Incident Resolution Team

DEPARTMENT OF VETERANS AFFAIRS
Office of Information and Technology
Office of Information Security
Risk Management and Incident Response
Incident Resolution Team

Monthly Report to Congress of Data Incidents

April 1 - 28, 2013

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000087487	Missing/Stolen Equipment	VISN 04 Coatesville, PA	4/2/2013	4/8/2013	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
VANSOC0588146	4/2/2013	INC000000273106	N/A	N/A	N/A		

Incident Summary

During an annual IT inventory, four Dell desktop computers and one WYSE thin client were reported missing from the inventory. The Chief Information Officer (CIO) and OIT staff are searching for the missing items.

Incident Update

04/08/13:
It is not believed that any personally identifiable information (PII) or protected health information (PHI) was stored on the devices. Additionally, since the initial report, two of the four missing desktops have been found. A VA Police report was filed.

NOTE: There were a total of 8 IT Equipment Inventory Incidents this reporting period. Because of repetition, the other 7 are not included in this report, but are included in the "IT Equipment Inventory Incidents" count at the end of this report.

Resolution

A Report of Survey was filed on 04/04/13 for the missing computers.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000087673	Mishandled/ Misused Physical or Verbal Information	VBA Milwaukee, WI	4/8/2013	4/10/2013	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
VANSOC0588355	4/8/2013	INC000000274182	N/A	N/A	N/A	1	

Incident Summary

A notification letter was released to Beneficiary A, which had a document for Beneficiary B erroneously attached to it. The attached document contained Beneficiary B's name, address, Social Security Number, home phone number, and bank account information. Beneficiary A called in to report the incident and has returned the document to the facility.

Incident Update

04/08/13:
Beneficiary B will be sent a letter offering credit protection services.

NOTE: There were a total of 114 Mis-Mailed incidents this reporting period. Because of repetition, the other 113 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 employees involved were issued verbal counseling regarding the importance of handling personally identifiable information (PII).

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000087680	Mishandled/ Misused Physical or Verbal Information	VISN 02 Buffalo, NY	4/8/2013	5/13/2013	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
VANSOC0588362	4/8/2013	INC000000274208	N/A	N/A	N/A		1

Incident Summary

Veteran A was discharged from a Post-Traumatic Stress Disorder (PTSD) program and given his medications in a plastic bag. Today when the Home Health Nurse went to visit, she noted the bag also contained medication for Veteran B. The label on the medication included Veteran B's name, medication, dose, instructions, date filled and the name of the provider who ordered it.

Incident Update

04/08/13:
Veteran B will be sent a HIPAA notification letter.

NOTE: There were a total of 113 Mis-Handling incidents this reporting period. Because of repetition, the other 112 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.

Resolution

The items were retrieved and returned to the pharmacy.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000087963	Mishandled/ Misused Physical or Verbal Information	VHA CMOP Chelmsford, MA	4/15/2013	4/17/2013	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
VANSOC0588624	4/15/2013	INC000000275735	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 East Orange VA Medical Center and a replacement has been requested for Patient B. Chelmsford 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.

Incident Update

04/15/13:
Patient B will be sent a notification letter.

NOTE: There were a total of 5 Mis-Mailed CMOP incidents out of 6,223,533 total packages (9,322,141 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.

Resolution

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

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000088080	Missing/Stolen Equipment	VISN 04 Butler, PA	4/17/2013	4/18/2013	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
VANSOC0588744	4/17/2013	INC000000276407	N/A	N/A	N/A		

Incident Summary

The Program Manager of Rehabilitation Therapy contacted the facility Information Security Officer (ISO) to report that a Medical Device laptop was missing. The laptop was purchased as a stand-alone device that worked with Pressure Monitoring Testing Equipment in Occupational Therapy (OT). The laptop was never connected to the VA Network. It was unencrypted and personally identifiable information (PII) and protected health information (PHI), including Veterans' name and last four digits of the SSN, was stored on the device. There is no way to know exactly how many Veterans could be involved. The last known time it was physically seen was when it was inventoried on 10/19/12 in Building 2 room 09. That area has been found unsecured a number of times. The ISO and Medical Staff have searched the VA facility. During the search it was stated by the OT Staff that they noticed the laptop was missing a few months ago while cleaning however they never notified anyone about it. The VA Police were informed of the loss today. The Police will provide the Police Report number to the facility ISO tomorrow and the ticket will be updated accordingly.

Incident Update

04/18/13:
In 2011, the hard drive on this medical device failed and was sent for destruction per VA policy. A new hard drive was installed and that unit was returned to service. Since that time, there have been 910 Veteran consults ordered for the Pressure Mapping. Staff have reviewed each of the 910 medical records and reviewed the progress notes to see if the Pressure Mapping equipment was utilized on the Veterans. Of the 910 consults reviewed, there were no notes regarding the device being used. Therefore, facility leadership is comfortable stating that the there was no PHI/PII on the new hard drive in the device.

Resolution

Staff are being educated on the importance of notifying the Information Security Officer and VA Police as soon as equipment is found missing. The facility is looking at all medical devices with laptops and checking on the status of encrypting them or getting the required Medical Device Waiver completed.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000088557	Mishandled/ Misused Physical or Verbal Information	VISN 05 Martinsburg, WV	4/26/2013	5/15/2013	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
VANSOC0589207	4/26/2013	INC000000278556	N/A	N/A	N/A		55

Incident Summary

The Privacy Officer (PO) found a patient appointment list in the patient computer lab of the Mental Health Building. The list was printed by My HealtheVet (MHV) staff. While assisting a Veteran with MHV enrollment, the staff member forgot the appointment list in the computer lab. There were 55 patient names on the list. The patient appointment list included the appointment date and time, clinic name, and the patients' last name. The PO removed the appointment list and secured it.

Incident Update

04/29/13:
The list was left in the room for approximately 2 hours. The lab was not staffed by an employee during the time the list was left there.

05/01/13:
The 55 Veterans will be sent HIPAA notification letters.

Resolution

Notification letters have been sent. Employee training and education has been provided. New procedures are being implemented to prevent this from happening again.

Total number of Internal Un-encrypted E-mail Incidents	84
Total number of Mis-Handling Incidents	113
Total number of Mis-Mailed Incidents	114
Total number of Mis-Mailed CMOP Incidents	5
Total number of IT Equipment Inventory Incidents	8
Total number of Missing/Stolen PC Incidents	0
Total number of Missing/Stolen Laptop Incidents	10 (9 encrypted)
Total number of Lost BlackBerry Incidents	18
Total number of Lost Non-BlackBerry Mobile Devices (Tablets, iPhones, Androids, etc.) Incidents	3