DEPARTMENT OF VETERANS AFFAIRS
Office of Information and Technology
Office of Information Security
Incident Resolution Service

Monthly Report to Congress of Data Incidents

February 3 - March 2, 2014

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Date of Initial DBCT Review
PSETS0000100001	Mishandled/ Misused Physical or Verbal Information	VISN 04 Lebanon, PA	2/3/2014	2/19/2014	

VA-NSOC Incident Number	Date US-CERT Notified	US-CERT Case Number/Category	Date OIG Notified	Reported to OIG	OIG Case Number	No. of Credit Monitoring	No. of Loss Notifications
VANSOC0601974	2/3/2014	INC000000343463 Category 6 -	N/A	N/A	N/A	1	

Incident Summary

Veteran A contacted the Medical Center to inform them that she received a packet of medical records in the mail from the Release of Information (ROI) staff. Inside the envelope, along with her medical records, were records on Veteran B. Information disclosed to Veteran A on Veteran B was full name, full social security number, and medical records including diagnosis. Fact finding will be performed to investigate the entire incident.

Incident Update

02/03/14:
Veteran B will receive a letter offering credit protection services.

Resolution

The Nursing Supervisor will remind the Nurse to ensure that only 1 patient's information is enclosed in the envelope when mailing information to Veterans.

DBCT **DBCT Decision Date:** N/A

No DBCT decision is required. This is informational for Mis-Mailed incidents and is the representative ticket. There were a total of 120 Mis-Mailed incidents this reporting period. Because of repetition, the other 119 are not included in this report, but are included in the "Mis-Mailed Incidents" count at the end of this report. In all incidents, Veterans will receive a notification letter and/or credit monitoring will be offered if appropriate.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Date of Initial DBCT Review
PSETS0000100026	Mishandled/ Misused Physical or Verbal Information	VISN 04 Erie, PA	2/3/2014	2/13/2014	

VA-NSOC Incident Number	Date US-CERT Notified	US-CERT Case Number/Category	Date OIG Notified	Reported to OIG	OIG Case Number	No. of Credit Monitoring	No. of Loss Notifications
VANSOC0601997	2/3/2014	INC000000343534 Category 6 -	N/A	N/A	N/A	1	

Incident Summary

Veteran A returned a hard copy written prescription order for Veteran B that he received along with his appointment letter. The prescription order contained Veteran B's name, address, date of birth and medication information.

Incident Update

02/03/14:
Veteran B will be sent a letter offering credit protection services due to name and date of birth being exposed.

Resolution

The staff member who caused the error could not be identified. Therefore, the Primary Care Managers will address the need to be diligent and cautious when handling paper documents with all staff so mis-mailings do not occur.

DBCT **DBCT Decision Date:** N/A

No DBCT decision is required. This is informational for Mis-Handling incidents and is the representative ticket. There were a total of 87 Mis-Handling incidents this reporting period. Because of repetition, the other 86 are not included in this report, but are included in the "Mis-Handling Incidents" count at the end of this report. In all incidents, Veterans will receive a notification letter and/or credit monitoring will be offered if appropriate.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Date of Initial DBCT Review
PSETS0000100306	Mishandled/ Misused Physical or Verbal Information	VHA CMOP Hines, IL	2/10/2014	2/19/2014	

VA-NSOC Incident Number	Date US-CERT Notified	US-CERT Case Number/Category	Date OIG Notified	Reported to OIG	OIG Case Number	No. of Credit Monitoring	No. of Loss Notifications
VANSOC0602270	2/10/2014	INC000000345280 Category 6 -	N/A	N/A	N/A		1

Incident Summary

Patient A received a prescription intended for Patient B. Patient B's name and type of medication was compromised. Patient A reported the incident to the medical center and a replacement has been requested for Patient B. Great Lakes Consolidated Mail Outpatient Pharmacy (CMOP) investigation concludes that this was a CMOP packing error. The CMOP employee will be counseled and retrained in proper packing procedures.

Incident Update

02/10/14:
Veteran B will be sent a notification letter.

Resolution

The CMOP employee was counseled and retrained in proper packing procedures.

DBCT **DBCT Decision Date:** N/A

No DBCT decision is required. This is informational for Mis-Mailed CMOP incidents and is the representative ticket. There were a total of 4 Mis-Mailed CMOP incidents out of 6,213,592 total packages (9,108,556 total prescriptions) mailed out for this reporting period. Because of repetition, the other 3 are not included in this report, but are included in the "Mis-Mailed CMOP Incidents" count at the end of this report. In all incidents, Veterans will receive a notification letter.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Date of Initial DBCT Review
PSETS0000100312	Missing/Stolen Equipment	VISN 09 Memphis, TN	2/10/2014	2/24/2014	

VA-NSOC Incident Number	Date US-CERT Notified	US-CERT Case Number/Category	Date OIG Notified	Reported to OIG	OIG Case Number	No. of Credit Monitoring	No. of Loss Notifications
VANSOC0602279	2/10/2014	INC000000346573 Category 1 -	N/A	N/A	N/A		

Incident Summary

According to the Memphis Logistics Equipment Technician and the Chief Information Officer (CIO), the turn over inventory has been completed and the facility has one encrypted laptop and 14 desktop PCs missing. OIT is conducting a search of paper turn in records to attempt to locate evidence of the devices being turned in.

Incident Update

02/10/13:
Per the Memphis CIO, the laptop has been found. OIT is continuing the search for the 14 desktop computers. They are searching for them in the turn in paper work also. In addition, the facility CIO has asked VISN Logistics to assist them in searching for these items.

02/13/14:
According to the Information Security Officer (ISO), an update has been requested. The ISO is awaiting the response from the CIO.

02/19/14:
Per the CIO, there was 1 laptop and 13 desktop PCs missing, for a total of 14 devices missing. The laptop and 9 PCs were located. OIT believes the remaining 4 PCs were turned in and the hard disk drives disposed of. Because these are so old, there are no records that can tie the serial numbers of the drives to the Equipment Inventory List (EIL) numbers. Since the devices were so old, it is doubtful they were encrypted.

Over the years employees have always been educated/advised never to save sensitive information on the hard drive. The Inventory Tracking (EE) numbers and hard drive serial numbers are now recorded on VA form 0751.

Resolution

Inventory is conducted once per year. If the actuary rate falls below 95%, it is conducted twice per year. Logistics generates the EE number or barcode number. The Inventory Tracking (EE) numbers and hard drive serial numbers are now recorded on VA form 0751.

The IT Custodial Officer is responsible for ensuring that each hard drive is marked with the EE number of the host system whenever the hard drive is removed from the host system. The EE number shall be written on the hard drive with an indelible marker at the time the hard drive is removed from the host system. ISO has verified with OIT Hardware Team Lead that this process is being followed.

DBCT **DBCT Decision Date:** N/A

No DBCT decision is required. This is informational for IT Equipment Inventory incidents and is the representative ticket. There were a total of 3 IT Equipment Inventory Incidents this reporting period. Because of repetition, the other 2 are not included in this report, but are included in the "IT Equipment Inventory Incidents" count at the end of this report.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Date of Initial DBCT Review
PSETS0000100772	Mishandled/ Misused Physical or Verbal Information	VISN 07 Charleston, SC	2/21/2014	3/7/2014	

VA-NSOC Incident Number	Date US-CERT Notified	US-CERT Case Number/Category	Date OIG Notified	Reported to OIG	OIG Case Number	No. of Credit Monitoring	No. of Loss Notifications
VANSOC0603023	2/28/2014	INC000000349977 Category 6 -	N/A	N/A	N/A	13	119

Incident Summary

Veteran A brought in a packet to the Savannah Primary Care (PC) Community Based Outpatient Clinic (CBOC) that he states he received at home about 2 weeks ago. The packet contains appointment letters and medical records for about 60-70 patients.

Incident Update

02/28/14:
Upon review, there were 132 Veterans' information included in the documentation. The information included full SSNs and DOBs on 13 Veterans. The other 119 had combinations of names, addresses, and some with medical information. Each of those will be sent letters of notification.

Resolution

The Privacy Officer (PO) spoke with Veteran A. He stated that he received it in the mail with his follow-up appointment letter on the top. When he realized that there were other Veterans' letters in it, he closed it and set it aside because he knew it wasn't his business. He waited until his next Home Bound Primary Care (HBPC) nurse visit 2 weeks later to get it returned to the clinic. The PO could not determine how these appointment letters and recall letters (some with progress notes and lab results), ended up in an open faced USPS envelope, which was mailed to a HBPC Veteran from our Savannah CBOC. Veteran A's letter was on the top in the open faced envelope, which is why he received it (also exposing his reminder letter for follow up appointment). Health Administration Management assisted with this investigation and has reviewed this complaint with all of their staff and stressed to them the importance of protecting our Veterans' and/or employees' personally identifiable information (PII) and protected health information (PHI) at all times. The breakdown of letters erroneously sent to Veteran A is as follows:

95 total patient Recall Letters (names and address only)
24 total patient f/u letters with future clinic appointments; some with lab results (names, addresses, lab results)
13 total patient Recall Letters with printed administrative progress notes (names, addresses, full SSN, DOB)

DBCT **DBCT Decision Date:** N/A

This incident was not reviewed by the DBCT. It was originally opened as a complaint on 02/21/14. Complaints are not reviewed by the DBCT. It was updated to an incident on 02/25/14.

Total number of Internal Un-encrypted E-mail Incidents	85
Total number of Mis-Handling Incidents	87
Total number of Mis-Mailed Incidents	120
Total number of Mis-Mailed CMOP Incidents	4
Total number of IT Equipment Inventory Incidents	3
Total number of Missing/Stolen PC Incidents	0
Total number of Missing/Stolen Laptop Incidents	0
Total number of Lost BlackBerry Incidents	20
Total number of Lost Non-BlackBerry Mobile Devices (Tablets, iPhones, Androids, etc.) Incidents	1