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

December 3 - 30, 2012

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000083148	Mishandled/ Misused Physical or Verbal Information	VHA CMOP Dallas, TX	12/3/2012	12/5/2012	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
VANSOC0583730	12/3/2012	INC000000249958	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 Amarillo VA Medical Center and a replacement prescription has been requested for Patient B. Dallas 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

12/03/12:
Patient B will be sent a notification letter.

NOTE: There were a total of 6 Mis-Mailed CMOP incidents out of 6,045,401 total packages (9,011,771 total prescriptions) mailed out for this reporting period. Because of repetition, the other 5 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
PSETS0000083187	Mishandled/ Misused Physical or Verbal Information	VISN 04 Altoona, PA	12/3/2012	12/4/2012	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
VANSOC0583766	12/3/2012	INC000000250066	N/A	N/A	N/A		1

Incident Summary

Veteran A reported that Veteran B's prescription leaflet containing Veteran B's full name, address and medication information was included with Veteran A's mailed medications.

Incident Update

12/03/12:
Veteran B will be sent a notification letter.

NOTE: There were a total of 79 Mis-Mailed incidents this reporting period. Because of repetition, the other 78 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 leaflet has been retrieved by the Pharmacy Service. Pharmacy Staff has been re-educated regarding the importance of protecting patient information at all times. Quality control measures are in place in the Pharmacy Service. The HIPAA notification letter has been sent to the patient.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000083474	Missing/Stolen Material (Non-Equipment)	VISN 09 Mountain Home, TN	12/10/2012	12/31/2012	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
VANSOC0584050	12/10/2012	INC000000251333	N/A	N/A	N/A	12	60

Incident Summary

A Registered Nurse from the nursing home reported that the Quality Improvement data log books are missing. Staff offices have been moved recently and the log books were maintained in different areas. The first floor is missing the log books for the years 2004, 2005, 2006, 2007, 2008 and the second floor is missing the log books for the years 2006 and 2009. The Privacy Officer (PO) is investigating to see how long the log books should be retained and to determine the exact data that is kept in the log books.

Incident Update

12/12/12:
The information that is entered in the log books for each patient includes the last name, SSN, date of birth and health information regarding the patient's wound. All books have been found except for one from 2006. Facility staff have run a report and determined that 76 patients would have information in the 2006 log book.

12/18/12:
Out of the 76 patients, four were duplicates and 60 were deceased. The 12 living patients will be offered credit protection services, and 60 next-of-kin (NOK) notification letters will be sent.

Resolution

The credit protection letters and NOK notification letters were placed in the mail. The employee was counseled and the nurse manager reviewed the necessity of maintaining the minimum amount of patient information. She also discontinued the practice of maintaining the patient's information in a log book since the information is placed in the medical record.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000083475	Mishandled/ Misused Physical or Verbal Information	VISN 16 Fayetteville, AR	12/10/2012		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
VANSOC0584051	12/10/2012	INC000000251332	N/A	N/A	N/A	120	

Incident Summary

A courier lost 120 travel vouchers. The vouchers contain the Veterans' name, full SSN and date of birth.

Incident Update

12/17/12:
The contract courier picked the vouchers up from a Community Based Outpatient Clinic (CBOC) on 11/20/12 and the vouchers have been lost since then. After a thorough search, they have not been found. All 120 Veterans will be offered credit monitoring services.

12/19/12:
The Privacy Officer (PO) has contacted the VA Police and left a voice mail and will call again today. The travel vouchers were cancelled and new travel vouchers were issued. The missing vouchers cannot be claimed for cash.

01/10/13:
The PO is working on the letters and expects that they will be mailed on 01/31/13.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000083886	Mishandled/ Misused Physical or Verbal Information	VISN 17 Harlingen, TX	12/19/2012	12/31/2012	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
VANSOC0584431	12/19/2012	INC000000253033	N/A	N/A	N/A		1

Incident Summary

A VA Pharmacist was preparing two different bags of prescriptions when he put a bottle of Veteran A's prescription into the bag for Veteran B. Veteran Bs' wife left the facility with the bag without noticing. The VA Pharmacist noticed the error when Veteran A picked up his medication and noticed that he was missing a prescription bottle. The VA Pharmacist contacted Veteran B's wife about 10 minutes later requesting her to return to the Pharmacy. Once she returned, the prescription in question was retrieved unopened and re-issued to Veteran A. The only information that was on the bottle was Veteran A's full name and medication name, along with provider name and prescription number.

Incident Update

12/19/12:
Veteran A will be sent a notification letter.

NOTE: There were a total of 85 Mis-Handling incidents this reporting period. Because of repetition, the other 84 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

On 12/20/12, additional training/counseling took place. Step by step procedures were discussed to be used to prevent misplacing of finished medication when filled and bagged prescriptions must be worked on.

Security Privacy Ticket Number	Incident Type	Organization	Date Opened	Date Closed	Risk Category
PSETS0000084098	Missing/Stolen Equipment	VISN 23 Minneapolis, MN	12/27/2012		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
VANSOC0584634	12/27/2012	INC000000253836	N/A	N/A	N/A		

Incident Summary

A desktop PC was identified as missing. The device had been removed from a Veterans Center and placed into an OIT storage area in August 2011. A recent inventory was unable to identify the current location. A Report of Survey and a VA Police Report were filed.

Incident Update

12/27/12:
It is believed the missing PC is a result of an inventory error. It was last known to be stored in an IT storage area. It was last used at a Veterans Center for general administrative use and is not known if it contained any sensitive data.

01/09/13:
There is evidence that the inventory was incorrect and that another PC workstation with a similar inventory number and an almost identical serial number was excessed two days prior to when the missing device was thought to have gone missing. Both systems were located in the same office space and then removed to the same OIT workspace. The Information Security Officer (ISO) is not sure that it can be conclusively determined at this point in time and will continue to investigate.

NOTE: There were a total of 4 IT Equipment Inventory Incidents this reporting period. Because of repetition, the other 3 are not included in this report, but are included in the "IT Equipment Inventory Incidents" count at the end of this report.

Total number of Internal Un-encrypted E-mail Incidents	73
Total number of Mis-Handling Incidents	85
Total number of Mis-Mailed Incidents	79
Total number of Mis-Mailed CMOP Incidents	6
Total number of IT Equipment Inventory Incidents	4
Total number of Missing/Stolen PC Incidents	4
Total number of Missing/Stolen Laptop Incidents	5 (5 encrypted)
Total number of Lost BlackBerry Incidents	14
Total number of Lost Non-BlackBerry Mobile Devices (Tablets, iPhones, Androids, etc.) Incidents	4