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Email enquiries@hta.gov.uk
Date 20 February 2018

[redacted]

By email to [redacted]

Dear [redacted]

Freedom of Information request

Thank you for your request for information under the Freedom of Information Act (FOIA), which was received by the Human Tissue Authority (HTA) on 23 January 2018. Your email outlined the following request:

> FREEDOM OF INFORMATION ACT REQUEST
>
> Previously in an email dated 20-2-2014 you provided a response to a Freedom of Information Act request where you detailed the location, incident classification and summarised description of HTARIs for the 2013 calendar year.
>
> Could you provide me with a similar response for HTARIs that took place in the 2017 calendar year?

Response

I can confirm that currently 95 post-mortem HTARIs have been reported and closed during 2017. The location, description and classification of each incident is set out in the table below.

It is useful to consider this information in the context of the number of bodies admitted to mortuaries licensed by the HTA each year. In 2014-15, mortuaries licensed by the HTA admitted around 330,000 bodies, and performed over 100,000 post-mortem examinations.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
1	The Royal London Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Delay in sensitive disposal of pregnancy remains due to administration error.
2	Royal Cornwall Hospital	Post-mortem examination of the wrong body	Due to an identification error, a post-mortem examination was commenced on the wrong body.
3	Royal Free Hospital	Viewing of the wrong body	Human error led to a viewing of the wrong body.
4	Royal Bolton Hospital	Loss of an organ	Human error led to loss of tissue.
5	James Cook University Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Administrative error led to inadvertent retention of blocks and slides.
6	Kingston Hospital	Serious security breach	Door to the mortuary was not secured following the admission of a body by security personnel.
7	Warrington Hospital	Release of the wrong body	Human error led to the short term release of the wrong body.
8	Sunderland Royal Hospital	Viewing of the wrong body	Procedural error led to the viewing of the wrong body.
9	Addenbrooke's Hospital	Accidental damage to a body	Human error led to damage to a deceased person during a post-mortem examination.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
10	Basildon University Hospital	Viewing of the wrong body	Human error led to the viewing of the wrong body.
11	Basildon University Hospital	Release of the wrong body	Human error led to the short-term release of the wrong body.
12	Central Manchester University Hospitals NHS Foundation Trust	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Mortuary reached capacity.
13	John Radcliffe Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Closure of viewing room due to use for a temporary storage facility.
14	Arrowe Park Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
15	The Royal London Hospital	Release of the wrong body	Human error led to the short-term release of the wrong body.
16	Royal Stoke University Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Administrative error led to a delay in cremation.
17	Barnsley Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
18	Addenbrooke's Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
19	Worcestershire Royal Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Human error led to the deceased being released without all risks being fully considered.
20	The Royal London Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
21	Countess of Chester Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
22	Worcestershire Royal Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
23	University Hospital of Wales	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
24	Central Manchester University Hospitals NHS Foundation Trust	Release of the wrong body	Human error led to the short-term release of the wrong body.
25	Chesterfield Royal Hospital	Viewing of the wrong body	Administrative error led to the viewing of the wrong body.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
26	Medico-Legal Centre	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
27	Royal Shrewsbury Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Human error led to delay in the cremation of pregnancy remains.
28	Worcestershire Royal Hospital	Discovery of an organ or tissue following post-mortem examination and release of body	Due to human error, tissue was discovered following release of a body.
29	Southport & Formby District General Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Human error led to cremation of pregnancy remains rather than being returned to the family.
30	Great Western Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
31	Darent Valley Hospital	Release of the wrong body	Procedural error led to the short-term release of the wrong body.
32	Torbay Hospital	Serious security breach	Procedural error led to unauthorised access to the mortuary.
33	Whiston Hospital	Release of the wrong body	Human error led to the short-term release of the wrong body.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
34	Holly Tree Lodge, Bournemouth Borough Council	Incident leading to the temporary unplanned closure of a mortuary resulting in inability to deliver services	An unforeseen incident led to temporary closure of the mortuary for post-mortem examinations.
35	Countess of Chester Hospital	Accidental damage to a body	Human error led to minor accidental damage to a deceased person whilst being transferred into the mortuary.
36	Medico-Legal Centre	Discovery of an organ or tissue following post-mortem examination and release of body	Deceased returned to the mortuary following release to funeral director so that organ could be returned to the body.
37	St Thomas' Hospital	Loss of an organ	Human error led to loss of small amounts of tissue.
38	Luton and Dunstable University Hospital	Serious security breach	An unauthorised individual gained access to the mortuary premises before being found by staff
39	Leicester Royal Infirmary	Loss of an organ	Human error led to loss of tissue traceability.
40	University Hospital of North Durham	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
41	Queen's Medical Centre	Loss of an organ	Human error lead to loss of part of an organ.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
42	Central Manchester University Hospitals NHS Foundation Trust	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Human error led to inadvertent disposal of tissue.
43	Royal Preston Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
44	Central Mortuary	Discovery of an organ or tissue following post-mortem examination and release of body	Due to human error, a body was released to the funeral director before the wishes of the family regarding samples taken at post-mortem examination were known.
45	Royal Liverpool University Hospital	Viewing of the wrong body	Human error led to the viewing of the wrong body.
46	Calderdale Royal Hospital	Serious security breach	An unaccompanied family member gained access to the viewing room.
47	Tameside General Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
48	Royal Derby Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
49	The Royal Oldham Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
50	Central Manchester University Hospitals NHS Foundation Trust	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Delay in instruction to carry out post-mortem examination led to delay in release of and deterioration of a deceased patient.
51	Worthing Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
52	Frimley Park Hospital	Release of the wrong body	Human error led to the short-term release of the wrong body.
53	Victoria Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Unexpected delay in release of body to the funeral director.
54	Medway Maritime Hospital	Viewing of the wrong body	Human error led to the viewing of the wrong body.
55	Southend Hospital NHS Trust	Viewing of the wrong body	Human error led to the viewing of the wrong body.
56	Salford Royal NHS Foundation Trust	Inadvertent disposal or retention of an organ against the express wishes of the family	Administrative error led to inadvertent retention of organ against family wishes.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
57	John Radcliffe Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Procedural error led to inadvertent retention of tissue.
58	Royal Stoke University Hospital	Viewing of the wrong body	Human error led to the viewing of the wrong body.
59	Addenbrooke's Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
60	Royal Stoke University Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person during post-mortem examination.
61	St George's Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person during post-mortem examination.
62	Barnet Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Human error led to loss of traceability of pregnancy remains.
63	Basingstoke and North Hampshire Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
64	Central Manchester University Hospitals NHS Foundation Trust	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
65	The Ipswich Hospital NHS Trust	Viewing of the wrong body	Human error led to the viewing of the wrong body.
66	King's College Hospital	Removal of tissue from a body without authorisation or consent	Use of incorrect consent form for a tissue biopsy.
67	Salisbury District Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
68	Broomfield Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Human error led to cremation of pregnancy remains, rather than them being returned to the family.
69	Southend Hospital NHS Trust	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Human error lead to loss of patient property.
70	Gloucester Royal Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
71	Birmingham Children's Hospital	Release of the wrong body	Procedural error led to the short-term release of the wrong body.
72	William Harvey Hospital	Post-mortem examination of the wrong body	Due to communication errors, a post-mortem examination was commenced on the wrong body.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
73	Royal Brompton Hospital	Inadvertent disposal or retention of an organ against the express wishes of the family	Administrative error led to inadvertent retention of blocks and slides.
74	The Ipswich Hospital NHS Trust	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
75	Princess Alexandra Hospital	Accidental damage to a body	Equipment failure led to minor damage to a deceased person whilst being transferred into the mortuary.
76	University Hospital of Wales	Any incident not listed here that could result in adverse publicity that may lead to damage to public confidence	Delay in transfer of deceased from the ward to the mortuary.
77	Addenbrooke's Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
78	St George's Hospital	Major equipment failure	Failure of extraction fan in post-mortem room.
79	Ashford & St Peter's Hospitals NHS Foundation Trust	Major equipment failure	Fridge failure resulted in transfer of bodies to another HTA licensed establishment.
80	Barnsley Hospital	Discovery of an organ or tissue following post-mortem examination and release of body	Human error led to loss of tissue traceability.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
81	Northern General Hospital	Discovery of an organ or tissue following post-mortem examination and release of body	Human error led to loss of tissue traceability.
82	Doncaster Royal Infirmary	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
83	Leighton Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
84	Norfolk and Norwich University Hospital	Loss of an organ	Human error led to loss of part of an organ.
85	Derriford Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
86	Addenbrooke's Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
87	Leighton Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Loss of traceability of products of conception.
88	Addenbrooke's Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.

HTA Reference Number	Reporting establishment	Incident classification	Summarised description of HTARI
89	The Royal Oldham Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
90	Whiston Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
91	George Eliot Hospital	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
92	Royal Albert Edward Infirmary	Release of the wrong body	Procedural error led to the short-term release of the wrong body.
93	Poole Hospital NHS Foundation Trust	Accidental damage to a body	Human error led to minor damage to a deceased person whilst being transferred into the mortuary.
94	Royal Berkshire Hospital	Post-mortem examination conducted was not in line with the consent given or the post-mortem examination proceeded with inadequate consent	Due to human error, a post-mortem examination was not conducted in line with the consent given.
95	Derriford Hospital	Accidental damage to a body	Equipment failure led to minor damage to a deceased person whilst being transferred from the mortuary.

Further information

If you are unhappy with the way the HTA has handled your request for information in this case, you may in the first instance ask us for an internal review by writing to us at the above postal or email address.

If you remain dissatisfied with the handling of your request or complaint, you have the right to appeal directly to the Information Commissioner for a decision, at the address below. There is no charge for making an appeal.

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 08456 30 60 60 or 01625 54 57 45
Website: www.ico.gov.uk

Yours sincerely