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[redacted]

By email to [redacted]

Date 26 February 2015

Dear [redacted]

Freedom of Information request

Thank you for your request for information under the Freedom of Information Act (FOI Act), which was received by the Human Tissue Authority (HTA) on 28 January 2015. Your email outlined the following request:

"Please accept this as a request for information under the FOI Act.

Could you please provide:

i) The number of HTA Reportable Incidents (HTARIs) that took place during 2013 and 2014;

ii) Please also provide a description of each incident and the classification given to each incident."

Response

The Human Tissue Act 2004 extends to England, Wales and Nortern Ireland; Scotland has its own legislation, the Human Tissue (Scotland) Act 2006 and the HTA does not license establishments in Scotland under the Human Tissue Act 2004.

We have performed a search of our licensing system and 176 HTA Reportable Incidents (HTARIs) were reported by licensed establishments in 2013 and 2014.

The classification and description of each of the HTARIs is in the table below:

Ref no	Incident classification	Description of HTARI
1	Release of the wrong body	Incorrect identification of deceased on release from mortuary. The error was corrected immediately upon discovery.

Ref no	Incident classification	Description of HTARI
2	Accidental damage to a body	Small cut to the forehead of a deceased patient happened 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	Release of the wrong body	Incorrect identification of deceased on release from mortuary. The error was corrected immediately upon discovery.
4	Major equipment failure	Major equipment failure leading to unintended freezing of stored fetuses.
5	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	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.
7	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 porters to follow guidance on storage of bariatric patients in wide slide spaces only.
8	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	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	Viewing of the wrong body	Viewing of the wrong body as a result of failure to follow documented procedures.
11	Viewing of the wrong body	Viewing of the wrong body, contributed to by failure in communication between mortuary staff and failure to follow documented identification procedures.
12	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.

Ref no	Incident classification	Description of HTARI
13	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	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.
15	Accidental damage to a body	Grazing to the arm of the deceased which occurred when the deceased was being placed into storage, as a result of ineffective placement of arm strapping by porter staff during transfer from ward.
16	Viewing of the wrong body	Viewing of the wrong body arising from a failure to follow documented identification procedures.
17	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	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	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	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	Removal of tissue from a body without authorisation or consent	Tissues retained at post mortem without appropriate authorisation.
22	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.

Ref no	Incident classification	Description of HTARI
23	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 an employee.
24	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	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	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 a method which was not the method requested by the family.
27	Loss of an organ	Inadvertent disposal of body part with clothing of deceased.
28	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	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.
30	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	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.

Ref no	Incident classification	Description of HTARI
32	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	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	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 to the patient.
35	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	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.
37	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	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	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	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.

Ref no	Incident classification	Description of HTARI
41	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	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	Loss of an organ	Loss of an organ following specialist examination, contributed to by failure to follow documented procedure for the storage of organs.
44	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	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	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	Post-mortem examination conducted was not in line with the consent given or the PM examination proceeded with inadequate consent	During a limited post mortem examination of the body an inadvertent incision was made in the skin of the scalp.
48	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 power failure within the body store.
49	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	Accidental damage to a body	Accidental damage to a body, contributed to by the fragility of the skin of the deceased and human error.

Ref no	Incident classification	Description of HTARI
51	Serious security breach	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	Serious security breach	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	Accidental damage to a body	Decomposition damage to bodies as a result of refrigeration equipment failure.
54	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 size of the deceased.
55	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	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	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	Major equipment failure	Failure of mortuary refrigeration equipment.
59	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	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	Release of the wrong body	Release of wrong body following post mortem examination contributed to by human error in transcribing patient details on report form. The error was corrected immediately upon discovery.
62	Accidental damage to a body	Decomposition of a body that was unable to be placed into the mortuary's refrigerated storage due to its size.

Ref no	Incident classification	Description of HTARI
63	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	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	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	Discovery of an organ or tissue following PME and release of body	Discovery of tissue inadvertently retained after release of body.
67	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.
68	Accidental damage to a body	Superficial scalp wound noted on a body in storage.
69	Accidental damage to a body	Superficial laceration to scalp noted on a body in storage.
70	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	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	Loss of an organ	Return of organ to the body for burial when it was needed for further examination by the pathologist.
73	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	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.

Ref no	Incident classification	Description of HTARI
75	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 post mortem examination due to statutory holiday, preventing viewing by the deceased's family.
76	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	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	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	Major equipment failure	Major refrigeration equipment failure, necessitating the movement of bodies to alternative premises, in line with contingency arrangements.
80	Accidental damage to a body	Unintended cuts to the skin of a body by a trainee pathologist during a post mortem.
81	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	Accidental damage to a body	Small graze to the arm of a deceased patient probably occurring during transfer into fridge.
83	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	Accidental damage to a body	Minor damage to elbows of deceased, potentially caused by incorrect handling of patient when placed into store.
85	Accidental damage to a body	Minor damage to elbows of deceased, potentially caused by incorrect handling of patient when placed into store.

Ref no	Incident classification	Description of HTARI
86	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	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.
88	Post-mortem examination conducted was not in line with consent given	The deceased was prepared for a post mortem and eviscerated before staff released it was the wrong body.
89	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
90	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination
91	Release of wrong body	The wrong body was released to the funeral director. The body was returned to mortuary as soon as the mistake was discovered.
92	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	A bariatric body was received out of hours; there was no contingency storage and the deceased had to be stored overnight in the post-mortem room.
93	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	The cremation of a fetus was planned to take place but transport had not turned up to collect it. Mortuary staff noticed the paperwork relating to the fetus, which had remained in the mortuary.
94	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Two families had been informed that their products of conception would be cremated. However, Histopathology staff discovered these products of conception specimens remained in storage in the laboratory.
95	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
96	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Failure to place a body in deep freeze while in prolonged storage at mortuary, prior to release for burial to funeral director.

Ref no	Incident classification	Description of HTARI
97	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Toxicology sample was lost that may result in unascertained cause of death.
98	Inadvertent disposal or retention of an organ against wishes of the family	A body was released to the funeral director after post mortem in which the brain had been retained. Shortly after, it was noted that the brain had not been repatriated with the body. The brain was immediately taken to the undertakers and repatriated with the body.
99	Viewing of the wrong body	The wrong body was prepared for a viewing by the family.
100	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	The deceased, a bariatric patient, had been stored in the freezer compartment of the body storage. Due to the way the body had frozen, the body was not able to be removed from the compartment in time for the funeral. The funeral was delayed until the freezer thawed to allow the release of the deceased.
101	Accidental damage to a body	Minor damage to the body of a deceased person while being removed from a mortuary fridge.
102	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	The family of the deceased made a complaint regarding the condition of the deceased's hair, which they had requested be returned to them.
103	Accidental damage to a body	Minor damage occurred to the body of a deceased person during transfer to the mortuary.
104	Discovery of an organ or tissue following post-mortem examination and release of body	A pathologist removed a brain from the deceased for examination. Standard procedure was followed and it was indicated on the body that organs needed to be repatriated. When the funeral director came to collect the body it was noted that the brain had not been repatriated. The body was released with the brain and a mortuary employee attended the funeral directors to repatriate the brain.
105	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
106	Discovery of an organ or tissue following post-mortem examination and release of body	A post mortem was conducted which included removing the heart and other tissue samples. The family had requested that all tissue be returned to the body prior to release. However, one sample was found years later during a checks of the frozen tissue store.

Ref no	Incident classification	Description of HTARI
107	Release of wrong body	There were two patients of the same name in the Department. Correct procedures were followed to identify them in the Mortuary. The funeral director was given the Cremation forms for the wrong patient by the Bereavement Office, and the Mortuary staff released the correct patient for the paperwork that was presented.
108	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	A mortuary fridge used for the storage or fetuses for the end of month service failed over the weekend. The fridge failure was not identified until routine fridge temperature monitoring. The fridge contained fetuses of under 20 weeks gestation at the time of the failure.
109	Accidental damage to a body	Minor damage to the body of a deceased person while being placed in the mortuary.
110	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Following an FOI inquiry regarding fetal disposal, a backlog was identified in regards to timely disposal of fetal remains following a termination of pregnancy or miscarriage under 24 weeks of gestation.
111	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	A formal complaint resulting from the viewing of a deceased patient by a family member, which was contrary to the wishes of the deceased's next of kin.
112	Post-mortem examination of the wrong body	Whilst labelling retained specimens, the pathologist noted that the specimen labels did not match the name on the toe-tag of the body. It was therefore established that the wrong body had been laid out for post mortem.
113	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Fetal specimen was lost in transit between theatres.
114	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
115	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
116	Release of wrong body	The wrong body was released to the funeral director. The body was returned to mortuary as soon as the mistake was discovered.

Ref no	Incident classification	Description of HTARI
117	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	After transfer from the body store at the hub premises to the mortuary fridge at the satellite premises, seven fetuses were released for cremation without proper checks of the associated paperwork. Two of the fetuses should have been buried.
118	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
119	Discovery of an organ or tissue following post-mortem examination and release of body	Toxicological samples were mistakenly not released with the rest of a deceased patient's tissue. The samples were found in the fridge when a separate patient's samples were being released.
120	Release of wrong body	The wrong body was released to the funeral director. The body was returned to mortuary as soon as the mistake was discovered.
121	Discovery of an additional organ(s) in a body on evisceration for a second post-mortem examination	Undertaker discovered a brain with other organs within the abdominal cavity of the deceased when starting the embalming process. The undertaker noticed the head of the deceased had not been opened in the post mortem examination and so the brain did not belong to the deceased. The brain was found to belong to a patient who had undergone a post mortem examination at the same time and was repatriated to the correct patient.
122	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	When returning to take a further histological block from products of conception specimen, part of the specimen wasn't in the container. This did not compromise the diagnostic assessment of the specimen but, the tissue was not able to be located.
123	Accidental damage to a body	The bodies of two deceased infants were not sent to the mortuary as soon as they should have been. When the error was realised one body was found to have severely deteriorated.
124	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
125	Major equipment failure	A fetus was sent to another hospital for a post mortem, however upon receiving the fetus the hospital realised that it was frozen. The temperature of the mortuary fridge was checked and was -7.5C; other fetuses were also frozen and removed from the fridge immediately.
126	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.

Ref no	Incident classification	Description of HTARI
127	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
128	Accidental damage to a body	There was no available deep freeze capacity as all available spaces were occupied. The body was stored in a body bag within a standard fridge with frequent checking of condition. During this period there were no records of any adverse temperature changes in this facility. On checking the body an odour had developed and there were signs of facial decomposition
129	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
130	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Fetus transferred for post mortem examination but traceability was lost. Searches of fridges carried out but not thoroughly enough. On third search fetus found.
131	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	An organ was discovered in the mortuary which should have been transferred to a research establishment approximately a year earlier.
132	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
133	Discovery of an organ or tissue following post-mortem examination and release of body	A block of tissue was separated from 11 others which were all supposed to be interred with the body at the funeral. The missing block was found the next day and returned to the body whilst at the funeral home.
134	Accidental damage to a bod	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
135	Major equipment failure	Fridge failure caused by an open door. No deterioration to bodies as bodies were moved. New door lock fitted and now daily checks on doors are made before leaving.
136	Accidental damage to a body	Minor damage to the body of a deceased person occurred whilst in mortuary.
137	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Products of conception tissues were disposed of against wishes of the mother. The mother had initially asked the hospital to dispose of the tissue, but changed her instructions and this information was not shared with the pathology laboratory.

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138	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Tissue blocks which had been taken from a deceased patient during the post mortem examination were mislaid.
139	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Ward staff attached the wrong ID bands to the deceased, but entered the correct details onto the notification form. On receipt at mortuary, the form was used to enter details in the register (ID bands not checked) and a mortuary wrist band attached with the correct details. On release, only mortuary band and paperwork were used to ID body. Funeral directors noted the incorrect bands while preparing the body.
140	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Communication was made between the family and staff in the Trust with regard to tissue destination / disposal. The tissue was cremated. The family had wanted the tissue returned for burial.
141	Viewing of the wrong body	The wrong body was prepared for a viewing by their family.
142	Disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family	A fetus was sent to the crematorium for a hospital-arranged cremation. Consent for a cremation had been given and the paperwork had been completed, but the mother had not decided which funeral option to take and had not contacted the hospital to arrange a contract or a private funeral.
143	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	A patient arrived unexpectedly at the Bereavement Office. The office contacted the mortuary to ascertain the whereabouts of her products of conception and realised they had been sent for cremation. On checking consent paperwork, it was confirmed that the patient had wished to make her own arrangements for disposal.
144	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
145	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
146	Serious security breach	An individual breached security online and uploaded an image and description of what they had seen during the decommissioning of the mortuary.
147	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.

Ref no	Incident classification	Description of HTARI
148	Release of wrong body	The wrong fetus was released to the funeral director. The fetus was returned to mortuary as soon as the mistake was discovered.
149	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	An early term fetus went missing. The parents had requested an individual cremation for the remains, but on investigation it became evident that the pregnancy remains had been sent to the crematorium for shared cremation.
150	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
151	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Use of an outdated version of a transfer form meant that an adult hospital post mortem examination which should have taken place, did not proceed.
152	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Two rings worn by the deceased were found to be missing when the funeral directors collected the body.
153	Accidental damage to a body	Minor damage to the body of a deceased person while being removed from a mortuary fridge.
154	Release of wrong body	The wrong body was released to the funeral director. The body was returned to mortuary as soon as the mistake was discovered.
155	Major equipment failure	When opening the fridges to remove a body for post mortem, the body was found to be frozen. The alarms were not working and the fridge temperature was not being monitored correctly
156	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
157	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Due to severe disruption of the body, the deceased's head and body were wrapped carefully after reconstruction and the body placed in a body bag with the zips closed; the following morning, the zips were found to have been opened. No further bodies had been placed in the fridge and there was no reason for the body to have been disturbed.

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158	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Three products of conception were accidently disposed of via the anatomical waste incineration route rather than the cremation route.
159	Accidental damage to a body	Deceased was in body bag placed on top of washington trolley cover. Straps released prior to checking body located in correct position on trolley. Deceased was not central and fell off.
160	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
161	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
162	Serious security breach	An unauthorised individual gained access to the mortuary premises before being found by staff.
163	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
164	Release of wrong body	The wrong body was released to the funeral director. The body was returned to mortuary as soon as the mistake was discovered.
165	Serious security breach	Unauthorised access by a contractor to the lavatory in the mortuary viewing suite, the main door to which had been left unlocked for a family viewing due to fire regulations.
166	Serious security breach	Unauthorised access by a patient to the viewing room due to card reader failure (observed on CCTV).
167	Incident leading to the temporary unplanned closure of mortuary	A failure in the air extraction and recirculation system resulted in an unsafe working environment within the main post mortem examination room.
168	Post-mortem examination conducted was not in line with consent given	A post mortem was carried out on an infant, when the consent form stated consent for an external examination only had been given.
169	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	A body was released without blocks and slides having been returned, which was contrary to the wishes of the deceased's family.

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170	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Individually packed fetuses were taken to the crematorium for cremation on the wrong day and were sent back to the mortuary; when they were subsequently sent to the crematorium, one fetus was found to be missing.
171	Post-mortem examination conducted was not in line with consent given	A CT scan was conducted, with consent from the family, prior to post mortem examination. The deceased was cannulated and ventilated as part of the CT scan procedure, although the consent given did not include consent for these procedures.
172	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
173	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence.	A fetus was stored in the refrigerated unit on the delivery suite. It was only noticed that it was still being retained after a midwife contacted the suite the following month. Consent forms had not been completed with family so the fetus had not been referred on for examination.
174	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
175	Serious security breach	An unauthorised individual gained access to the mortuary premises before being found by staff.
176	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Fetus cremated against the wishes of the family.

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

There is no charge for making an appeal.

Yours sincerely

[redacted]

[redacted]