

| Security Privacy Ticket Number | Incident Type | Organization | Date Opened | Date Closed | Risk Category | | |
|--|--|------------------------|-------------------|-----------------|-----------------|--------------------------|---------------------------|
| PSETS0000084164 | Mishandled/ Misused Physical or Verbal Information | VISN 11 Fort Wayne, IN | 12/31/2012 | 1/11/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0584696 | 12/31/2012 | INC000000254221 | N/A | N/A | N/A | | 1 |
| <p>Incident Summary Veteran A's prescription medication was dispensed to Veteran B. Veteran B realized the error and returned the medication to the Pharmacy. Veteran A's name and type of medication was disclosed.</p> | | | | | | | |
| <p>Incident Update 01/02/13: Veteran A will be sent a notification letter due to Protected Health Information (PHI) being disclosed.</p> <p>NOTE: There were a total of 122 Mis-Handling incidents this reporting period. Because of repetition, the other 121 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.</p> | | | | | | | |
| <p>Resolution All Pharmacy staff will be re-educated on the need to check Veteran's names with the medication before dispensing.</p> | | | | | | | |

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|--|--|---------------------|-------------------|-----------------|-----------------|--------------------------|---------------------------|
| PSETS0000084167 | Mishandled/ Misused Physical or Verbal Information | VHA CMOP Hines, IL | 12/31/2012 | 1/7/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0584699 | 12/31/2012 | INC000000254239 | N/A | N/A | N/A | | 1 |
| <p>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(s) will be counseled and retrained in proper packing procedures.</p> | | | | | | | |
| <p>Incident Update 01/02/13: Patient B will be sent a notification letter due to Protected Health Information (PHI) being disclosed.</p> <p>NOTE: There were a total of 5 Mis-Mailed CMOP incidents out of 7,623,887 total packages (11,398,409 total prescriptions) mailed out for this reporting period. Because of repetition, the other 4 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.</p> | | | | | | | |
| <p>Resolution The CMOP employee(s) was counseled and retrained in proper packing procedures.</p> | | | | | | | |

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| PSETS0000084182 | Mishandled/ Misused Physical or Verbal Information | VBA St Paul, MN | 1/2/2013 | 1/7/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0584714 | 1/2/2013 | INC000000254354 | N/A | N/A | N/A | 1 | |
| Incident Summary | | | | | | | |
| Veteran A received a letter that contained another letter belonging to Veteran B. The letter contained Veteran B's name, address and full SSN. | | | | | | | |
| Incident Update | | | | | | | |
| 01/02/13: Due to full SSN being disclosed, Veteran B will be sent a letter offering credit protection services. | | | | | | | |
| NOTE: There were a total of 115 Mis-Mailed incidents this reporting period. Because of repetition, the other 114 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. | | | | | | | |
| Resolution | | | | | | | |
| The supervisor counseled the team on the importance of double checking outgoing mail for accuracy of personally identifiable information (PII) in claimants' records. | | | | | | | |

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| PSETS0000084208 | Missing/Stolen Equipment | VISN 03 Bronx, NY | 1/2/2013 | 1/7/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0584744 | 1/2/2013 | INC000000254463 | N/A | N/A | N/A | | |
| Incident Summary | | | | | | | |
| A VA IT desktop computer and monitor were stolen from the sixth floor. The machine is dedicated to MyHealthVet. It uses a locked-down image and stores no data whatsoever. A VA Police report will follow. | | | | | | | |
| Incident Update | | | | | | | |
| 01/02/13: No data breach occurred. The workstation is locked down and does not save data. | | | | | | | |
| Resolution | | | | | | | |
| The machine image does not allow sensitive information to be stored on the device. | | | | | | | |

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| PSETS0000084489 | Missing/Stolen Equipment | VISN 09 Lexington, KY | 1/10/2013 | 1/30/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0585037 | 1/10/2013 | INC000000255784 | N/A | N/A | N/A | | |
| Incident Summary | | | | | | | |
| A desktop computer was installed into the Men's break/dressing room of the Cooper Drive division three weeks ago. The desktop was last seen on 01/04/13. Reports indicate that the desktop was last logged into on 01/04/13. On 01/07/13, Environmental Management Service (EMS) reported the desktop and monitor missing. The Information Security Officer (ISO) was not notified of the theft until 01/10/13. | | | | | | | |
| Incident Update | | | | | | | |
| 01/10/13: The hard drive was not encrypted and the desktop was used for employees to access email and the internet. It did not store any data. | | | | | | | |
| Resolution | | | | | | | |
| No data breach occurred. | | | | | | | |

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| PSETS0000084512 | Mishandled/ Misused Physical or Verbal Information | VISN 08 Miami, FL | 1/10/2013 | 1/17/2013 | Medium |

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|-------------------------|-----------------------|---------------------|-------------------|-----------------|-----------------|--------------------------|---------------------------|
| VANSOC0585061 | 1/10/2013 | INC000000255856 | N/A | N/A | N/A | 26 | 49 |

Incident Summary

A Logistics supervisor reported that an unlocked filing cabinet was brought to the loading dock and was left unsecured for two days. The supervisor indicated that the filing cabinet contained patient information. The Privacy Officer (PO) accompanied the supervisor to the area and found that the filing cabinet had research protocol information and a logbook (dated 2002-2003). The information included patients' full name, date of birth, full social security number, lab reports, and medical data for seventy-five patients. Questioning of supervisor indicated that there are several non-VHA personnel that egress through the area. A review of police surveillance cameras was not able to identify the person responsible for placing the filing cabinet with the research information on the loading dock. Surveillance was also not able to determine if the filing cabinet was opened by any other third party while left unsecured. The research department indicated that they did not transport a filing cabinet and did not authorize anyone to transport a filing cabinet to the loading dock area.

Incident Update

01/11/13:
Letters offering credit protection services will be offered to 75 patients.

01/14/13:
Updated information from the Privacy Officer indicates that 49 of the patients are deceased. This will result in 26 patients receiving letters offering credit protection services and 49 Next-of-Kin notifications.

Resolution

The filing cabinet was retrieved. Next of kin notification letters were sent to 49 deceased next of kin. Credit protection notifications were sent to 26 patients. Records manager will work with the Institutional Review Board (IRB) liaison to properly archive the research data.

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| PSETS0000084960 | Missing/Stolen Equipment | VISN 16 Biloxi, MS | 1/23/2013 | 1/30/2013 | Medium | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0585458 | 1/23/2013 | INC000000258137 | N/A | N/A | N/A | | |
| <p>Incident Summary</p> <p>The Chief Information Officer (CIO) reports that a Bar Code Medication Administration (BCMA) laptop is missing from the unit and may have been stolen from one of the facility inpatient wards. An extensive search is still being conducted. The laptop is verified as encrypted as reported by the Symantec Endpoint Encryption (SEE) utility. The last time the laptop checked in on the management software was on 11/21/12 at 12:56 PM. VA Police have been notified and a copy of the police report will be made available to the Information Security Officer (ISO). Since this is a BCMA laptop the facility believes there were no individual manually generated (word processing, excel, etc.) data, so it is difficult to determine the number of Veterans this may affect.</p> | | | | | | | |
| <p>Incident Update</p> <p>01/23/13: An IT tech arrived at the unit this morning on a job and noticed a BCMA cart without a laptop. The tech further reported the part of the cart that secures the laptop to the cart had been bent to allow the laptop to be removed. The tech inventoried the unit area and accounted for all devices but the laptop reported as missing. The last inventoried date for the device was 11/12/12 and was last on the network and checked into the SEE utility on 11/21/12 as described.</p> <p>The IT Tech has provided a signed Report of Contact detailing his discovery and actions which are summarized above. The ISO hopes the VA Police will be able to interview some of the other staff and supply some additional details. The incident was just reported to the VA Police at the same time this ticket was entered, so it may be a bit before they can come up with some additional details.</p> <p>01/28/13: The ISO requested an update from the CIO. The VA Police Report is pending.</p> | | | | | | | |
| <p>Resolution</p> <p>Investigators questioned staff but they thought the laptop was out being repaired. The case was closed pending any further leads.</p> | | | | | | | |

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| PSETS0000084990 | Privacy | VISN 09 Mountain Home, TN | 1/24/2013 | | Low |

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|-------------------------|-----------------------|---------------------|-------------------|-----------------|-----------------|--------------------------|---------------------------|
| VANSOC0585686 | 1/30/2013 | INC000000259374 | N/A | N/A | N/A | 64 | |

Incident Summary

Veteran A presented to the Patient Advocate that while he was a patient at the Halfway house, he was given the 12 step workbook for the program. In the back of the workbook were the names, SSN and dates of birth of all the Veterans in the Program. The Veteran had left the building when he discovered this. He stopped by an office that he stated was occupied by a VA employee and left the workbook. The Privacy Officer (PO) is working with the Community Based Outpatient Clinic in the area for retrieval of the workbook, and communication with the apparent VA employee that has the workbook to get specific details.

Incident Update

02/01/13:

Social Work staff spoke with the owner of the Halfway house regarding the issue the Veteran discussed with the Patient Advocate. The book that was given to the Veteran was a stapled copy of the workbook used by the Halfway house. It appears that someone had copied the Census and inadvertently left it on the copier. When the workbook was copied, all materials were copied were picked up and stapled together. The other Veterans in the group were surveyed and denied that they had received the Census in their workbook. The pages will be forwarded to the Privacy Officer.

The Census given to staff at the Halfway home will no longer include their social security number. The Census given to the VA will only include a Veteran's last four digits of the SSN. The facility has agreed that all information containing a Veteran's full social will be kept behind locked doors and a shredder will be utilized to shred information related to Veteran's sensitive information. They are hopeful that this will help to eliminate problems in the future. The Privacy Officer received a copy of the Census sheet that was attached to the back of the Veteran's workbook. It has been attached to this incident ticket and contained 55 names. Along with the names are the full social security numbers, dates of birth, admission dates and military service dates (years only).

Since the book was given to a Veteran and was taken off station, all 54 Veterans will be offered credit protection services. It is 54 (not 55) since the Veteran's own information was one of the 55 on the form.

02/06/13:

On further review 64 Veterans had their information disclosed and will be offered credit protection services.

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| PSETS0000085033 | Missing/Stolen Material (Non-Equipment) | VISN 22 Long Beach, CA | 1/24/2013 | 2/12/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0585519 | 1/24/2013 | INC000000258438 | N/A | N/A | N/A | | |
| Incident Summary | | | | | | | |
| VA Detective called the VA Long Beach Healthcare System (LBHS) Information Security Officer (ISO) around 1:50 PM to report missing items from last year. | | | | | | | |
| Incident Update | | | | | | | |
| 01/24/13: This incident is under investigation. | | | | | | | |
| 01/25/13: On 01/25/13 the VA Police reported to the ISO of an incident that occurred back on 05/08/12 involving the theft of VA equipment and items from the Recreation Therapy Room in Bldg. 150 room 205. The multiple items were taken on three (3) separate occasions from within a closet. The following items were reported stolen: DVD booklet containing over 1000 DVDs, one camera, 3 Government owned laptops (older laptops). The laptops were not encrypted. According to the police report there is no patient information on the laptops. It was not reported to the ISO until now, because it was believed that it did not need to be reported to the ISO since no personally identifiable information (PII) or protected health information (PHI) was on the laptops. The ISO is checking to see if the laptops were encrypted or not. They were used to watch the DVDs that were stolen and were never on the VA network. | | | | | | | |
| 1/28/13: According to the ISO the laptops were donated to the VA for viewing the DVDs that were also stolen. They were not Government Furnished Equipment (GFE). | | | | | | | |
| Resolution | | | | | | | |
| After providing required information, ISOs are waiting on NSOC reply to close ticket. Thanks | | | | | | | |

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| PSETS0000085279 | Missing/Stolen Equipment | VISN 01 Providence, RI | 1/31/2013 | 2/4/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0585743 | 1/31/2013 | INC000000259701 | N/A | N/A | N/A | | |
| Incident Summary | | | | | | | |
| A PC that did not contain personally identifiable information (PII) or protected health information (PHI) was stolen last night (01/30/13). It was discovered missing by the Environmental Management Service (EMS) staff during morning rounds. | | | | | | | |
| Incident Update | | | | | | | |
| 01/31/13: The PC was intended for general use. It was not encrypted, however it is believed that it did not store any personally identifiable information (PII) or protected health information (PHI). A VA Police report was filed. | | | | | | | |
| Resolution | | | | | | | |
| The PC was intended for general use. It was not encrypted however it is believed that it did not store any PII or PHI. A VA Police report was filed. | | | | | | | |

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| PSETS0000085320 | Missing/Stolen Equipment | VISN 19 Fort Harrison, MT | 1/31/2013 | 2/4/2013 | Low | | |
| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
| VANSOC0585778 | 1/31/2013 | INC000000259861 | N/A | N/A | N/A | | |
| <p>Incident Summary A burglary of the Kalispell, MT Community Based Outpatient Clinic (CBOC) was discovered when the first employee arrived at 6:45 AM on 01/31/13. Approximately 15 office doors were open and signs of forced entry were exhibited. This was reported to the facility VA Police at the VAMC at 7:05 AM. No medications were missing. No evidence of any breach of VA Sensitive Information (SI) was noted. Apparently stolen in the burglary was one VA BlackBerry and one VA owned Galaxy Note Pad (used for training) which contained no SI. The BlackBerry was disabled after 10:00 AM (when it was discovered missing). The Information Security Officer (ISO) was notified at 1:00 PM and VA Police delivered their Investigative Report (IR) to the ISO at 1:13 PM. VA Police at the VAMC have not yet received the IR from the Kalispell Police Department.</p> | | | | | | | |
| <p>Incident Update 02/01/13: The BlackBerry was disabled and the tablet contained no sensitive information. No data breach has occurred.</p> | | | | | | | |
| <p>Resolution No data breach has occurred.</p> | | | | | | | |

| Security Privacy Ticket Number | Incident Type | Organization | Date Opened | Date Closed | Risk Category |
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| PSETS0000085384 | Missing/Stolen Equipment | VISN 22 Los Angeles CA | 2/1/2013 | | Low |

| VA-NSOC Incident Number | Date US-CERT Notified | US-CERT Case Number | Date OIG Notified | Reported to OIG | OIG Case Number | No. of Credit Monitoring | No. of Loss Notifications |
|-------------------------|-----------------------|---------------------|-------------------|-----------------|-----------------|--------------------------|---------------------------|
| VANSOC0585841 | 2/1/2013 | INC000000260199 | N/A | N/A | N/A | | |

Incident Summary

It was reported that a desktop computer and a Bar Code Medication Administration (BCMA) device were removed from a Restricted Inpatient Medical Unit.

Incident Update

02/04/13:

VA Police reported that the items were last seen was Building 500 Ward 2 South POD C/D. There is construction being conducted on the ward. The IT Department reported that they did not have the items. The items were not moved to another area.

As of now the items are reported as missing and the VA Police Service classification code is loss. There are no leads to indicate that it was stolen, however the items were entered in the California Enforcement Telecommunications System (CLETS) as stolen.

| | |
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| Total number of Internal Un-encrypted E-mail Incidents | 7 |
| Total number of Mis-Handling Incidents | 122 |
| Total number of Mis-Mailed Incidents | 115 |
| Total number of Mis-Mailed CMOP Incidents | 5 |
| Total number of IT Equipment Inventory Incidents | 0 |
| Total number of Missing/Stolen PC Incidents | 5 |
| Total number of Missing/Stolen Laptop Incidents | 9 (7 encrypted) |
| Total number of Lost BlackBerry Incidents | 22 |
| Total number of Lost Non-BlackBerry Mobile Devices (Tablets, iPhones, Androids, etc.) Incidents | 5 |