps for Core Hours Per Hour, Total amount lost due to non-compliance with Monitor Pay Cap, Engaging under or over 12 weeks YES/NO, Worker Pay rate per hour Core and Unsocial and Reason for agency doctor e.g. sickness, long term vacancy
IGI/12313	The Bridges Medical Centre (J81073)	25-Sep-17	The handyman for our practice was doing some tidying up out at our branch surgery. He was clearing out some rubbish for disposal. He thought he was careful and following his information governance training by checking what he was throwing away was not any personal identifiable or confidential information. He was aware not to throw anything of a sensitive nature away in a non-secure fashion, but to keep any personal or confidential records securely until they could be disposed of in a proper fashion, i.e. shredded using our normal procedures. The non-confidential waste was then placed in a non-secure waste disposal facility in the surgery car park. Unfortunately our surgery was contacted by one of our neighbouring practices on Monday afternoon. One of their patients had walked by our surgery and thought they had seen some documents in the waste. As soon	Approximately 800-1000 flu consent slips. These were an old style inhouse document we utilised prior to 2012. They were used on the day of flu immunisation to ask the patient about fitness to have their immunisation and any risk factors and basic information. They include, name, date of birth, telephone number, smoking history, previous reaction to immunisation or egg allergy, along with questions about any significant history that would have affected their suitability to have an immunisation, e.g. steroid use, recent cancer treatment etc. (final figure 991) Also a paper copy of the information the surgery gets from the local child

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			as we were told of this concern the doctor at our surgery immediately checked the waste. A large volume of old flu injection consent slips was found along with a data sheet detailing recalls for child immunisations. The rest of the non-secure waste was checked immediately, and no other confidential or personal information was found. The documents were taken back into the secure area of the practice for safekeeping.	health department regarding recall for immunisations was also found in a non-secure manner. On this there were approximately 50-100 patient details, again detailing from 2012. This contained the child's name, address, nhs number and details regarding their immunisations.
IGI/12550	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	08-Sep-17	Gender ID service appointment letter sent to wrong address. A neighbour of the service user contacted the service to state that she had received an appointment letter which had been sent to the wrong address. The letter had been sent to number 2 when it should have been sent to number 12. The neighbour at number 2 had opened the letter and then contacted the service to inform that the letter had been sent to the wrong address. In review- processes were followed- It was noted that the address on Paris and the NHS Spine did not match. The administrator contacted the GP surgery to confirm the correct address. The administrator recorded this call as a case note entry on Paris. In changing this on Paris, the administrator recorded the address as no 2 rather than no 12 The letter was then created on Paris using the no 2 address	1 appointment letter.

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			This letter would have been put into second checking against Paris and Spine details It is not recorded who completed the second checking as this is not current procedure.	
IGI/12314	Cherrymead Surgery (K82029)	14-Aug-17	Referral letter for one patient intended for the Diabetic Eye Screening Programme was included with a letter to another patient in error. Referral letter included patient demographic details as well as a short clinical summary	Patient demographic details plus clinical information
IGI/12473	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	30-Aug-17	A member of staff used another colleague's computer (with their log-on credentials) when they were away from their desk to access another member of staff's details (ED Medway PAS (hospital system) documentation).	NHS patient data.
IGI/12521	Marie Curie (London)	18-Sep-17	A fundraiser took a Lottery direct debit mandate home and subsequently went on leave without returning the copy to head office. The form was left in the fundraiser's home during this time. On return from leave he was reminded to post the form but there was a further delay as the fundraiser's son was unwell and he forgot to post the form. He transferred the form into a bag to remind himself to post it and left the bag in his car. His car was broken into and the bag was stolen.	One direct debit mandate
IGI/12280	Trent CBT Services Ltd	14-Aug-17	Client discharge letter sent in error by clinician to the clients GP after client had requested no information be sent to GP. The letter disclosed client had DNA mental health iapt appointment. The client should have been offered a second appointment but was discharged in error and letter should not have been sent to GP.	discharge DNA letter with client's name address and fact he had DNA and therapy appointment. no further clinical information in letter

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			Client has been given a verbal apology by both operational manager and managing director. GP surgery has been spoken to and letter has been sent to GP asking letter to be returned. Client is not accepting apology so has been given ICO details to make a complaint.	
IGI/12255	City Centre Health Centre (Y02849)	25-Sep-17	Patients' blood results faxed to an incorrect number resulting in breach of patient confidentiality. Patient Blood results requested by hospital department. Staff member faxed the results across but unfortunately it was sent to a non-NHS company in error. The member of the public who received the fax within their organisation contacted our practice to confirm they were in receipt of these patient details, the person was asked to destroy the information as per the fax front message which she confirmed she would do. The patient then rang the practice to say that she had received a call from a colleague in her workplace who informed her that they had a phone call from a member of the public to confirm she had her medical records.	Patient name Patient DOB Patient address NHS number blood test results
IGI/13636	WYE VALLEY NHS TRUST (RLQ)	20-Sep-17	Discharge summary for patient 1 sent home with patient 2. Discharge summary for patient 1 sent home with patient 2, the mother of patient 2 discovered this and has put in a complaint	Clinical information
IGI/12205	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	26-Jul-17	Letter sent to incorrect address	paper appointment letter

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IGI/12238	OLDERCARE GROUP OF COMPANIES (A1QE)	31-Aug-17	Patient returning from CTO assessment from another service unit. Escorting nurse discovered whilst in transit in hospital transport returning the patient back to hospital where he is an inpatient that the envelope containing the CTO form was missing. Incident was raised, and Caldicott Guardian informed, IG lead and SIRI. Further investigation ongoing but noted that a copy of the patient medicine chart and CPA minutes were also in the same envelope. Some of the details in the documents would be available to the public and some information was confidential information with patient identification. Only one patient's data is affected in this incident	Diagnosis, name. NHS number, DOB, medicines prescribed, notes of last Care Program Approach meeting. MHA status.
IGI/12241	PORTSMOUTH HOSPITALS NHS TRUST	09-Aug-17	Handover sheet printed on yellow paper and folded, found by member of staff on a public street. Member of staff recognised the yellow paper and picked up the sheets. Details of 31 patients including name, age, consultant, diagnosis, previous medical history, treatments, infections, ulcers, interventions, mobility, diet, elimination, D/C plans and flags.	Name, consultant, diagnosis, previous medical history, treatment, infections, ulcers, interventions, mobility, diet, elimination, D/C plans, flags
IGI/12326	EAST LANCASHIRE HOSPITALS NHS TRUST	07-Aug-17	Staff discussing handover at nurse's station post-natal ward. Overheard by patient effected and one other. Discussion involved sensitive personal data. Led to embarrassment and distress for the patient concerned as the patient who overheard then discussed details with other patients and visitors. Complaint was made by patient effected.	verbal disclosure by accident
IGI/12378	Marie Curie (London)	16-Aug-17	A Fundraising event rep contacted event participants by email. The rep was instructed to ensure the bcc email field was used so that addresses would not be	Email addresses were shared.

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			shared inappropriately but the email had already been circulated and email addresses were shared with all participants. Individual participants had specifically asked for their details not to be shared. A number of weeks after the email had been sent a participant noticed that all email addresses had been circulated and contacted the Fundraising team to notify them. There was a lack of understanding by the event rep that circulating email addresses was a potential breach. It was not recorded as an incident immediately once the error was identified.	
IGI/12225	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	08-Sep-17	Opened by erroneous recipient who then contacted the service expressing his concerns about his own information.	1 x patient care plan
IGI/12203	Integrated Care 24 Limited	01-Sep-17	Staff identifiable details emailed to CCG. Information requested by our CCG for tendering process related to TUPE however only required non-identifiable information. The template required Job Titles which were included. In addition, staff Forename & Surnames of 117 individuals were included in a password protected file.	Staff Employee Number, Forename, Surname & Salary
IGI/12329	Marie Curie (London)	16-Aug-17	A member of the public raised concerns about the conduct of a member of staff. As part of the disciplinary process information was shared with the member of staff. An un-redacted copy of the concerns raised by the member of the public were also shared. The member of the public became aware that the member of staff had been given a copy of the information that outlined his concerns.	One sheet of information about concerns raised that included name and contact details of the member of the public.

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IGI/12375	North Cumbria University Hospitals NHS Trust	22-Sep-17	Payslips containing personal information (staff ID number, national Insurance number, pay details) have gone missing in transit twice (end of May and end of June)	Name, Job Title, Staff ID number, Department, Salary, Pay Banding, Union payment, Travel expenses payments, Gross pay, National Insurance Number, Hours of work, Tax Code, Pensionable Pay, SD reference Number.
IGI/12353	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	14-Aug-17	Discharge letter contains: Name, Address, Date of Birth, Hospital & NHS Numbers, clinical details of hospital attendance. The incorrect discharge letter has been returned by the patient's mother.	Name, Address, Date of Birth, Hospital & NHS Numbers, clinical details of hospital attendance for one patient
IGI/12145	EAST LANCASHIRE HOSPITALS NHS TRUST	07-Aug-17	Handover sheet with 13 patient's details dropped on stairwell next to ward. Found by member of public on the same day and handed back to the ward. Though it is reportable the sheet was found and secured quickly and therefore the risk of data of a major data protection breach averted.	patient's names and sensitive clinical data for 13 patients in surgical triage unit
IGI/12146	Locala	30-Aug-17	The breach occurred in Locala's Customer Liaison team, whose primary function is to handle and process NHS complaints against Locala services. Part of this process is acknowledging the complaint when it comes in and advising of the next steps to the Complainant. Complaints can be received via a number of methods – verbally, by post, and in this instance by e-mail. The breach occurred when the Staff Member e-mailed an acknowledgment back to a Complainant.	Details of complaint, including name, address, details of consultation

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			The Staff Member had received a number of telephone calls, and two e-mails that appeared to be raising the same issue with one of Locala's services. They were attempting to identify a trend in the Complaints being received by comparing the data provided. Usually this would be done by having the e-mails open side by side, or printed off, or by comparing Datix entries; however, on this occasion the Staff Member chose to copy and paste details into one e-mail. The Staff Member reports this was on a particularly busy day, and unfortunately, by human error, the Staff Member came back to the e-mail, didn't double check the contents, drafted an acknowledgment at the top of the reply e-mail and sent it to the Complainant not realising that the Patient's details were still at the bottom of the e-mail. The Complainant contacted a Locala Customer Engagement Manager and identified the mistake to them and informed that manager that they had contacted CQC regarding the breach. The Manager immediately spoke with the Staff Member and verified the breach, and the Staff Member then formally recorded the incident on Datix, and the Customer Engagement Manager took appropriate next steps in informing the Complainant and Patient.	

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IGI/12151	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	15-Sep-17	Patient, whose child is currently in foster care, was sent home with the foster carer's address in her discharge paperwork. We are currently investigating precisely how this incident occurred. The incident came to light during a home visit to the patient by a midwife. The midwife identified that the foster carer's address had been disclosed and recovered the information.	Home address of foster carer.
IGI/12338	WYE VALLEY NHS TRUST (RLQ)	08-Sep-17	Patient 1 received a referral letter relating to patient 2. The information disclosed re patient 2 to patient 1 included NHS no, name dob and address and details regarding their operation prep and the fact that they had now been reinstated as a 2ww patient.	local hospital number, NHS no Name DOB Address comments re previous treatment mentioned that the patient had now been reinstated as a 2ww referral
IGI/12140	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L)	12-Sep-17	Missing patient visit list. Visit list included 13 individuals' details (name, address, DOB, telephone numbers, NHS numbers, diagnosis and reason for visit). Staff member was out visiting patients when they misplaced the document.	Visit list included 13 individual's details (name, address, DOB, telephone numbers, NHS numbers, diagnosis and reason for visit). Staff member was out visiting patients when they misplaced the document.
IGI/12165	PENNINE CARE NHS FOUNDATION TRUST	26-Jul-17	I arranged an emergency Respite Placement for redacted at Drakelow Care Home in Heaton Moor. redacted was to be taken there over the weekend by her friend. I agreed to supply the home with a copy of the most recent Review so that they knew what the recent concerns are and what the plan is and what care she needs. I was also seeking Respite for redacted and had typed a new Review. Drakelow House told me that their fax machine was out of order,	2 x care reviews

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			so I promised to put a copy of the Review into their letter box which is secure and can only be accessed by staff unlocking the doors, so they had it in time for her admission there the next day. That evening I printed out the Review. In error I picked up both Reviews from the printer and stapled a copy of patient1 front sheet. I had only intended to take the Review for patient 2 but instead put both in the envelope which I marked for the attention of the Manager and Private and Confidential. I duly posted the envelope. On my next working day I was informed that I had in error delivered patient 1 Review to the Home and it had been seen by the Owner/Registered Manager. She had kept the document safe realising that it was sent in error and I retrieved patient 1 document and telephoned my Manager to tell her that I had breached Data Protection and Confidentiality. The owner had not shared the information with anyone else. She is also under a duty of Confidentiality and she is aware that she cannot discuss this with anyone else.	
IGI/12084	EAST LONDON NHS FOUNDATION TRUST	18-Jul-17	Patient reported that the email sent to her with the documentation for initial consultation also had a document attached which listed the full names, addresses, mobile telephone numbers and NHS numbers of 43 other patients.	Contact details
IGI/12220	Cherrymead Surgery (K82029)	02-Aug-17	Two sets of health check results stuck together. Both results sent to one patient.	NHS Health Check results

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IGI/12131	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	02-Aug-17	2 medical records found unattended by external business partner onsite in public area.	2 medical records (2 data subjects concerned). The medical record identifies the patient and contains clinical information regarding the data subject's case history at the trust.
IGI/12217	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	08-Sep-17	Staff at WNW ICS team sent a taxi to collect a service user for a patient. They gave the wrong details to the taxi firm (wrong house number), resulting in the taxi going to the wrong house. The service user came out of her house at the time and heard the taxi driver give her name and the service / address to the person that answered the door in earshot of the service user. Service user described as being angry and in need of being calmed down on arrival at service. Discussed with manager investigating who felt that the additional grading factor relating to distress and embarrassment was engaged based on the service user's presentation on arrival	Patient name and their status as a user of mental health services.
IGI/12073	MEDWAY NHS FOUNDATION TRUST	20-Jul-17	The Trust physiotherapy team realised that a paper diary containing the daily schedule of visits to patient homes was missing. The diary was kept in a staff -only room on a shelf and was not meant to leave the office. The diary contains on average, details of three visits a day, with patient details and the business mobile number of the relevant physiotherapist. The diary was also used by technicians scheduled to deliver equipment to patients.	the following patient data: name (some with NHS number) / address / some patient phone numbers / some alternative family contact identifiers and contact details / identity of physiotherapist and business mobile phone number

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IGI/12036	DARTFORD AND GRAVESHAM NHS TRUST	04-Sep-17	A member of the site team (nurse) found a ward handover sheet on the stairs of the main hospital building. The handover sheet was originally added to the confidential waste bin. On receiving details of the incident via Datix, the IG manager retrieved the documentation from the confidential waste to use as evidence.	Ward handover sheet contains bed number, patient name, system ID, DOB, age, gender, diagnosis, social status, investigations, treatment/progress, issues/jobs.
IGI/12169	NHS Nene CCG	18-Jul-17	Incumbent provider bidder submitted procurement documents including TUPE summary which was passed by commissioner to Commissioner support who uploaded the document to the online procurement portal. Tupe Summary contains approx. 100 staff names and salaries on an un-named spreadsheet tab. Uploaded to portal and at the time of taking down had been accessed by 3/14 potential registered bidders Data was uploaded in early June, but the error was not noticed and pulled from website publication until late June.	Staff names, salaries and hours of work
IGI/12061	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	17-Jul-17	Patient received 9 letters of other patients with names, date of birth NHS numbers and confidential details along with their own appointment letter. The 9 letters the patient received were returned to the Trust and it was stated that they had not been read. 6 of these letters were appointment letters which have patient details such as addresses, NHS numbers and dates of birth and the venue of the appointment but nothing else. 3 of them were assessment and discharge letters (half a page to one page each)- they had details of scores on depression and anxiety, and presenting problems.	Patient data - in 6 letters: addresses, NHS numbers and dates of birth and the venue of the appointment but nothing else. In 3 letters: assessment and discharge letters (half a page to one page each) - they had details of scores on depression and anxiety, and presenting problems.

ID	Organisation Name	Date of Closure	Details of Incident	Data
IGI/12016	Second Step	03-Sep-17	As part of the implementation of our new Cascade HR system, DLIT our IT providers had been instructed to set up access for all Second Step Users via a link on their desktop. This took place on 5/6/17. An email had been sent out from HR on Friday 2/6 informing all Second Step system users that they would be receiving this link on 5/6. When setting up user profiles HR had been instructed to base the profiles on an existing user. The only users currently set up were the HR Team, so the profile was based on a member of the team, with access changed to “Employee” User profiles were sent out from HR using an automated process. HR were alerted by one of the Team Managers, that they had access to the full system – 293 Employees records at all levels. This access should only be available to the Head of HR, and the Senior HR Advisor. It transpired that managers that had direct reports, 12 x Senior Managers and 12 x Team Managers had been given Full Admin Access. This information was not accessible to the general Second step user population, and was not made	Employees personal records

ID	Organisation Name	Date of Closure	Details of Incident	Data
			available outside of the organisation. It was restricted to Senior Managers within Second Step	
IGI/12026	John Taylor Hospice Community Interest Company (NR9)	10-Jul-17	Confidential information had not been correctly destroyed for some time and was becoming untidy. The administrator redacted placed confidential information into a general waste bag to be put aside for shredding on their return which is not usual practice. On their return to work the general waste bag with patient information had been removed and could not be found by JTH staff. This was raised with housekeeping, nursing staff and ward manager. Housekeeper saw the bag at the weekend during their shift, so was presumably removed on the Sunday, assumption that it has been thrown into general waste and was brought to the attention of IPU Manager. NHS properties confirmed that waste had been collected on the Monday morning and taken to landfill. The following day contact was made with the domestic on shift who confirmed that the black bag was removed as it was placed next to the general waste bin in the In-Patient Unit office.	a) Handover sheets containing the following information: Room name, Preferred name, Date of birth, Age, Next of kin, Resus status, Date of admission, Admitted from, Admitted for, Bed type, Diagnosis, Falls Risk, Tissue Viability, Barrier Nursed, Continence, Catheter, Bowels last opened, Dysphagia, Diet, Diabetic, Drug information, Mobility, Phase of illness, Karnofsky score and Free text for changes/interventions over previous 24hrs. b) GP letters (death notifications) c) R.I.P and Discharge information All of the above information is between Thursday 25th May – Thursday 1st June 2017
IGI/11970	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	16-Aug-17	Staff member has reported that their car, which was parked on the driveway at home, was broken into. Their work bag, which was locked in the boot of the car, was stolen. Work bag contained discharge/referral letters and clinical results for 44 patients on a mixture of paper and a digital Dictaphone. In addition, an encrypted Trust laptop was in the bag.	Full demographic details Investigation Results Consultant letters to GP Dictaphone - Identification by full name and hospital number. SMDT Minutes - dictated

ID	Organisation Name	Date of Closure	Details of Incident	Data
IGI/11921	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	14-Aug-17	A District Nursing Team red bag has been returned to the Trust by a car auction house that contains confidential/sensitive information of over 100 service users contained in ledgers. The red bag was discovered in the car during the car inspection as the car had been sold onto a trader by the auction house. The staff member involved sold her car to a garage in March 2017 The car was kept in a secure compound at the garage but all staff had access to the compound so it is not known who would have had access to the bag The car was taken in May 2017 to an auction house where it was sold to a trader The bag was discovered by the auction house during a routine inspection prior to releasing it to the trader. The red bag was returned by recorded delivery to the Trust The contents of the bag included: 24 ledgers each of which contain the details of 5-6 service users to be visited by the DN that day the ledgers go back to June 2016, the information within the ledgers contain: Full names Addresses Telephone numbers Key codes for 6 service users (1 since deceased) And details of the reason for the visit	24 ledgers each of which contain the details of 5-6 service users to be visited by the DN that day the ledgers go back to June 2016, the information within the ledgers contain: Full names Addresses Telephone numbers Key codes for 6 service users (1 since deceased) And details of the reason for the visit Detailed MDT notes from a surgery which included: Full names of 4 patients with notes and actions relating to their conditions Reviews of 10 patients full names admission and discharge details Details of 2 patients full names non MDT but possible case finding Referral from Addenbrookes dated June 2016 for a potential service user containing, full name, address NHS no, DoB, GP, daughters name, admission details and reason for referral Personal staff P6 form dated 2015

ID	Organisation Name	Date of Closure	Details of Incident	Data
			Detailed MDT notes from a surgery which included: Full names of 4 patients with notes and actions relating to their conditions Reviews of 10 patients full names admission and discharge details Details of 2 patients full names non MDT but possible case finding Referral from Addenbrookes dated June 2016 for a potential service user containing, full name, address NHS no, DoB, GP, daughters name, admission details and reason for referral Personal staff P6 form dated 2015	
IGI/12037	Sussex Community NHS Trust	09-Aug-17	A member of the public found ward handover sheets in a public recycle bin and returned them to Sussex Community NHS Foundation Trust. The member of the public was reassured that appropriate action would be taken, and an investigation is to commence regarding the cause of the incident. The member of staff who lost the handover sheets has been identified from the documentation and will be interviewed as part of the investigation. The incident was reported to Executive team who confirmed it as a Serious Incident in June 2017. The incident was reported on STEIS (reference: redacted).	Personal sensitive information. The data included handover sheets of 31 patients in a bedded unit including: name, DOB, NHS number, GP name, admission date, planned discharge date, diagnosis, and notes on hygiene, mobility, nutrition and discharge plans.
IGI/12087	AVON AND WILTSHIRE MENTAL HEALTH	19-Jul-17	letter sent to incorrect person. Information sent to person listed as nearest relative, who wasn't. Team	name, NHS number and sectioned under MHA

ID	Organisation Name	Date of Closure	Details of Incident	Data
	PARTNERSHIP NHS TRUST		were advised of this, but did not investigate and sent second letter out.	
IGI/11875	Optum Health Solutions (UK) Ltd incorporating UnitedHealth UK Ltd	08-Aug-17	A letter was sent from the Referral Management Service to a Brighton patient to acknowledge their complaint letter, with another patient's referral form enclosed. The recipient of the letter, enlisted the help of their Care Home manager (representative) to send an email to the RMS to advise of this breach.	The clinical summary contained the Patient B's NHS Number, Full Name, Date of Birth, and audiology referral clinical summary.
IGI/12053	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	02-Aug-17	• A small group of staff had been emailing reablement referral forms containing sensitive information to another private health organisation. • The process has been used for over a year long period. • The recipients were entitled to the level of information sent and were the correct recipients, however, the email was not encrypted or password protected. • The patients had also consented to their information being shared with the private health organisation. • Including the next of kin data, the estimated total of data subjects range between 3650 and 7300 • There have been no reports of data breached, or the data being compromised. • The private health organisation has confirmed receipt of all the sent reablement referral forms.	• Patient name • DOB • Address • Ethnicity • NHS number • Reason of care • Past medical conditions • Patient next of kin name • Patient next of kin address
IGI/11822	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	04-Aug-17	Theft of IT equipment from the IT Workshop by the IT Workshop Team Lead. Evidence of potentially trying to sell the equipment via eBay. The IT Workshop Team	The equipment that was stolen by the individual was a GP Server and CPFT laptops / PCs, phones, etc.

ID	Organisation Name	Date of Closure	Details of Incident	Data
			Leader advised the Police that the data had been removed	
IGI/11803	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	31-Jul-17	An e-mail was sent without removing patient identifiers. A spreadsheet of costs was e-mailed to recipients without removing patient information. In error the sender included dob, NHS number, post code and details of a medical device fitted. The e-mail was sent from the Trust to 2 members of staff at NHS Supplies Dept. The e-mail was sent from a Trust e-mail account without encryption. The sender of the e-mail realised the error and asked the recipient to delete the e-mail without opening it. There is no evidence to show that patients data has been compromised by sending an insecure e-mail.	Patient
IGI/11743	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	24-Jul-17	A scanned document, which contained patient information was sent by staff member A to staff member B in error, as an attachment. Staff member B forwarded the email, including the attachment to 2 internal staff members and 1 external supplier. .	name, surname, date of birth, diagnosis, diagnostic tests and treatments.
IGI/11799	KIMS Hospital Ltd	27-Jul-17	Spreadsheet sent to 2 individuals, one of which it was not intended and should not have received this highly sensitive data	A spreadsheet containing 105 patient's information including full name, address, phone number, DOB, GP details, NHS number, NHS Hospital ID, Consultant and planned procedure
IGI/11699	NHS Birmingham Crosscity CCG	10-Jul-17	Sent Re--audit data which contained patient data, approximately 48 patients (including patient name, NHS number and DOB with some clinical information) to GP and instead of copying in practice manager I	ID Forename Surname Gender, DOB Age Diagnosis

ID	Organisation Name	Date of Closure	Details of Incident	Data
			copied in another person with the same first name who works in an outside non-NHS organisation.	Intervention Treatment Intervention Comments
IGI/11615	Barts Health NHS Trust	03-Jul-17	The police attended on 12th April. The machine requires a login, so the patient information is not readily accessible. The view from the police is that theft is unlikely as the machine is large and would require a minimum of 2 people and a large estate car/van to move it. Enquiries to estates and the company have confirmed the machine is not with them. On site searches will be completed.	name, date of birth, MRN, hospital number and scans
IGI/11585	STOKE-ON-TRENT CITY COUNCIL	03-Jul-17	Sensitive personal information posted to the incorrect address. The recipient opened and viewed the information. 14 pages of adult social care information were posted to the incorrect address and viewed by the incorrect recipient. Two separate assessments were put into two separate envelopes. The envelopes were not written on and did not include a typed letter so could only be identified by looking in the envelope. The officer then posted the incorrect envelope and only realised when going to post the second envelope. There is a risk that the incident will hamper on-going social work with the data subject.	Sensitive personal data, namely adult social care data, including physical and mental health conditions relating to one individual. It also contains the names and ages of 6 other data subject related to the main data subject in some way.

Appendix A – Incidents closed using the 'auto closure[4]' facility 1st. July to 30th. September 2017

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/12193	Middlesbrough Mind Limited	29-Sep-17	11	Theft of allocated work laptop and patient identifiable information from a member of staff. The equipment and paper records had been locked in the car boot overnight. Allocated work laptop holds no local saved work, this is held on a central location accessed via double layered password protection systems. Paper records included the service user work completed during individual support sessions with the worker and a copy of the full referral form for the individual	Completed referral forms for 11 service users (all aged under 14 years). Includes names, date of birth, address and contact details. Parents names, some information around reason for referral. Links to other services and organisations are included in some of the referrals including notice of involvement with social services or child protection services. Some include specific details of family dynamics, including prison status or domestic violence.
IGI/12195	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	29-Sep-17	1	YDH 2WW Suspected Breast Cancer Bookings. Patient referred by practice and appropriate form faxed to unit with correct current address and contact details for patient. Letter sent to patients previously registered address by 2WW bookings. Presumably their PAS had her former address, and this was not checked against the	PID, name, address, dob, appointment date, time, consultant, appointment type. Suspected cancer patient information leaflet Patient Questionnaire

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

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				incoming referral. Person living at her old address opened letter, read content and then passed to another third party who knew the current address of patient. This second third party also read the letter before passing it on. Therefore, breach of confidential information to at least two third parties.	
IGI/12201	Gladstone Medical Centre (E84036)	30-Sep-17	Not Known	A former partner, who had been dismissed from the partnership that day, took home with her a practice computer. The NWL IT department was informed and they made contact with her. The NW London IT department reported that when they made telephone contact with her after she had taken it home to download files. She returned the equipment the next morning. It has been securely stored and not touched since. We do not know if anything was accessed while this equipment was out of the practice	we have no idea what if any data was accessed and will depend on it experts to identify this
IGI/12200	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	25-Sep-17	500	An email publicising the Trust's summer celebration event was sent to all the Trust members using the To: field rather than blind copy (b.c.c.). The information sent was not sensitive or confidential, but all members were able to see the email addresses of each other. The normal process is to use blind copy for these types of communications. In this instance the member of staff made a mistake. 7 persons contacted the Trust pointing out the	Email address

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				error. One of these has requested that her details are removed from the email distribution list - which has been done.	
IGI/12148	Princes Gardens Surgery (J82178)	25-Sep-17	1	Informed by a patient who was viewing their records via EMIS online Patient Access that another patient's confidentiality has been breached. Another patients EMIS summary printout has been scanned in as part of a referral letter that we have sent to the hospital. This summary printout contains the patient's identifiable information, medication, problems significant and past – these problems included sensitive information.	NHS Patient Data
IGI/12152	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	25-Sep-17	1	Patient 1 phoned and asked for copies of her clinic letters. The PA that took the call printed the letters out, believed that she still had the correct details on her screen printed off an address label and stuck it on the envelope. Patient 2 that received the letters opened them, and then hand delivered them to the correct patient. Staff member should have checked the address label to the information inside the envelope when sending out any patient information.	3 very detailed clinic letters regarding a mastectomy
IGI/12207	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	25-Sep-17	1000-1500	A newsletter to participants of the Cardiovascular Biobank was inadvertently copied to all recipients, so that recipients' email addresses were visible. The newsletter was sent out to approx. 1580 participants, with a number of non-delivery	Patient email addresses

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				notifications received (approx. 500) so the number of affected individuals is approx. 1080.	
IGI/12204	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	30-Sep-17	2	Summary letter sent to wrong patient. Summary of Person Details 1 Virtual Fracture Clinic discussion were sent in error to parents of Person details 2 This includes a description of injury, x-ray review confirming fracture and brief discussion details of conversation with Fracture Clinic Sister.	Patient personal details - name, address, date of birth Sensitive information - description of injury, x-ray review confirming fracture and brief discussion details of conversation with Fracture Clinic Sister.
IGI/12206	PENNINE CARE NHS FOUNDATION TRUST	27-Sep-17	1	A clinic letter about a looked after child has been copied in to the birth parents, therefore the birth family will know the foster carers address	Clinic letter
IGI/12537	Buckinghamshire Healthcare NHS Trust	08-Sep-17	86	181 records were identified as having more than one NHS number on PACS (Picture Archiving and Communication System). 95 records were genuine duplicates. Of the 86 remaining records, 28 have events on the radiology information system that were performed at other Trusts whilst the system was part of the shared domain system which was part of NPfit. Following the initial review, it became apparent that the majority of the affected records were not in fact related to the matching issue.	Radiology imaging and reports
IGI/12130	LANCASHIRE CARE NHS FOUNDATION TRUST	21-Sep-17	approx. 18 pages	a formal subject access request (SAR) was received from a Service User (SU). The application was processed by the Burnley and Pendle Subject Access Request (SAR) administrator. On the same day a 'Request for	PVP document containing third party information - 18 pages Overall disclosure document

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				Payment' letter was sent out to the SU and a copy of the SU's medical notes were printed and sent to a clinician for appropriate review and redaction of 3rd party information. The clinician had been identified as the SU's Care Co-ordinator. The SU's medical notes were received back by the SAR administrator which was the disclosure deadline. As per the Trust Policy and process the medical notes were accompanied by an Application Processing form (Appendix A) signed by the clinician confirming limited access due to identification of third party information (available on request). On receipt of the medical notes from the clinician the SAR administrator posted them out to the SU using recorded delivery. A copy of the reviewed and redacted notes was not made. A redaction summary does not exist either. An email was received from the SU by the Burnley and Pendle SAR administrator. The email thanked the Trust for providing information that has allegedly been withheld from the SU. Specifically, the SU stated 'The data I received included from Police national computer which named individuals who I am going to report for making false statements and resulting in detention'. It has been established that the data referred to in the disclosure by the SU is a Lancashire Constabulary PVP (Protection of Vulnerable	(patient record) was approx. 200 - 250 pages

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				Person) Database Summary, marked 'Restricted Police Eyes Only'. Having looked through a copy of the medical notes since the incident was advised, it would seem that this document has been filed twice and therefore copied twice as part of the full medical notes provided. The Police PVP document relates to the SU but also contains third party information, particularly potentially personal information regarding their landlady and the identification of people who the SU alleges have made false statements about them, resulting in detention as an in-patient with Lancs. Care Contained within the medical notes is reference to the arrangement of a CHANNEL interview with the SU as well (part of the anti- terrorism PREVENTION strategy) whilst receiving treatment from Lancs. Care. There is also information in the medical notes from SU's family members. There is no indication in the medical notes that consent has been obtained from family members for the information that they have provided to be shared with the SU. The SU has not been in receipt of services from Lancs. care since 2015	
IGI/12067	North Cumbria University Hospitals NHS Trust	27-Sep-17	13	Discharge letters sent to wrong recipient	Patient demographic information and medical information including 1) Learning difficulties. (High Sensitivity factor - Particularly sensitive information at risk e.g. Mental Health).

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
					2) Details of previous miscarriages. (High Sensitivity factor - Particularly sensitive information at risk e.g. Children). 3) Confirms PMH of anxiety. (High Sensitivity factor - Particularly sensitive information at risk e.g. Mental Health). 4) Patient asking for oramorph but left the department without being seen (High Sensitivity factor - Individuals affected are likely to suffer significant distress or embarrassment). 5) Four children - High Sensitivity factor - Particularly sensitive information at risk and possible safeguarding issues
IGI/12239	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	22-Sep-17	128	Disciplinary file not received at destination	Disciplinary file with witness statements
IGI/12063	KETTERING GENERAL HOSPITAL NHS	12-Sep-17	100-200	As part of a process to respond to a subject access request the Trust identified that during 2011/12 the Trust had not complied with national guidance in that casualty notes containing patient	Personal sensitive data containing name, demographics, presenting complaint, treatment/outcome

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
	FOUNDATION TRUST			details and attendance details for approximately 200 patients had been destroyed. It was identified that destruction of these records had not complied with national guidance and had not kept a record of the number of cards, patient details or attendance details of the cards that were destroyed. The Trust is unable to determine at this time what year the attendances related to and whether these records contained details pertaining to adults or children.	and other information relevant to the episode of care
IGI/12196	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	26-Sep-17	1	Complaint received from Breast Cancer patient that her confidentiality had been breached causing her distress. Although new address was available on national breast screening system, reception staff (in 2 areas) on 3 different occasions failed to check with the patient that her demographics were up-to-date on Trust systems, as per SOPs. This lead to 3 different clinic letters containing clinical information on physical and mental health going to her old address where her ex-partner still resides, causing the patient distress as she didn't want them to know.	3 separate clinic letters containing detailed information on the patient's physical & mental health (including cancer diagnosis and mental state), personal history (including social care) and personal relationships.
IGI/12074	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	13-Sep-17	43	Trainee reporter contacted Trust's Communications team to report that he had been handed various documents that were found in a black sack in Abbey Road. These consisted of a handover Sheet dated 24/2/17 for 8a East (this contained details of 23 patients although only 3 entries included the full name of the patient) and torn-up pieces of 3 handover sheets (dated	Patient name (including hospital number / home location (i.e. town or village name) Age Summary of Medical History Diagnosis

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				19/3/17 8/4/17 & 11/4/17) for New Timber – the pieces contained the names of 40 patients including full names.	Current Plan Social information
IGI/12141	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	15-Sep-17	One-page A4	A clinician in a Crisis Resolution Home Treatment team faxed a discharge summary record to the main CQC helpline instead of to a local GP practice. The fax contained comment on an identifiable service user's current mental health, that he was not acutely ill and being discharged to his existing mental health team.	A clinician in a Crisis Resolution Home Treatment team faxed a discharge summary record to the main CQC helpline instead of to a local GP practice. The fax contained comment on an identifiable service user's current mental health, that he was not acutely ill and being discharged to his existing mental health team.
IGI/12079	Sefton Council	19-Sep-17	1	A core assessment and support plan for a service user of Adult Social Care were sent to an incorrect address. The recipient contacted the Local Authority and returned the documents to the Data Protection Officer the following day. The details as to how the incident occurred were established following an interview with the member of staff concerned yesterday. The postcode of the address of the intended recipient had not been recorded in the Council's case management system. The member of staff looked for the address via the Internet and used the first postcode they found, which they believed to be correct. In turn, the documents were sent to this address which was not the correct postal address.	Paper - hard copy of core assessment and support plan

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/11978	Apex Medical Centre (G82679)	31-Aug-17	1	Read code entered onto patient's electronic record in 2015 stating a procedure had taken place. Information was incorrect. Mistake was discovered by patient from recent referral letter. The Incorrect data belonged to another family member. A discussion took place between the two-family members, which resulted in the incident being reported to Practice Manager.	NHS patient data
IGI/12050	Cambridgeshire Community Services NHS Trust	07-Sep-17	2 patients	Original Records lost in post. Original records send via Royal Mail. Three files in two envelopes. Envelope A was appropriate addressed and stamped, using Royal Mail Recorded Delivery. Envelope B was attached to Envelope B using elastic bands. No delivery address on B, return address on the back of B.	NHS patient records for two children
IGI/11938	Croydon Health Services NHS Trust	29-Aug-17	26	Patient surgery list containing 26 patient details left in LiA meeting room. Patients details including Patient name, Hospital number, age, Surgery and date for surgery	Patient name, Moo Number, Age, Surgery, Date for Surgery
IGI/11934	WALSALL HEALTHCARE NHS TRUST	14-Sep-17	2	A letter regarding a forthcoming operation was sent to two wrong patients. The incorrect letter was placed behind the correct pre-assessment letter.	Patient information - name, NHS Number, date and time of operation
IGI/11981	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	31-Aug-17	2	Patient was sent wrong assessment that was cut and pasted information from previous patient assessment	mental health assessment letter

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
IGI/12071	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	12-Sep-17	5	List of vulnerable children emailed securely to GP Surgery, the list contained details of 5 children not registered with the GP	Name, date of birth, NHS number, postcode, registered GP surgery, level of HV service (i.e. vulnerable child or child protection).
IGI/11973	EAST LONDON NHS FOUNDATION TRUST	31-Aug-17	1	Car was broken into and Inquest bundle including staff statements, patient records (patient of SEPTs), Police statements and IPCC report were in bundle of papers. Barrister instructed to act on behalf of Trust at Inquest left Inquest bundle in boot of car following pre-Inquest meeting in Luton.	Patient notes.
IGI/12033	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	06-Sep-17	18	MDT minutes of 18 patients was sent to 40 health care professionals. Some professionals no longer work within the Trust. The information was sent using an existing internal email group that had been set up locally within the team. This list had not been updated.	NHS numbers Hospital Number Patient Names Dates of Birth Consultant Names Diagnosis MDT Outcome (treatment plan)
IGI/11923	Hertfordshire Community NHS Trust (RY4)	24-Aug-17	1	Waiting lists that should have been sent from an @nhs.net account to @nhs.net accounts were instead sent from an @hct.nhs.uk account to @nhs.net accounts.	1x Excel spreadsheet containing lists of NHS Numbers, Date of Birth and full postcode for 13,380 patients
IGI/12198	St Andrew's Healthcare (Original code of NTY85)	30-Sep-17	2	An external professional was conducting a visit at STAH in relation to a patient. STAH staff member was asked to print off the CPA report and minutes to provide to the external professional. Unfortunately, the STAH staff member went into	CPA report and minutes

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				an incorrect patients file and printed the wrong patients CPA report and supporting minutes. The external professional has confirmed that they have securely disposed of the incorrect documentation. STAH has information governance policies and procedures in place.	
IGI/12024	DEVON PARTNERSHIP NHS TRUST	05-Sep-17	8	Pack with sensitive information sent to incorrect address. Person reported receiving opened packet from neighbour. Handwritten address included wrong house number	Packet containing sensitive information including witness statements relating to a disciplinary investigation. Sensitive information related to one individual, but personal information of others included.
IGI/11926	ROYAL BOROUGH OF KINGSTON-UPON-THAMES COUNCIL	05-Sep-17	52	The Better Bones Team commission an online database, bespoke to the Kingston service, from Lab-Lateral. The database is secure and meets national standards, and the commissioner/ service manager can use this to export patient details to an Excel spreadsheet for necessary tasks. In this incident a spreadsheet was created to send 52 patients individual information in relation to the service they had received. The service manager, who has secure access to the database, exported the data; made necessary adjustments to the Excel spreadsheet; and then transferred this to administrators who produced address labels.	Personal information like name of patient; complete postal address; and some medical details were compromised, and whilst such details were not high risk confidential nor detailed clinical/ care case notes, we do believe this to be a Level 2 breach.

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
				However, in error the service manager sorted one field only of the Excel spreadsheet, meaning that address labels were placed on envelopes for another individual. The result is that the 52 letters issued contained data relating to other individuals. Letters were issued in May 2017. A patient contacted the service later in May 2017 to state they had received incorrect information and the Caldicott guardian was informed, and remedial actions immediately put in place. The departments IG lead was informed, and this incident report made. Personal information like name of patient; complete postal address; and some medical details were compromised, and whilst such details were not high risk confidential nor detailed clinical/ care case notes, we do believe this to be a Level 2 breach.	
IGI/11907	Solent NHS Trust	22-Aug-17	1	Telecom to patient after he alleged in a consultation that his confidentiality had been breached by a member of staff. Disclosure of HIV status to family member via a third party.	HIV status
IGI/11917	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS	24-Aug-17	169	Internal auditors reviewing requested Maternity safeguarding policies and procedures. Auditor had been told he was not entitled to patient level data. Auditor requested data from midwife who shared the spreadsheets via unencrypted e-mail,	Details relate to pregnant women/new mothers subject to safeguarding and include name, age, list of safeguarding issues, due/delivery date and

ID	Organisation Name	Date of Closure	Volume	Details of Incident	Data
	FOUNDATION TRUST			believing it to be a legitimate request as an internal audit.	additional details such as termination of pregnancy, delivery route etc.
IGI/11922	Central London Community Healthcare NHS Trust	08-Sep-17	7	Member of staff in CLCH PALS received a call from a lady who had found some papers from the DN team at Edgware in the middle of the road and advised there has been a breach of confidential information as it has PID of 7 different patients. The document contained patient demographics and a key code to patient property for one of the patients involved. Document also contained a small amount of detailed information. The documents have since been recovered and an investigation is underway.	Personal information - Patient name, address, date of birth. Detailed information - Treatment type Key safe access code
IGI/11988	St Andrew's Healthcare (Original code of NTY85)	31-Aug-17	1	Gatekeeping assessment sent to incorrect recipient. Member of staff sent a gatekeeping assessment to an incorrect recipient via NHS.net. The incorrect recipient had the same name as the individual who the email should have gone to which is how this human error occurred.	Gatekeeping Assessment
IGI/11940	Croydon Health Services NHS Trust	29-Aug-17	8 pages	Handover notes lost in the picnic area. Member of staff found the data in the picnic area of the Trust	On looking at the data it contains, name, age, M00 number (Hospital number), (PMH) past medical history, investigation and plan.
IGI/11881	ISLE OF WIGHT NHS TRUST	01-Sep-17	1	A patient was sent home upon discharge with an envelope containing medical notes relating to a different individual, and medicines for that individual. The patient identified that a Ward HCA	NHS patient data including Name, date of birth, address, discharge notes, observations, diagnoses.

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				placed the notes and medicines in the patient's lap when the patient was being transferred via wheelchair from the ward to the discharge lounge. It was apparent upon collecting the notes and medicines from the patient at their home that they had accessed the information as they commented on the address, age and medical condition of that individual.	
IGI/12075	WYE VALLEY NHS TRUST (RLQ)	21-Aug-17	1	Member of staff with no direct involvement in the care of the patient accessed their information. Patient information was accessed	detailed information from the Health Record and other systems.
IGI/11906	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	22-Aug-17	29	CAMHS CPE and CAMHS Rapid Response are conducting a patient satisfaction survey. The survey is sent by email requesting the form is completed by email and returned to the CAMHS CPE email address. The Honorary Assistant Psychologist who sent out the email with personal email addresses in the 'To:' box. This has resulted in all patients receiving the email being able to see the email addresses of the other people on the list. A recipient has contacted to let us know about this. The recipient has understandably been angry about this breach of confidentiality. We have also received a questionnaire back from a different patient who has used 'Reply All' into the reply.	Personal email addresses Receipt of the email would confirm the person as a CAMHS patient
IGI/11851	Bollington Medical Centre (N81022)	16-Aug-17	1-2	Diary noted to be lost following afternoon clinic. Diary had been on the GP desk closed and at the furthest point from the patient seat. GP had left the room for up to 5mins to discuss management	Patient summaries from EMIS containing problem headings,

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				of one patient whilst they remained in the room - it is suspected that the diary was taken at this time. Diary contained one or two patient clinical summaries and some patient initials and surnames relating to the dates they were seen in clinic. Incident reported to the police	medication and some detail of immunisation/ test results
IGI/11901	LANCASHIRE CARE NHS FOUNDATION TRUST	22-Aug-17	Several Sheets	Copies of personal documents have been posted out in error to an incorrect recipient. The documents have not been received. A service user (SU) attended SP with a number of documents in a clear poly file. The SU requested to speak to someone in the Hearing Feedback team (HFt) to make a complaint, but they were unavailable. Instead a member of the Datix team was contacted by reception and they met with the SU and took copies of their paperwork. The original documents were returned to the SU. They were held securely and confidentially until the following working day by the Datix team. The Volunteer Lead was then contacted by the Datix team about the documents. The Datix team and the Volunteer Lead are members of the wider Quality and Safety Department. On this basis the Volunteer Lead reviewed the documents and observed a survey form with an address on it. As the document pack contained a survey and the team that manages the Friends and Family Test (FFT) are also based in the same office a decision was made by the Volunteer Lead to send the documents onto the address stated on the survey, believing this to be the appropriate action. The	The paperwork was believed to contain a clinical letter regarding the SU diagnosis, a letter from the DVLA revoking the SU driving license and a CQC survey form.

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				documents were passed to an admin who posted them out to the identified address. The address belongs to the CQC in Oxford. The documents should have remained within the control of the Trust and only passed to the HFt for the complaint to be followed up. The incident came to light because the SU has subsequently contacted the HFT to ascertain progress in regard to the complaint that they thought they had made and the documents that they have provided. The documents have neither been received by the CQC or been retrieved to date.	
IGI/13558	THE ROYAL WOLVERHAMPTON NHS TRUST	23-Aug-17	1000	A condemned medical device (Optical Coherence Tomography Machine OCT) was sent for sale to a Trust approved medical equipment auctioneer company. When they tested the device, they found patient identifiable data. Company then contacted manager to make aware that the device still contains this data. Device was returned, and investigation undertaken into why this occurred. 1. Clinical Engineering staff not fully appreciating/recognising the OCT had patient data. 2 Insufficient communication & lack of appropriate labelling on devices by Clinical Engineering staff when devices were taken to the Disposal Hold. 3 MPCE staff not following relevant Clinical Engineering Procedure 21 for the removal of	data contained patient's name, DOB, hospital number, Consultant, some images of scans of the eye, and examination dates belonging to one thousand patients.

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				equipment to the basement or HS11 Management of Medical Devices Policy Protocol 9. 4. Same room used for condemned devices for: - devices waiting for any patient data to be removed and WEEE waste. 5. No mention or tick boxes of removal of patient identifiable data in the Condemnation Work Request in f2.	
IGI/12099	Sussex Community NHS Trust	05-Sep-17	15	Whilst attending to an emergency event outside Horsham hospital, member of staff from Horizon unit was administering first aid and lost a handover sheet. It was initially thought the sheet got picked up by an attending emergency service representative; however, the sheet was not found following the incident by any of the emergency service crew and despite a thorough search of the area following the incident. The sheet contained patient confidential information for 15 patients including the name, diagnosis and updated details of care. The incident was reported in May 2017; however, confirmation of the details that were lost had been delayed.	The handover sheet contained 15 patients and included: name, age, diagnosis, past medical history and notes/risk rating
IGI/11824	DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	14-Aug-17	1	Alleged Breach of Confidence whereby a Healthcare Assistant (HCA) has informed the trust that they told their daughter that a gentleman - who was visible from a bus window and who was known to them - had recently been into her department for a diagnostic investigation. The	NHS Patient Data

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				HCA did not say what the diagnosis was, and in fact the gentleman concerned has not formally been given that diagnosis. It has now become apparent from statements made at the children's school, that personal information about the patient has been discussed between 3rd parties including his own son. As we currently understand it, the HCA's daughter did not speak directly to the patient's son who is in the same academic year	
IGI/11931	Virgin Care Services Ltd	25-Aug-17	25 records	Sensitive personal data relating to 25 data subject's occupational health records were sent in error to the wrong recipient by our OH provider. The information was sent securely on an encrypted data stick and was downloaded to a secure area with limited access to 2 individuals. The information was retrieved by our OH provider and assessed. The intended new provider has been made aware of the situation and are working with us to facilitate communications to the individuals affected. We are carrying out a full investigation in conjunction with our OH provider and have already instigated changes in the process.	Occupational health data relating to employees that were subject to TUPE and exiting out of our organisation.
IGI/11802	NHS Digital	29-Aug-17	344,503	Leeds teaching Hospitals raised an incident that the SUS+ extract had returned patients records that did not relate to them. This was one user at LTHT who had noticed the error. This user views the extracts for LTHT with appropriate approvals in place.	Personal Sensitive Data. Includes patient demographics and health data. However more high risk confidential patient information that has restrictions such as HIV or gender reassignment were not

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				The SUS team suspended the SUS+ portal immediately after this issue was raised, which prevented any further downloads. SUS also has taken steps to ensure compromised data was inaccessible A fix to the problem was implemented and tested. The problem was caused by an error in the field generation within the SUS system - user reports would overwrite previously generated reports and potentially added patient data that related to other organisations. The fix after assurance testing was deployed. Leeds TH re-ran their extracts after the code fix went in and the extracts were generated correctly. The SUS + portal went live again.	included as system safeguards prevented this data being extracted.
IGI/12092	NHS England	19-Sep-17	1	Fishermead Surgery (K82064) reported that a PCSE sealed tamper-proof bag containing 1 medical record was found outside the surgery by a patient, subsequently handed in to Fishermead Surgery. The practice manager opened the bag (no barcode) to check the patient details. The practice manager realised this patient did not belong to the surgery and notified PCSE. Further analysis indicates that the regular collection was a day after it was worked by City Sprint. The medical records team instructed the practice to bag and reseal the record for repatriation the following day in the practices next collection.	1 medical record

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IGI/11969	NHS North Somerset CCG	31-Aug-17	3,527	During a conference call involving senior paediatric clinicians, the Director of Operations for an acute trust forwarded an Excel file in order to give information about demand patterns at the acute trust A&E. CCG member of staff agreed to forward the file to the CSU BI for the programme so that further analysis could be completed as part of the work of the North Somerset Sustainability Board. CCG member of staff forwarded the information to the CSU BI lead. The CSU BI lead replied having considered the detail of the data received to alert CCG member of staff to the fact that the file contained patient identifiable data.	date of birth, gender, postcode, registered GP
IGI/11990	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	09-Aug-17	1 x double-sided letter	Mental health discharge summary from ENE CMHT team was sent to wrong postal address. (no. 22 instead of no. 26). Letter returned having been opened and re-sealed, with the sender's return address written on the envelope and original address scribbled out.	1 x double-sided mental health discharge summary letter.
IGI/12051	The Grange Group Practice (B85028) (HUDDERSFIELD)	07-Sep-17	not known	This morning a lady rang the surgery from Croft Flats in Bingley and spoke to reception, who then rang me for advice. The lady had hired a skip and has found some confidential material has been put in it. She has found a lot of prescriptions and confidential information regarding medication for patients registered at this surgery and other surgeries. She was in the process of ringing around all the surgeries involved. The prescriptions had an address of Tesco’s	Prescription data including patient details and medication.

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				Pharmacy, Viaduct Street, Huddersfield. I spoke the lady in Bingley and told her we were trying to contact the CCG and that they would contact her regarding this matter. I contacted The CCG and I red buttoned the incident and the CCG advised us to contact NHS England. Contact details – redacted @nhs.net. It was reported to another team at NHS England who are investigating. We have passed the name of the lady who found the information to NHS England (after checking with the lady that this was ok to do so).	
IGI/12223	Buckinghamshire Healthcare NHS Trust	09-Aug-17	157	A member of the Quality Team at Aylesbury Vale CCG identified surnames within a CQUIN tracker that had been submitted by Bucks Healthcare. The surnames appeared as part of an embedded document which had been embedded as part of the Trust's CQUIN evidence. Immediate action was taken. The CCG notified BHT and advised that the PID (surnames) would need to be removed before they could analyse the data. BHT removed the PID and resubmitted, but unfortunately further PID was found in other columns of the spreadsheet. BHT were contacted again and the matter was resolved. The only PID disclosed was surnames - no other identifier.	NHS patient surnames only - 157 patients

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IGI/11783	NHS Bassetlaw CCG	09-Aug-17	1 Individual	A Continuing Healthcare Decision Support Tools (DST) and covering letter were returned to the CCG which had been sent to an incorrect address. The envelope had been opened when returned to the CCG. Upon notification, the CCG have identified that this incident involves the information of one individual and all information disclosed in error has been retrieved. This was a clerical error whereby the information was intended for a new care home in the area and therefore was unfamiliar but was accidently sent to another Health and Social Care Unit of a similar name (Greenacres Care Centre rather than Greenacres Grange).	Continuing Healthcare Decision Support Tool (DST) containing NHS patient data
IGI/11809	ROYAL UNITED HOSPITAL BATH NHS TRUST	14-Aug-17	1142	Payslips are stored on Personal Computer (PC) when viewed via Electronic Staff Record (ESR), pressing Save (the only way currently to open them) stores this in the PC downloads folder. On a generic (or kiosk) account this folder is viewable by all, and many payslips were stored there (mine included for the test). I did this test in both Library and clinical ward, both results the same. Spoken with Information Governance, IT Manager, Spoken with ESR Manager, spoken with Finance. Meeting to take place, IT is writing a script to purge downloads on generic accounts. Organisation have deployed a temporary fix to the trust, this has been in place since 1 pm today and has reduced the number of files from 1142 to 87.	Payslips that contains personal details including pay band, salary, NI number, Tax, pension and union membership.

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IGI/11989	THE WHITTINGTON HOSPITAL NHS TRUST	12-Sep-17	3	CAMHS and Community Child Psychologist lost an unencrypted USB memory stick on. It contained 4 clinic letters containing PCD. 4 Letters containing detailed psychological and other health info about 3 patients stored on unencrypted USB stick. The stick was lost in transit and not recovered. Clinician was taking the letters home to finish off. It is unclear yet how the data was able to be transferred to an unencrypted memory stick as our Trust PCs should be blocked from accessing non-Trust issued unencrypted USB sticks.	Full name. Address. DoB. NHS No. Detailed clinical information. x3 patients.
IGI/11827	St Andrew's Healthcare (Original code of NTY85)	15-Aug-17	1	Incorrect patient's interim discharge summary sent to community team member of staff. St Andrew's member of staff attached the wrong patient's interim discharge summary and sent this to the relevant community team member of staff. This was sent via NHS.net to NHS.net. The email was attempted to be recalled however this was not possible. The member of staff who the email was sent to is off work for an unknown period of time so at present the email has not been accessed.	Interim discharge summary. This includes full patient details, GP details, discharge details, clinical details
IGI/11836	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	15-Aug-17	316	Confidential information had been left in a steel cabinet. The cabinet had been removed to outside the building and was left unsecure overnight. The following day a member of staff went into the cabinet and discovered a tray containing contact information. The information involved duty professional logs that identified patient names, NHS number or date of birth and details of the	On Thursday the 11 May 2017 the Health Records Manager visited Lymebrook. The information involved was papers that had been placed in a tray waiting for shredding. The Health Records Manager has removed the

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				contact. An incident was raised at Lymebrook following the removal of a metal cabinet from Reception and placed outside the building. The staff believe that the cabinet was placed outside. This was arranged via the Estates Department and completed by a local contractor. Emails confirm staff internally were tasked with ensuring the cabinet was cleared before being removed. One of the staff member identified was working a bank role and had not completed IG training. A member of staff had gone to the cabinet outside and checked inside to discover a tray with old duty professional contact slips and various other paper work. The incident form was referred to the Health Records Manager, who left a message for the person who raised the incident to contact her as there was not sufficient information on the incident form e.g. number of individuals, what kind of information etc. The Health Records Manager escalated the incident via e-mail to the Chief Information Officer asking if this would be considered as a serious incident. First thing in the morning Health Records Manager and Chief Information Officer (CIO) discussed, CIO had discussed the issue with the Patient Safety Team who had initiated a local investigation. The CIO raised the issue with the SIRO and outlined the initial investigation and that more information was being gathered, this was then discussed with the Caldicott Guardian.	documentation and they are now stored within the Health Records Department at Trust HQ, Trentham. 113 duty professional sheets - 74 individuals - 113 instances of personal data - 87 instances of sensitive data 40 pages of a shorthand note pad - 204 individuals - 234 instances of personal data - 27 instances of sensitive data Other individual documents - 8 individuals - 9 instances of personal data - 4 instances of sensitive data

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				CIO contacted the Health Records Manager at the Harplands Hospital and requested that she visits Lymebrook to provide a detailed review of the incident to support the initial investigation and a detailed breakdown of the information involved. The Health Records Manager met with the Caseload Manager Richard Powell and all the information sheets were handed to her. Details of the incident included in this report were collated and the breakdown of the data involved. 113 duty professional sheets - 74 individuals - 113 instances of personal data - 87 instances of sensitive data 40 pages of a shorthand note pad - 204 individuals - 234 instances of personal data - 27 instances of sensitive data Other individual documents - 8 individuals - 9 instances of personal data - 4 instances of sensitive data This information was provided to the CIO and SIRO and with the information involved would need to be submitted as a SIRI. The SIRO has highlighted that the call should have been logged initially with the ICO before the initial investigation and should not have waited for the detailed review to be completed. The CIO called the ICO to describe the incident and delays and for clarity regarding the details of	

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				the incident and then proceed to log the incident on the web portal. This was delayed due to the cyber-attack affecting connectivity and also the recovery on Monday 15th May.	
IGI/11761	WALSALL HEALTHCARE NHS TRUST	22-Aug-17	8 pages	A formal complaint response letter containing sensitive information was sent to the incorrect address. The letter was regarding a deceased patient and all of the information within the letter was about the deceased and the care they had received. The letter was addressed to the deceased patient's son. The house number had been entered incorrectly. A formal complaint response letter containing sensitive information about inpatient treatment was sent to another address by a member of the Complaints team. A family member personally attended the PALS team to establish the delay in receiving the formal response. Representation from the PALS team apologized to the patient's relative in person once the administrative error was identified and confirmed.	The letter was regarding a deceased patient and all of the information within the letter was about the deceased and the care they had received. The letter was addressed to the deceased patient's son. The house number had been entered incorrectly.
IGI/11768	Solent NHS Trust	08-Aug-17	1	Member of staff has accessed her granddaughter medical records. The member of staff is new to the Trust and was not aware she could not do this. Once she realised she self-reported the incident	Health Record
IGI/11820	ISLE OF WIGHT NHS TRUST	14-Aug-17	515	Information about discharges from medical specialisms was to be shared in pseudonymised form with a trusted third-party organisation. The information was not pseudonymised; the local	NHS patient data including local hospital number, patient

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				hospital reference (not the NHS number) was included. The email was not sent via a secure email account and the attachment was not password protected.	age, and patient medical conditions.
IGI/11804	Norfolk Community Health and Care NHS Trust	01-Sep-17	13	152 dental records have been lost in transit from Norwich Community Hospital to 3rd party scanning company. As part of a wider project to digitize dental health records Norfolk Community Health & Care NHS Trust (NCHC) has entered into a commercial contract with a framework approved supplier (Storetec). This arrangement has dental health records being moved from Norwich Community Hospital to the Storetec base in Hull. As part of this arrangement the dental health records were collected by the scanning company pre-boxed (by NCHC) and delivered direct to the Storetec base in Hull for processing/digitizing. 3 boxes containing a total of 708 records were arrange for collection in April. This collection was made by a subcontracted 3rd party to Storetec (UPS) (arranged by Storetec) and upon arrival at Storetec in Hull the boxes were badly damaged/replaced. Upon review of items sent against items received it has been identified that 152 dental health records are missing/lost.	13 dental health records.
IGI/11758	LUTON NHS WALK-IN CENTRE	08-Aug-17	not known	Break in at the surgery on the 1st May which resulted in the theft of the server and 1 back up drive. 2 males entered the building using a device	PID in the form of patient names and / or nhs numbers Staff records

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				to unlock the security doors on the 3rd floor (services were operational in the building at the time). Same device used to unlock server room door where they then removed the server and 1 back up drive. Devices are encrypted and not likely any PID or staff data could be accessed.	
IGI/11982	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	31-Aug-17	1	Wrong letter sent to patient used previous letter as template.	mental health information
IGI/11839	The Village Medical Centre (K81082)	16-Aug-17	130	The practice collected e-mail addresses of a group of patients in order that they could be informed of future practice plans. Unfortunately, the first communication to the group detailed all members e-mail addresses.	Patient Email addresses disclosed
IGI/12166	CARE UK Ltd	07-Aug-17	less than 18	A prisoner at HMP Bullington reported to the ICO that they received confidential data in error about other prisoners included when the prisoner requested their Medical records through a SAR. The subject reported the incident to the ICO Case ref redacted. The information that was printed in error and included with a stack of medical records for the prisoner was: • Two hospital letters regarding different patients • A list of prisoners in the prison's segregation unit containing information such as length of sentence and release dates. The prison segregation zone holds a maximum of 18 prisoners at a time. It is known how many	Two letters List of Records of Prisoners in the segregation unit containing confidential data such as length of sentence and release dates

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				records were on the list The printer setup allowed different print jobs from different users to be printed. This presented the risk that different print jobs could be mixed up as happened in this case.	
IGI/11709	Sirona Care & Health	27-Jul-17	1	Complaint response containing sensitive information sent to wrong address. Complaint received February 2017 for the Lifetime service • Service lead drafted response • Formal complaint letter signed by Chief Exec was sent to complainant dated March 2017 • Complaint case closed in customer care • Today customer care received an email from the complainant asking where her response was as she had not received anything from Chief Exec as promised in the acknowledgement letter. • I emailed the complainant back to say I would look into the matter and be back in contact shortly • I looked on file and found the letter • I called Service Lead but other member of staff in the lifetime service picked up the call. Confirmed that the letter had been sent to an incorrect address. Member of staff told me she would leave a message for service lead to call me. I also emailed service lead asking her to call me. • I met with service lead and Head of Children's Services at Corum and asked them to log as an adverse event and suggested that one of them make a phone call to the complainant	Complaint response

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IGI/11983	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	31-Aug-17	1	Report contained information about a different patient. The previous report was used as a template	mental health information
IGI/11698	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	25-Jul-17	Approx. 56 clients	A member of Trust staff stored two laptops in the boot of her car. One of the laptops was registered to her, and the other to a colleague whom she had borrowed the equipment from. The car was left overnight outside the staff members house and was broken into, with the laptops being stolen. Both laptops were fully encrypted machines. However, within the laptop bag for the colleague's laptop there was paperwork relating to clients seen by the colleague. This amounts to approximately 50 clients.	Information related to clients treated within the criminal justice liaison and diversion service and therefore include detail of health care and also criminal offences information
IGI/11711	PENNINE CARE NHS FOUNDATION TRUST	28-Jul-17	2	Letters sent to the wrong address. On reviewing medical records, it was noticed that recent clinic letters and referrals had been sent to the wrong address. One letter had sensitive clinical information related to being Looked After and Adoption. At this stage we have no evidence if the letters have been opened or not.	Appointment and referral letters
IGI/11655	Medway Community Healthcare	20-Jul-17	4	Relative visiting patient on the ward found patient notes x 3 in the car park in the grounds of the hospice next to her car. She brought these into reception and handed them over to an admin member of staff. Later that day a rotational Doctor entered General	These were photocopies of patient records containing highly confidential and sensitive information relating to the patients i.e. Name, date of birth, religion, next of kin, family tree, diagnosis,

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				Office and said she had found another set of notes.	consultations and generic prescriptions.
IGI/11652	PENNINE ACUTE HOSPITALS NHS TRUST	25-Jul-17	1	Complaint received regarding unauthorised access to patient records. Allegation of confidentiality breach by member of staff accessing patients records without their authority.	NHS patient data
IGI/11657	Anglian Community Enterprise (Social Enterprise)	25-Jul-17	300 - 500	Member of the public reported notes blowing along a street in Colchester. IG Lead attended site to retrieve all records which included between 300 - 500 individual's demographic information and clinical visit information from 2014. All produced by one individual HCA working for ACE. A full investigation is being carried out by ACE.	Community Nursing clinic lists and notes.
IGI/11731	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	02-Aug-17	27	Medical ward handover sheet found in the main road in front of the hospital buildings. Investigation instigated. Details of 27 patients included. Sheet secured by member of staff. Handover sheets are available to be printed from the Trust EPR system for clinical staff to use when receiving handover at the start of a shift, the sheet includes patient name and hospital number, which bed they are in and a summary of diagnosis, history and patient requirements. It is then annotated by the nurse, doctor or AHP by hand as an aid memoir for use throughout the shift. These annotations include additional information such as frequency of observations required. A handover sheet was found by another member of trust staff in the road. The sheet was secured, and the incident reported	Header; Ward name, hospital date time and name of member of staff printing the sheet. Individual row for each patient including; Bed number, Name, NHS number, Hospital number, DOB, age, gender, consultant, Abbreviated summary of Diagnosis and History, Patients requirements e.g. IV antibiotics and mobilisation assistance required, Indication of any involvement from multi-disciplinary team;

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				on the trust incident reporting and management system. A similar incident was reported to the ICO in 2016 Ref. redacted. and two more recently Ref. redacted and redacted. Following feedback more frequent and varied reminders have been communicated. The trust has previously treated similar incidents where the handover sheet was found and secured by another member of trust staff and not by a member of the public as a near miss as the staff are all bound by the NHS code of confidentiality. Following the incident in 2016 and further advice from the ICO Casework office these incidents are no longer treated as a near miss, but as a reportable incident. As this Incident follows so soon after similar already reported incidents trend escalated and discussed with SIRO.	Physiotherapist, Occupational Therapist, Dietician or Speech and language therapist. Dietary needs, expected discharge date and discharge planning
IGI/12070	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	12-Sep-17	39	List of children aged 9-12 months was disclosed in error to another Trust. Children's details listed and sealed in an envelope address to Berkshire Healthcare recipient first name only. Inadvertently collected by Frimley Park NHS Midwifery Service and delivered to Wexham Park Hospital Antenatal Clerk, this staff member had the same first name as the intended recipient and opened the envelope. Once the mistake was noticed the data was returned to Berkshire Healthcare Safeguarding Lead.	Name, date of birth, NHS number, client phone number and level of HV service offered
IGI/11633	Middleton Lodge Practice (C84021)	24-Jul-17	911	A patient attending an appointment with the midwife handed over documents which had been mistakenly given to the patient at a previous	Patient names, Date of birth, NHS numbers, record of inclusion on asthma register

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				appointment with a practice nurse. The document was a register of patients with asthma being used for audit purposes. The register contained names, dates of birth, NHS numbers and details of the patient having asthma. The nurse involved is not back at work until Tuesday when a meeting will be held with her to establish the facts around the incident. This will be updated following the meeting.	
IGI/12247	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	11-Sep-17	1	Letter was typed and sent to the wrong person (estranged twin sister) in error that disclosed the patient's medical condition (the letter was not patient identifiable). This incident was assessed as an IG Incident Severity Level 1, however, as it is clear that the patient is claiming significant distress and may escalate her complaint, the Information Governance Manager and Caldicott Guardian are both in agreement that the scoring of this incident should be increased to a IG Incident Severity Level 2.	Patient data.
IGI/11715	WYE VALLEY NHS TRUST (RLQ)	28-Jul-17	1	Cannula Assessment Record found outside the Day Case Unit and handed in by a member of the public. Patient name, address, RLQ number, NHS number, time and date of cannula assessment, consent information, location of cannulation, reason for insertion – IV access + bloods, number of attempts, local anaesthetic, successful flush insertion, Name of the clinician completing the cannulation.	Cannula assessment sheet

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IGI/11606	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	11-Jul-17	Number of papers disclosed in error = Seven pages of a complaint response	Complainant (RC) received a complaint response from the Trust dated in early April, which had the correct first page, but the following seven pages related to a different complaint. She telephoned the Trust on a Saturday to inform the Complaints staff what had happened, but was unable to contact them as it was a Saturday. She stated that she had scanned a copy and emailed it to the Complaints coordinator also. The incident was reported to the Executive offices on Monday.	Number of people affected = Two - the complainant (RC) who received the wrong information and the second complainant MM, whose information was sent in error. To note MM's complaint and the detailed response related to her late husband. Number of papers disclosed in error = Seven pages of a complaint response
IGI/11676	WEST LONDON MENTAL HEALTH NHS TRUST	21-Jul-17	60	A member of staff sent out email invitations to two groups of service users to attend an involvement group using the cc (rather than the bcc) function of email. There were 60 service users in total who received these email communications. An internal incident has been raised and the senior management team have been informed. We plan to communicate the error with service users on Monday 24th April 2017 due to the weekend. The Information Governance Manager will conduct a full investigation and work with services across the Trust to put the necessary safeguards in place to prevent future reoccurrence.	Email address Phone number Email one entitled CAMHS Service User Involvement Group Email two entitled CAMHS LGBTQ+ Group TODAY Reminder
IGI/11629	WYE VALLEY NHS TRUST (RLQ)	14-Jul-17	1	A patient was sent home with another patients TTO record, Patients key worker rang to advise of	detailed clinical information

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				the error. Patients detailed clinical information on the TTO record, given to the wrong patient	
IGI/11589	WALSALL HEALTHCARE NHS TRUST	08-Jul-17	1	A discharge summary was attached to another patient's record - this was discovered once the patient had returned to their care home.	patient data
IGI/11626	Solent NHS Trust	14-Jul-17	1	The parent of a patient has stated that his daughter (young person receiving therapy at CAMHS) had received information about another young person through the post. The letter was addressed to his daughter, but the contents of the envelope contained another young person's discharge summary which included her name, date of birth, address, nhs number, diagnosis, goals, interventions, risk/safeguarding concerns and recommendations. The parent stated that his daughter was very distressed to open this and that she was possibly worried that her information had been sent in the envelope to this young person. Currently we have no evidence that this has happened.	contained another young person's discharge summary which included her name, date of birth, address, nhs number, diagnosis, goals, interventions, risk/safeguarding concerns and recommendations.
IGI/11628	WYE VALLEY NHS TRUST (RLQ)	14-Jul-17	1	A ward hand over sheet was found by a patient within WVT site, handed back to ward staff.	detailed clinical information
IGI/11806	Optum Health Solutions (UK) Ltd incorporating UnitedHealth UK Ltd	08-Aug-17	one	In early April 2017 a possible IG Incident involving one patient was identified. The Optum Referral Facilitation Service received 2 Referrals from a GP for the same child on the 31st March. The child was being referred to two	Patients GP clinical summary

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				providers. 1. Developmental health service at Carmelita House Community Service 2. Great Ormond Street Hospital. The referrals contained a fairly detailed clinical summary for the child. As well as identifiable data (Name, Address, Date of Birth and NHS Number). The referrals were triaged by a medical professional. The following day a facilitator processed the first referral, as the services were not advertised on the NHS eReferral service, it was decided to e-mail the referrals. Unfortunately, they were both incorrectly forwarded to a group mail box at the first provider, Developmental health service at Carmelita House Community Service. This was not the referral mailbox that should have been used. On the 3rd April two emails were sent to the RFS by the recipients of the email. (a Safeguarding nurse at Ealing CCG and a Consultant Paediatrician) both were recipients of the mail from the Group Mailbox. There emails were to alert the RFS that they had received the referral in error. These e-mails were read by a manager at the RFS who realized the error. Following investigation, it is apparent that the Group Mailbox used in the e-mail of the referral to	

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				the Developmental health service at Carmelita House Community Service, is dormant and according to the service should have been removed from NHS Mail. Only 2 medical staff have access to that mailbox, the safeguarding nurse and a consultant paediatrician. Whilst the e-mail was sent to an incorrect Group Mailbox at the Developmental health service at Carmelita House Community Service, the medical staff who have alerted the RFS to receiving an incorrect e-mail referral, the consultant paediatrician does have a legitimate relationship and is involved in the child's treatment anyway. Also, as the recipients are both medical staff they have a duty of confidentiality to that patient's information. The e-mail alerts from the medical staff were that they were not responsible for receiving referrals and that the wrong mailbox had been chosen. Finally, it should be noted that immediately on discovery of the incident, both referrals were reprocessed within the KPI of 5 days. Providers have confirmed receipt of these referrals. Therefore, the patient will not have suffered clinical harm caused by this incident and will receive the treatment expected. The incident has been reported to the CCG Patient Safety Manager. I have amended the	

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				initial report to reflect what is now known and that includes the amended sensitivity score.	
IGI/11587	Birmingham Women's and Children's NHS Foundation Trust	24-Jul-17	Not known	Two cameras and a laptop were stolen from one of the departments in the Trust. There was a break in and two digital cameras contained in camera bags were stolen along with a laptop. One of the bags contained a battery charger and the other bag a flash and SD card. The SD card contained identifiable images of parents and children and it later transpired that it also includes images of the associated consent forms in some cases. The consent forms contain personal information such as name dob, address, contact numbers, email addresses etc. The exact number of people affected by the incident is unknown at this point but is estimated to be about 40. The lap top was a trust issue encrypted device and IT wiped the device when informed of the incident. Therefore, data is not at risk.	Images, personal information e.g. name address, dob, contact numbers, email address
IGI/11584	CENTRAL SURREY HEALTH (NHS SOCIAL ENTERPRISE)	03-Jul-17	300000	CSH Surrey undertook a takeover of Adults and Children services as of 00:00 on 01/04/2017 from Virgin Care which required the transfer of all active records to enable safe and effective delivery of patient care. During the transfer of digital records an estimated 300,000 patient medical records held within the RIO clinical system were not made available to CSH Surrey. This included personal information, medical history, case notes and referrals to service.	Patient files on Rio system in entirety; Personal details (all), clinical care given, medical history

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				The data has not been erroneously transferred and remains with Virgin Care securely whilst it is in process of being correctly transferred. A copy of all records is also held securely by CSH Surrey; however, many are held in a 'logically deleted' state meaning they are unavailable to CSH Surrey staff. Virgin Care have now made the children's records (an estimated 280,000) available to CSH Surrey and are working on a fix expected shortly for the final set of records relating to adults. CSH Surrey are implementing testing and data analysis to ensure no further errors are encountered. Current risks that are present are the lack of available and necessary clinical information which may lead to an untoward clinical event in some of the services now provided by CSH Surrey.	