Human Tissue Authority
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SW1W 9SZ

Tel 020 7269 1900
Email "[***redacted***]"
Web www.hta.gov.uk
Date 20 February 2014

"[***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). You initially contacted the Human Tissue Authority by email on 20 January 2014, outlining the following request:

"Please can you provide the following information under the Freedom of Information Act 2000.

Please can you provide the number of "reportable incidents" which occurred in NHS establishments in England, Scotland and Wales during 2012.

Please can you provide a brief description, including the location, for each of these incidents."

The HTA responded to your request on 22 January 2014 with a link to our disclosure log where a list of all Serious Untoward Incidents (SUIs), now known as HTA Reportable Incidents (HTARIs) reported to the HTA in 2012 can be found.

You responded to this email on 22 January stating:

"The disclosure log seems to show all incidents from 2012. I was hoping you could provide the same information (i.e. a list of HTARIs) for the whole of 2013 (Jan to December)."

Response

The term HTA Reportable Incident (HTARI) replaced the term Serious Untoward Incident (SUI) on 1 April 2013. The term HTARI is used throughout the response, to reflect the fact the term changed three months into the 12 month period of data you have requested.

The HTA operates a hub/satellite licensing system, where establishments operating under the same governance system can apply for a main hub licence with separate satellite sites listed under the same licence number. More information on this licensing arrangement can be found on our website here. It is the responsibility of the hub to report any incidents occurring at the satellite sites to the HTA. A full list of the hub and satellite sites we licence in the post mortem sector can be found here.

The data you requested are provided in the table below. Please note the establishments listed below may or may not have satellite sites so the incident may have taken place at a location other than that of the reporting establishment.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
1.	11208	Norfolk and Norwich University Hospital	Release of the wrong body	Incorrect identification of deceased on release from mortuary. The error was corrected immediately upon discovery.
2.	11208	Norfolk and Norwich University Hospital	Accidental damage to a body	Small cut to the forehead of a deceased occasioned during transfer of the body from store to undertakers trolley, contributed to in part by handling difficulties as a result of the size and weight of the body.
3.	11208	Norfolk and Norwich University Hospital	Release of the wrong body	Incorrect identification of deceased on release from mortuary. The error was corrected immediately upon discovery.
4.	12001	Sheffield Children's Hospital	Major equipment failure	Major equipment failure leading to unintended freezing of stored fetuses.
5.	12003	Great Western Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Allegation of theft of patient property while within the hospital ward prior to property being transferred to mortuary with the body of the deceased.
6.	12013	Royal Free London NHS Foundation Trust	Accidental damage to a body	Decomposition of a body resulting from delay in return of the body to refrigerated storage following removal for a viewing.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
7.	12014	Royal Hampshire County Hospital	Accidental damage to a body	Superficial damage to the arm of a deceased patient occurring during transfer into store, contributed to by failure of hospital porter staff to follow guidance on storage of bariatric patients in wide slide spaces only.
8.	12014	Royal Hampshire County Hospital	Release of the wrong body	Release of the wrong body as a result of failure to follow correct release procedures. The error was corrected immediately upon discovery.
9.	12029	Chesterfield Royal Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family	Disposal of a fetus by cremation which was not the method requested by the family.
10.	12031	Stepping Hill Hospital	Viewing of the wrong body	Viewing of the wrong body as a result of failure to follow documented procedures.
11.	12034	Derriford Hospital	Viewing of the wrong body	Viewing of the wrong body, contributed to by failure in communication between mortuary staff members and failure to follow documented identification procedures.
12.	12034	Derriford Hospital	Accidental damage to a body	Small cut to the face of a body, arising as a result of handling errors when body was placed into store by attending ambulance staff.
13.	12034	Derriford Hospital	Discovery of an organ or tissue following post-mortem examination and release of body	Discovery of an organ following release of the body as a result of error in transcription on tissue retention paperwork.
14.	12037	Royal Preston Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Initial incision made to a body before information received that no post mortem was authorised, as a result of human error and failures in communication.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
15.	12047	Salisbury District Hospital	Accidental damage to a body	Grazing to the arm of the deceased which occurred when the deceased was when being placed into storage, as a result of ineffective placement of arm strapping by porter staff during transfer from ward.
16.	12047	Salisbury District Hospital	Viewing of the wrong body	Viewing of the wrong body arising as a result of failure to follow documented identification procedures.
17.	12051	Basildon Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Two products of conception delivered to the mortuary without accompanying paperwork, contributed to by failures in communication and lack of awareness by ward staff of relevant procedures.
18.	12051	Basildon Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family	Inadvertent retention of two products of conception, contributed to by inadequate procedures for the management of fetal tissue and failures in communication between staff.
19.	12051	Basildon Hospital	Release of the wrong body	Release of the wrong body as a result of failure to follow documented release procedures. The error was corrected immediately upon discovery.
20.	12058	University Hospital Aintree	Post-mortem examination of the wrong body	Post mortem examination on the wrong body, contributed to by human error and failure to follow documented identification procedures.
21.	12067	Tameside General Hospital	Removal of tissue from a body without authorisation	Tissues retained at post mortem without appropriate authorisation.
22.	12081	Croydon Public Mortuary	Post mortem examination of the wrong body	Post mortem examination on the wrong body contributed to by human error and failure to follow documented identification procedures.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
23.	12082	Hemel Hempstead General Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Trust investigation into an allegation of misconduct about a pathology employee.
24.	12082	Hemel Hempstead General Hospital	Accidental damage to a body	Unintended defrosting of a frozen body, contributed to by failure of freezer equipment and failure of switchboard staff to follow documented alarm response procedures.
25.	12083	Taunton and Somerset NHS Trust	Accidental damage to a body	Bruising to a body during transfer into body storage, contributed to by errors in handling when moving the body from the trolley into the refrigerator.
26.	12086	Pinderfields Hospital	Disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family	Disposal of a fetus by burial, which was not the method requested by the family.
27.	12086	Pinderfields Hospital	Loss of an organ	Inadvertent disposal of body part with clothing of deceased.
28.	12090	Medway Maritime Hospital	Accidental damage to a body	Possible decomposition damage to bodies, as a result of refrigeration equipment failure and potentially contributed to by failures in communication between staff on ward and mortuary.
29.	12090	Medway Maritime Hospital	Post-mortem examination conducted was not in line with the consent given or the PM examination proceeded with inadequate consent	Post mortem examination carried out after consent had been withdrawn, contributed to by failings in communication between bereavement staff and mortuary.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
30.	12091	Cumberland Infirmary	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	The face of a body was not fully shrouded and inadvertently seen by a passer-by during transfer from a vehicle to the mortuary, who reported the incident.
31.	12091	Cumberland Infirmary	Accidental damage to a body	Decomposition damage to a body as a result of it being stored long term within a fridge rather than a freezer, contributed to by failures in communication and equipment failure.
32.	12091	Cumberland Infirmary	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	FOI request to establishment in relation to a non-reportable mortuary incident.
33.	12093	York Teaching Hospital NHS Foundation Trust	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Theft of a digital camera used to record post mortem images for evidential or teaching purposes.
34.	12093	York Teaching Hospital NHS Foundation Trust	Accidental damage to a body	Accidental damage to the scalp of a body occurring during transfer of a body from an undertakers stretcher to a mortuary trolley, contributed to by the unusual size of the deceased and the use by the undertaker of a stretcher not suited for this patient.
35.	12118	Harrogate District Hospital	Accidental damage to a body	Small cut to the nose of deceased caused by staff inadvertently causing an item of furniture to topple and make contact with the body.
36.	12142	Royal Sussex County Hospital	Release of the wrong body	Release of the wrong body, contributed to by failure to follow documented release procedures and two deceased having similar names. The error was corrected immediately upon discovery.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
37.	12145	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 fetal tissue during transfer from ward to mortuary.
38.	12151	Department of Cellular Pathology, University Hospitals Bristol NHS Foundation Trust	Release of the wrong body	Release of the wrong body contributed to by human error and failure to follow documented release procedures. The error was corrected immediately upon discovery.
39.	12153	Glan Clwyd Hospital	Accidental damage to a body	Grazing and cut to the hand of a deceased as a result of incorrect placement of the body on the refrigerator tray.
40.	12163	University Hospital of Wales, Cardiff and Vale University Local Health Board	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Staff miscommunicated the date of disposal of fetal tissue to the family.
41.	12163	University Hospital of Wales, Cardiff and Vale University Local Health Board	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Delay in returning blocks and slides to the family.
42.	12163	University Hospital of Wales, Cardiff and Vale University Local Health Board	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Small sample of tissue lost during transport between mortuaries.
43.	12203	Wythenshawe Hospital	Loss of an organ	Loss of an organ following specialist examination, contributed to by failure to follow documented procedure for the storage of organs.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
44.	12208	Royal Cornwall Hospital	Release of the wrong body	Release of the wrong body, contributed to by failure to follow documented release procedures and similar names of two deceased. The error was corrected immediately upon discovery.
45.	12208	Royal Cornwall Hospital	Release of the wrong body	Release of the wrong body, contributed to by two deceased having similar names and failure to follow documented release procedures. The error was corrected immediately upon discovery.
46.	12208	Royal Cornwall Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Tissue sample retained without appropriate consent.
47.	12214	Southampton General Hospital	Post-mortem examination conducted was not in line with the consent given or the PM examination proceeded with inadequate consent	During a limited PM examination of the body an inadvertent incision was made in the skin of the scalp.
48.	12214	Southampton General Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Decomposition damage to two bodies following catastrophic power failure within the body store.
49.	12222	Royal Surrey County Hospital	Post-mortem examination of the wrong body	Post mortem examination on the wrong body, contributed to by failure to follow correct identification procedure and two deceased having similar names.
50.	12224	Mortuary and Histopathology Laboratory, University Hospital of North Staffordshire NHS Trust	Accidental damage to a body	Accidental damage to a body, contributed to by the fragility of the skin of the deceased, and human error on the part of the APT involved in the post mortem procedure.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
51.	12229	Belfast Health and Social Care Trust	Serious security breach	Serious security breach arising when failure of card access lock allowed hospital staff without automatic right of access to accidentally enter an office area within the mortuary premises. They were immediately redirected. .
52.	12229	Belfast Health and Social Care Trust	Serious security breach	Serious security breach arising when failure of card access lock allowed hospital staff without automatic right of access to accidentally enter an office area within the mortuary premises. They were immediately redirected. .
53.	12232	Royal Berkshire Hospital	Accidental damage to a body	Decomposition damage to bodies as a result of refrigeration equipment failure.
54.	12242	West Suffolk Hospital	Accidental damage to a body	Grazing to the scalp of a body during placement into the body store, contributed to by human error in handling and unusual body morphology of the deceased.
55.	12243	Guy's and St Thomas' Hospitals, Cellular Pathology	Serious security breach	Serious security breach outside the mortuary resulting in loss of personal possessions and some tissue slides, contributed to by the failure of a member of staff to take appropriate security precautions.
56.	12243	Guy's & St. Thomas' Hospitals; Cellular Pathology	Discovery of an organ or tissue following post-mortem examination and release of body	Inadvertent retention of tissue blocks and slides which should have been cremated, contributed to by human error and shortcomings in the procedure for returning tissue samples to the body.
57.	12243	Guy's & St. Thomas' Hospitals; Cellular Pathology	Accidental damage to a body	Damage to a body during transfer from bed to trolley, contributed to by human error in failing to fully lock the trolley wheels.
58.	12243	Guy's & St. Thomas' Hospitals; Cellular Pathology	Major equipment failure	Failure of mortuary refrigeration equipment.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
59.	12243	Guy's & St. Thomas' Hospitals; Cellular Pathology	Release of the wrong body	Release of the wrong body contributed to by human error and failure to follow documented release procedures. The error was corrected immediately upon discovery.
60.	12244	Bradford Royal Infirmary	Post-mortem examination conducted was not in line	Post mortem examination conducted was not in line with consent, contributed to by errors in communicating that an organ would be removed from the body for specialist examination.
61.	12288	Rotherham General Hospital	Release of the wrong body	Release of wrong body following PM examination contributed to by human error in transcribing incorrect patient details on report form. The error was corrected immediately upon discovery.
62.	12314	Pathlinks, Lincoln	Accidental damage to a body	Decomposition of a body that was unable to be placed into the mortuary's refrigerated storage due to size.
63.	12323	Wexham Park Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Failure to place body in freezer storage, leading to decomposition.
64.	12329	Queen Elizabeth Hospital Birmingham	Accidental damage to a body	Abrasions to the leg of a deceased patient, which may have been contributed to by staff attempting to place a bariatric body into a standard fridge space.
65.	12337	Leicester Royal Infirmary	Viewing of the wrong body	Wrong body viewed as a result of failure to follow documented identification procedures and similar names of two deceased in store.
66.	12337	Leicester Royal Infirmary	Discovery of an organ or tissue following PME and release of body	Discovery of tissue inadvertently retained after release of body.
67.	12346	Barnsley Hospital NHS Foundation Trust	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Tissue sample retained without appropriate consent.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
68.	12346	Barnsley Hospital NHS Foundation Trust	Accidental damage to a body	Superficial scalp wound noted on a body in storage. Cause still to be determined.
69.	12346	Barnsley Hospital NHS Foundation Trust	Accidental damage to a body	Superficial laceration to scalp noted on a body in storage. Cause still to be determined.
70.	12377	King's College Hospital	Release of the wrong body	Release of the wrong body occurring as a result of failure to follow documented release procedures. The error was corrected immediately upon discovery.
71.	12405	Public Mortuary, Bournemouth Borough Council	Accidental damage to a body	Grazing to the head of a body arising as a result of human error in failing to fully latch body slide to trolley during transfer.
72.	12405	Public Mortuary, Bournemouth Borough Council	Loss of an organ	Return of organ to the body for burial when it was needed for further examination by the pathologist.
73.	12451	King's Mill Hospital	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Disposal of products of conception as clinical waste, in contravention of departmental policy but not in contravention of national standards.
74.	12461	University Hospital of North Durham	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Discovery of fetal material held within a storage area awaiting documented instructions for disposal. Extended period of storage contributed to by failures in communication and error in record taking.
75.	12541	Salford Royal NHS Foundation Trust	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Decomposition of a body, contributed to by delay in PM examination due to statutory holiday, preventing viewing by the deceased's family.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
76.	12553	St. Mary's Hospital	Major equipment failure	Major equipment failure as a result of failure of power supply. Repairs carried out and contingency plans in place. No consequential damage to stored bodies.
77.	12554	Central Manchester University Hospitals NHS Foundation Trust	Accidental damage to a body	Superficial damage to the arms of a deceased patient occurring during transfer into store, contributed to by hospital porters placing a bariatric patient into a standard sized slide and failure to follow documented patient handling procedures.
78.	12554	Central Manchester University Hospitals NHS Foundation Trust	Accidental damage to a body	Damage to a body during a supervised post mortem examination by a trainee pathologist, resulting in need for additional reconstruction work.
79.	12554	Central Manchester University Hospitals NHS Foundation Trust	Major equipment failure	Major refrigeration equipment failure, necessitating the movement of bodies to alternative premises, in line with contingency arrangements.
80.	12554	Central Manchester University Hospitals NHS Foundation Trust	Accidental damage to a body	Unintended cuts to the skin of a body by a trainee pathologist during a post mortem.
81.	12554	Central Manchester University Hospitals NHS Foundation Trust	Post-mortem examination conducted was not in line with the consent given or the PM examination proceeded with inadequate consent	Removal of organs during post mortem following initial consent, which had been withdrawn, contributed to by failure in communication between ward and mortuary.
82.	12554	Central Manchester University Hospitals NHS Foundation Trust	Accidental damage to a body	Small graze to the arm of a deceased patient probably occurring during transfer into fridge.

HTA ref. no.	Reporting licence number	Reporting establishment	Incident classification	Summarised description of incident
83.	12554	Central Manchester University Hospitals NHS Foundation Trust	Accidental damage to a body	Incision made on the wrong area of a deceased patient's body, contributed to by human error and staff misunderstanding of instructions given.
84.	30008	Pathology Department Gloucester Royal Hospital	Accidental damage to a body	Minor damage to elbows of deceased, potentially caused by incorrect handling of patient when placed into store
85.	30008	Pathology Department Gloucester Royal Hospital	Accidental damage to a body	Minor damage to elbows of deceased, potentially caused by incorrect handling of patient when placed into store.
86.	30008	Pathology Department Gloucester Royal Hospital	Accidental damage to a body	Minor damage to the arm of a patient, caused by the failure to follow defined procedure requiring restraint of limbs when transferred from ward to mortuary and incorrect handling during transfer to store.
87.	30018	University Hospitals Coventry and Warwickshire	Discovery of an organ or tissue following post-mortem examination and release of body	Inadvertent retention of two tissue slides which should have been returned to next of kin.

We have considered whether to disclose the full description provided in each incident report and decided against this for the reasons set out below. We have instead provided a summarised description of each incident.

Section 31 FOIA

Section 31(1)(g) FOIA provides an exemption for "the exercise by any public authority of its functions for any of certain specified purposes". Those specified purposes include the purpose of "ascertaining whether circumstances which would justify regulatory action in pursuance of any enactment exist or may arise".

The HTA's functions, which are set out in general terms at section 15 of the Human Tissue Act 2004 (the Act), include superintending compliance with requirements imposed by, or under, Part 1 of the Act and with codes of practice made under the Act.

The HTA made a regulatory decision that all licensed establishments are required to report HTARIs to the HTA, partly so that we can identify trends and share learning across the sector, but also so that we can take regulatory action in appropriate cases, for example by attaching licence conditions to an establishment's licence. While it is a regulatory

requirement that licensed establishments must report HTARIs, we rely on establishments to supply detailed, frank and full accounts of incidents rather than adopting a 'tick box' approach to HTARI reporting. Establishments are encouraged to supply all relevant information at an appropriate level of detail so that regulatory action can be taken where necessary and also so that sector-wide risks can be identified and acted upon.

Our view is that the disclosure of the full incident description provided in HTARI reports in response to FOIA requests would have an adverse impact on the quality of HTARI reports supplied to us by licensed establishments, and in particular the level of detail supplied in the body of HTARI reports. Currently licensed establishments are very open with us when completing HTARI reports, but the prospect of disclosure under FOIA is likely to result in a cautious and restrictive approach to HTARI reporting because of fear of adverse publicity on the part of establishments.

Our assessment is that if establishments are deterred by the prospect of disclosure from providing us with detailed and frank reports this would clearly prejudice our supervisory functions in relation to licensed establishments and would make it more difficult for us to establish whether formal regulatory action is required in specific cases.

We are satisfied that full disclosure of the detail in the HTARI reports is information which, if disclosed, would prejudice our ability to exercise our regulatory functions insofar as they relate to the supervision of licensed centres and that section 31(1)(g) therefore applies.

Public interest test

Section 31 FOIA is a conditional or qualified exemption. This means that, even where it is considered to apply, it may be relied on only if the public interest in applying the exemption outweighs the public interest in disclosure.

We acknowledge that there is a significant public interest in accessing information regarding untoward incidents that take place in HTA licensed mortuaries and that there is also real public interest in access to information that relates to our effectiveness as a regulator. We also appreciate there is a public interest in openness and transparency generally.

We are mindful that we are already providing summary information regarding HTARIs reported to the HTA in 2013. This information gives a sufficiently full and fair indication of the nature of reported incidents and also identifies the licensed establishments involved. Given the information that has already been disclosed, we are not satisfied that disclosure of the full descriptions provided in the reports would be likely to add significantly to public understanding of the issues.

There are a number of reasons why it would be contrary to the public interest for the full substance of the reports to be disclosed. There is a very strong public interest in ensuring that licensed establishments are regulated effectively. As indicated above, the prospect of publication is likely to have an adverse effect on the quality of future HTARI reporting and there is a real risk that this in turn would have an adverse impact on our ability to scrutinise reported incidents and adherence to licence conditions and to identify cases where regulatory action is required.

Furthermore, we rely on the submission of full and frank HTARI reports from licensed establishments to enable us to identify trends or sector specific risks in order to issue alerts or guidance. The provision of frank and suitably detailed reports makes a very important contribution to our ability to raise standards and take appropriate action to prevent similar incidents happening elsewhere. In order to carry out this work, we need access to detailed information about incidents and the events which lead to them. It is clearly in the public interest that establishments should not be inhibited from supplying us with information at the necessary level of detail.

In view of the very considerable public interest in ensuring that licensed establishments should not be deterred from supplying us with the information we require in order to discharge our regulatory functions and promote safe practice, we have concluded that the public interest test in this case favours the application of the section 31(g) exemption to justify the summary disclosure rather than the full incident report. We do not believe that the public interest is served by providing a further level of detail which may jeopardise the effectiveness of the HTARI notification system, which in turn would reduce the effectiveness of our regulatory activity in this area.

Section 40 and section 41 Freedom of Information Act (FOIA)

In reviewing the information you requested we noted some of the descriptions contain information which is exempt by virtue of the fact that it is personal data, disclosure of which would be unfair to the individuals concerned, or which is confidential information relating to deceased individuals which could amount to personal data relating to some of their family members.

Section 40(3)(a)(i) FOIA provides that information is absolutely exempt if its disclosure would breach any of the Data Protection Act's data protection principles. Insofar as the documents contain information relating to identifiable staff members and relatives of deceased individuals, we have concluded that disclosure under FOIA would breach the first data protection principle. This is because it would be unfair to the individuals mentioned in the incident descriptions, who could have no expectation that information relating to them in the incident report descriptions would be made public.

Section 41 FOIA is also an absolute exemption. It applies to information supplied to us, disclosure of which would amount to a breach of confidence actionable by any person. It has been established in a series of decided cases that confidential information relating to deceased identifiable hospital patients is exempt from disclosure under section 41, given that the disclosure of such information to the public at large would give rise to an actionable breach of confidence.

In accordance with section 40 and section 41 of the FOIA the descriptions provided in this response have been summarised so that they do not include any information which could lead to a person being identified, such as names of staff, patients, causes of death and dates of birth and death.

Further information

The information we have provided relates only to HTA reportable incidents in the post mortem sector, as this is what we have discussed in correspondence and understand you were requesting. We also have reporting systems for the organ donation and human application sectors, and we would be happy to supply this information too.

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:

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

There is no charge for making an appeal.

Yours sincerely,

"[***redacted***]"
"[***redacted***]"