Human Tissue Authority
151 Buckingham Palace Road
London
SW1W 9SZ

Tel 020 7269 1900
Web www.hta.gov.uk
Email [redacted]

[redacted]

By email to [redacted]

Date 16 February 2016

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 18 January 2016. Your email outlined the following request:

"Please could the following information be released under the Freedom of Information Act?

1) The number of HTA Reportable Incidents (HTARIs) that took place during 2014 and 2015, where they took place and when

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

Response

We have performed a search of our licensing system and 195 HTA Reportable Incidents (HTARIs) were reported in 2014 and 2015. The data you requested are provided in the table below.

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 can be found here. 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 establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
1	Queen's Hospital, Barking, Havering & Redbridge Hospitals NHS Trust	Jan-14	Post-mortem examination conducted was not in line with consent given	The deceased was prepared for a post mortem and eviscerated before staff realised it was the wrong body.
2	Worthing Hospital	Jan-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
3	Tameside General Hospital	Jan-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
4	QE II Hospital	Jan-14	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.
5	Wrightington, Wigan & Leigh NHS Trust	Jan-14	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.
6	Countess of Chester	Jan-14	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.
7	Doncaster Royal Infirmary	Jan-14	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

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
8	Princess Alexandra Hospital	Jan-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge
9	Miller House Mortuary	Jan-14	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.
10	Leicester Royal Infirmary	Jan-14	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.
11	Leicester Royal Infirmary	Jan-14	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.
12	Gloucester Royal Hospital	Jan-14	Viewing of the wrong body	The wrong body was prepared for a viewing by the family.
13	King's College Hospital	Jan-14	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. The funeral was delayed until freezer thawed to allow the release of the deceased.
14	St Michael's Hospital	Feb-14	Accidental damage to a body	Minor damage to the body of a deceased person while being removed from a mortuary fridge.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
15	King's College Hospital	Feb-14	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.
16	Wednesfield Public Mortuary	Feb-14	Accidental damage to a body	Minor damage occurred to the body of a deceased person during transfer to the mortuary.
17	Pinderfields Public Mortuary	Feb-14	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.
18	Kettering General Hospital	Feb-14	Removal of tissue from a body without authorisation or consent	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 checks of the frozen tissue store.
19	Medway Maritime Hospital	Feb-14	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
20	Gloucester Royal Hospital	Feb-14	Release of wrong body	There were two patients of the same name. 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

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
				Office, and the Mortuary staff released the correct patient for the paperwork that was presented.
21	Central Manchester University Hospital	Feb-14	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 of 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.
22	State Pathologist's Department	Feb-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed in the mortuary.
23	Manor Hospital	Feb-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	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.
24	University Hospitals of North Midlands NHS Trust	Feb-14	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.
25	State Pathologist's Department	Feb-14	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.
26	Craigavon Area Hospital	Feb-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	Fetal specimen was lost in transit between theatres.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
27	Medico-Legal Centre	Mar-14	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Staff misunderstood limit of consent given for scanning procedure, resulting in an invasive procedure
28	Royal Liverpool University Hospital	Mar-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
29	Worcestershire Royal Hospital	Mar-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
30	Heart of England NHS Foundation Trust	Mar-14	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.
31	The Pennine Acute Hospitals NHS Trust	Mar-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	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.
32	Victoria Hospital	Mar-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
33	Brighton and Hove City Mortuary	Mar-14	Discovery of an organ or tissue following post-mortem examination and release of body	Following a coronial autopsy, tissue was retained in formalin in case needed for histological examination. The pot was placed on the wrong fridge tray and was discovered after the funeral had taken place. The family was kept fully informed once the discovery had been made.
34	The Christie	Mar-14	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

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
				discovered.
35	Warwick Hospital	Mar-14	Discovery of an additional organ(s) in a body on evisceration for a second post-mortem examination	Undertaker discovered a brain with other organs in the organ bag 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.
36	Pathlinks	Apr-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	When returning to take a further histological block from a products of conception specimen, part of the specimen was not in the container. This did not compromise the diagnostic assessment of the specimen but, the tissue was not able to be located.
37	Medway Maritime Hospital	Apr-14	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.
38	King's College Hospital	Apr-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
39	East Surrey Hospital	Apr-14	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.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
40	William Harvey Hospital Mortuary	Apr-14	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
41	Cumberland Infirmary	May-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
42	Southampton General Hospital	May-14	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.
43	St George's Hospital	May-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
44	Central Manchester University Hospitals NHS Foundation Trust	May-14	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Fetus transferred for post mortem but traceability lost. Searches of fridges carried out but not thoroughly enough. On third search, fetus found.
45	Craigavon Area Hospital	May-14	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.
46	Southport & Formby District General Hospital	May-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
47	Norfolk and Norwich University Hospital	Jun-14	Discovery of an organ or tissue following post-mortem examination	A block of tissue was separated from 11 others which were all supposed to be interred with the body at the funeral. The missing

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
			and release of body	block was found the next day and returned to the body whilst at the funeral home.
48	Royal Bolton Hospital	Jun-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
49	Royal Liverpool University Hospital	Jun-14	Major equipment failure	Fridge failure caused by an open door. No deterioration to bodies as bodies were moved. New door lock fitted and checks on doors made before leaving.
50	Worcestershire Royal Hospital	Jun-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred whilst in mortuary.
51	Craigavon Area Hospital	Jun-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	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.
52	Southmead Hospital Bristol	Jul-14	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.
53	Leicester Royal Infirmary	Jul-14	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.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
54	Royal Victoria Hospital	Jul-14	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.
55	Whiston Hospital	Jul-14	Viewing of the wrong body	The wrong body was prepared for a viewing by their family.
56	Victoria Hospital	Jul-14	Disposal or retention of a whole fetus or fetal tissue more than 24 weeks	Arrangements for the burial of a fetus did not meet the mother's wishes.
57	Pathlinks	Jul-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	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.
58	Royal Sussex County Hospital	Jul-14	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
59	Gloucester Royal Hospital	Jul-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
60	Southmead Hospital Bristol	Aug-14	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.
61	Worcestershire Royal Hospital	Aug-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
62	Heart of England NHS Foundation Trust	Aug-14	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.
63	Pathlinks	Aug-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	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.
64	Alexandra Hospital	Aug-14	Major equipment failure	A bank of mortuary fridges for adult bodies stopped functioning, causing its internal temperature to rise.
65	Royal Victoria Hospital	Aug-14	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 PM examination which should have taken place, did not proceed.
66	West Suffolk Hospital	Aug-14	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.
67	Pinderfields Hospital	Aug-14	Accidental damage to a body	Minor damage to the body of a deceased person while being removed from a mortuary fridge.
68	Arrowe Park Hospital	Aug-14	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.
69	Pinderfields Hospital	Sep-14	Incident leading to the temporary unplanned closure of mortuary	When opening the fridges to remove a body for post mortem it was noted that the body was extremely cold, on undressing the body was frozen. The alarms

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
				were not working and the fridge temperature was not being monitored correctly.
70	Sheffield Children's Hospital	Sep-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
71	Bedford Hospital	Sep-14	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.
72	Royal Lancaster Infirmary	Oct-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	Three products of conception specimens were accidently disposed of via the anatomical waste incineration route rather than the cremation route.
73	Eastbourne District General Hospital	Oct-14	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.
74	Tameside General Hospital	Oct-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.
75	Taunton and Somerset NHS Trust	Oct-14	Accidental damage to a body	Minor damage to the body of a deceased person occurred in the course of a post mortem examination.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
76	UCL Hospitals NHS Foundation Trust	Oct-14	Serious security breach	An unauthorised individual gained access to the mortuary premises before being found by staff.
77	Derriford Hospital	Oct-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
78	Guy's & St Thomas' Hospital	Nov-14	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.
79	Royal Berkshire Hospital	Nov-14	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.
80	Royal Berkshire Hospital	Dec-14	Serious security breach	Unauthorised access by a patient (due to card reader failure) to the viewing room (observed on CCTV).
81	St George's Hospital	Dec-14	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.
82	The Royal London Hospital	Dec-14	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.
83	Guy's & St Thomas' Hospital	Dec-14	Disposal or retention of a whole fetus or fetal tissue less than 24 weeks	A body was released without blocks and slides having been returned, which was contrary to the wishes of the deceased's family.
84	Arrowe Park Hospital	Dec-14	Any incident not listed here that could result in adverse publicity that may	Individually packed fetuses were taken to the crematorium for cremation on the wrong day and were sent back to the mortuary;

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
			lead to damage in public confidence	when they were subsequently sent to the crematorium, one fetus was found to be missing.
85	Leicester Royal Infirmary	Dec-14	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.
86	Victoria Hospital	Dec-14	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Contingency arrangements for body storage insufficient for the capacity required over Christmas and New Year.
87	Cumberland Infirmary	Dec-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
88	Cumberland Infirmary	Dec-14	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
89	Royal Hampshire County Hospital	Jan-15	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
90	Countess of Chester Hospital	Jan-15	Release of the wrong body	Human error and failure to follow documented procedure resulted in the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
91	Basildon Hospital	Jan-15	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Error in completing release form led to the fetus being released for cremation in error.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
92	Medway Maritime Hospital	Jan-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Insufficient capacity to store bodies due to winter pressures.
93	Leeds General Infirmary	Jan-15	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
94	Haringey Public Mortuary	Jan-15	Release of the wrong body	Human error led to release of the wrong body to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
95	Royal Glamorgan Hospital	Jan-15	Viewing of the wrong body	Human error led to the viewing of the wrong body.
96	Royal Victoria Infirmary	Jan-15	Release of the wrong body	Human error led to release of the wrong body. The body was returned to the mortuary as soon as the mistake was discovered.
97	Royal Victoria Infirmary	Jan-15	Accidental damage to a body	Minor damage to body of deceased person during PM examination.
98	King's College Hospital	Jan-15	Discovery of an organ or tissue following post-mortem examination and release of body	Due to lack of rigorous audit procedures, retained blocks and slides were not identified.
99	King's College Hospital	Jan-15	Viewing of the wrong body	Human error led to the viewing of the wrong body.
100	Derriford Hospital	Feb-15	Inadvertent disposal or retention of an organ against the express wishes of the family	Miscommunication between the coroner and the mortuary team resulted in blocks and slides not being repatriated with a body before release.
101	Manor hospital	Feb-15	Any incident not listed here that could result in adverse	A filing error led to delay in locating blocks from one case.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
			publicity that may lead to damage in public confidence	
102	Royal Sussex County Hospital	Feb-15	Accidental damage to a body	Accidental damage to the body of the deceased.
103	Royal Cornwall Hospital	Feb-15	Discovery of an organ or tissue following post-mortem examination and release of body	Failure to document removal of organ during post-mortem examination.
104	Darent Valley Hospital	Feb-15	Release of the wrong body	Human error led to the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
105	Worthing Hospital	Feb-15	Accidental damage to a body	Small laceration to scalp of body during removal from fridge.
106	Good Hope Hospital	Feb-15	Release of the wrong body	The wrong body was released from the establishment's contingency body store at a funeral directors to the mortuary, and subsequently cremated.
107	University Hospital of North Tees	Feb-15	Release of the wrong body	The wrong body was released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
108	Colchester General Hospital	Mar-15	Accidental damage to a body	Human error resulted in accidental damage when the deceased was placed into fridge.
109	Colchester General Hospital	Mar-15	Accidental damage to a body	Human error resulted in accidental damage to the body of a deceased person while being placed into a mortuary fridge.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
110	Brighton & Hove City Mortuary	Mar-15	Post mortem examination conducted was not in line with the consent given or the post-mortem examination proceeded with inadequate consent	Due to ineffective communication, a post mortem examination was conducted without coronial authorisation.
111	Arrowe Park Hospital	Mar-15	Major equipment failure	Hospital-wide power outage led to fridge failure.
112	Chesterfield Royal Hospital	Mar-15	Accidental damage to a body	Human error led to minor damage to the body of a deceased person occurring in the course of a post mortem examination.
113	Southport & Formby District General Hospital	Mar-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Administrative error led to blocks and slides being inadvertently disposed of.
114	Hemel Hempstead General Hospital	Mar-15	Release of the wrong body	Human error led to the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
115	Hemel Hempstead General Hospital	Mar-15	Major equipment failure	Mortuary fridge failure.
116	York Teaching Hospital NHS Foundation Trust	Mar-15	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 the accidental disposal of a fetus.
117	Birmingham Children's Hospital	Mar-15	Any incident not listed here that could result in adverse publicity that may	A delay in providing the written PM examination report to the parents led to a complaint.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
			lead to damage in public confidence	
118	Eastbourne District General Hospital	Mar-15	Serious security breach	Unauthorised access to mortuary out of hours.
119	Royal Victoria Hospital	Mar-15	Inadvertent disposal or retention of an organ against the express wishes of the family	Communication failures led to inadvertent retention of an organ against the family's wishes.
120	St Thomas' Hospital	Mar-15	Release of the wrong body	Human error in recording details of a referring hospital in a patient record resulted in the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
121	Wycombe Hospital	Mar-15	Major equipment failure	Mortuary fridge failure.
122	University Hospital Lewisham	Mar-15	Release of the wrong body	Human error led to the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
123	Sunderland Royal Hospital	Mar-15	Release of the wrong body	Human error led to the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
124	Queen's Hosptial	Mar-15	Accidental damage to a body	Human error led to minor damage to a deceased person whist being placed into mortuary fridge.
125	Royal Victoria Infirmary	Mar-15	Accidental damage to a body	Human error led to minor damage to the body of a deceased person occurring in the course of a post mortem examination.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
126	Royal Victoria Infirmary	Mar-15	Accidental damage to a body	Human error resulted in minor damage to the body of the deceased occurred during a post mortem examination.
127	William Harvey Hospital	Mar-15	Viewing of the wrong body	Human error led to the viewing of the wrong body.
128	Norfolk and Norwich University	Apr-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Concerns raised with establishment regarding handling of pregnancy remains.
129	Derriford Hospital	Apr-15	Release of the wrong body	Human error resulted in the release of the wrong body. The body was returned to the mortuary as soon as the mistake was discovered.
130	Medico-Legal Centre	Apr-15	Release of the wrong body	Due to an administration error, the wrong body was released to the funeral director. The body was returned as soon as the error was noticed.
131	Queen Elizabeth Hospital	Apr-15	Accidental damage to a body	Body not placed in correct location within the mortuary led to accidental damage of the body.
132	Cannock Chase Public Mortuary	Apr-15	Release of the wrong body	As a result of human error, the wrong body was released to the funeral director. The body was returned to the mortuary as soon as the mistake was discovered.
133	Pathlinks	Apr-15	Accidental damage to a body	Failure to follow procedure resulted in minor damage to a body while being stored in the mortuary.
134	King's College Hospital	Apr-15	Release of the wrong body	Due to human error, the wrong body was transferred to another establishment for post mortem examination. It was returned as soon as the mistake was discovered and no post mortem

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
				examination took place.
135	Northern General Hospital	Apr-15	Accidental damage to a body	Due to the morphology of the deceased, minor damage to the body was sustained while being removed from the fridge.
136	Flax Bourton Public Mortuary	Apr-15	Accidental damage to a body	Due to the clinical history and frailty of the deceased, minor damage occurred to their body during undressing.
137	St Mary's Hospital	Apr-15	Major equipment failure	Power cut led to fridge failure.
138	Manchester Royal Infirmary	Apr-15	Viewing of the wrong body	Identification error, led to the viewing of the wrong body.
139	Leicester Royal Infirmary	Apr-15	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 inappropriate disposal of pregnancy remains.
140	Craigavon Area Hospital	May-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Post-mortem samples taken with consent, but on unlicensed premises.
141	Craigavon Area Hospital	May-15	Release of the wrong body	Due to human error, the wrong body was released to the funeral director. The body was returned as soon as the error was noticed.
142	Leeds General Infirmary	May-15	Release of the wrong body	Human error led to the release of the wrong body to the funeral director. The body was returned to the Mortuary as soon as the mistake was discovered.
143	Queen's Medical Centre	May-15	Discovery of an organ or tissue following post-mortem examination and release of body	Release of body for funeral before the blocks & slides had been repatriated in accordance with the wishes of the family.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
144	Royal Glamorgan Hospital	May-15	Viewing of the wrong body	Due to human error, the wrong body was prepared and presented for viewing by the family.
145	St George's Hospital	May-15	Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services	Poor communication led to temporary unplanned closure of the mortuary.
146	Morriston Hospital	May-15	Release of the wrong body	Human error led to release of the wrong body to the funeral director.
147	Countess Chester Hospital	May-15	Serious security breach	Failure to follow the establishment's procedures resulted in unauthorised access to the mortuary.
148	Papworth Hospital	May-15	Discovery of an organ or tissue following post-mortem examination and release of body	Due to a failure to follow procedures, toxicology samples were not sent for analysis as they should have been.
149	Queen's Medical Centre	May-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Due to an error, the wrong clinical history was provided to the pathologist prior to their conducting a Coroner’s post mortem examination.
150	The Royal Stoke University Hospital	Jun-15	Release of the wrong body	Error led to the release of the wrong body to the funeral director. The body was returned to the Mortuary as soon as the mistake was discovered.
151	The Royal Stoke University Hospital	Jun-15	Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services	Chemical incident led to unplanned temporary closure of mortuary.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
152	Queen's Medical Centre	Jun-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Concerns raised about information provided to relatives of the deceased.
153	St Mary's Hospital	Jun-15	Serious security breach	Failure to follow the establishment's procedures resulted in unauthorised access to the mortuary.
154	Peterborough City Hospital	Jun-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Allegation received from a member of the public that there was damage to a body whilst it was in the mortuary.
155	St Thomas' Hospital	Jun-15	Major equipment failure	Temporary fault with the chiller unit in the post mortem room led to delay in some post mortem examinations being carried out.
156	Manchester Royal Infirmary	Jun-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Poor technique resulted in poor reconstruction of deceased.
157	William Harvey Hospital	Jun-15	Accidental damage to a body	Minor damage to the body of a deceased person while being placed into a mortuary fridge.
158	The Ipswich Hospital	Jul-15	Accidental damage to a body	Accidental damage to body due to manual handling problems when placing the body into the fridge.
159	North Devon District Hospital	Jul-15	Accidental damage to a body	Failure to follow proper procedure led to accidental damage to a body.
160	Musgrove Park Hospital	Jul-15	Accidental damage to a body	Human error led to accidental damage to a body during post-mortem examination.
161	Leicester Royal Infirmary	Jul-15	Accidental damage to a body	Human error led to minor damage to a body.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
162	Cumberland Infirmary	Jul-15	Accidental damage to a body	Minor damage caused to the deceased's hand when the body was being removed from a fridge.
163	St George's Hospital	Jul-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Body being stored in a temporary fridge unit led to accelerated decomposition of the body.
164	Queen's Medical Centre	Jul-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Due to poor communication and record keeping, an organ was not sent promptly to another establishment for specialist examination.
165	St George's Hospital	Jul-15	Major equipment failure	Failure of the power supply led to failure of three fridges.
166	University Hospitals Coventry and Warwickshire	Jul-15	Viewing of the wrong body	Due to poor communication, the family was taken into the viewing room to view the wrong body.
167	Southmead Hospital	Aug-15	Accidental damage to a body	Due to human error, a body was damaged while being removed from a mortuary fridge.
168	Derriford Hospital	Aug-15	Accidental damage to a body	Human error led to minor damage to a body whilst it was being placed into a mortuary fridge.
169	Mid Essex Hospital	Aug-15	Accidental damage to a body	Human error led to minor damage to a body whilst it was being placed into mortuary fridge.
170	St Thomas' Hospital	Aug-15	Accidental damage to a body	Human error led to a body being left out of the fridge for longer than planned resulting in slight decomposition.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
171	The Royal Stoke University Hospital	Aug-15	Accidental damage to a body	Human error led to accidental damage to a body.
172	King's Mill Hospital	Aug-15	Accidental damage to a body	Human error resulted in accidental damage to a body.
173	Sheffield Childrens Hospital	Aug-15	Discovery of an organ or tissue following post-mortem examination and release of body	Due to ineffective recording systems for tissues and organs removed under PACE, the establishment was not aware that these tissues and organs were being stored on-site.
174	The Royal London Hospital	Aug-15	Release of the wrong body	Failure of staff member to follow mortuary procedures led to the wrong body being released to the funeral director. The body was returned to the mortuary as soon as the mistake was identified.
175	Broomfield Hospital	Aug-15	Release of the wrong body	Human error led to release of the wrong body. The body was returned to the mortuary as soon as the mistake was identified.
176	City of Westminster Public Mortuary	Aug-15	Viewing of the wrong body	Administrative error led to a family viewing the wrong body.
177	University Hospitals Coventry and Warwickshire	Sep-15	Accidental damage to a body	Human error led to accidental damage to a body.
178	Glangwili General Hospital	Sep-15	Accidental damage to a body	Human error resulted in accidental damage to a body.
179	Royal Cornwall Hospital	Sep-15	Accidental damage to a body	Failure to follow correct procedures when placing a body into the fridge caused damage to the deceased.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
180	Countess of Chester Hospital	Sep-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	The standard procedure for release of a body to another licensed establishment was not followed by a member of the portering staff.
181	North Tyneside General Hospital	Sep-15	Release of the wrong body	An administrative error led to the release of the wrong body to a funeral director, the incident was rectified quickly once the error was discovered.
182	St Marys Hospital	Sep-15	Viewing of the wrong body	Ineffective communication between departments led to viewing of the wrong body.
183	Royal Sussex County Hospital	Nov-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	A delay in paperwork resulted in a delay in the arrangement of a post-mortem examination for a 21 week fetus.
184	The Royal Stoke University Hospital	Oct-15	Accidental damage to a body	Accidental damage to the deceased, the cause has yet to be confirmed.
185	Darent Valley Hospital	Oct-15	Major equipment failure	The alarm on the mortuary fridges failed to notify staff when the temperature increased to 13C during the weekend. No apparent impact on bodies in storage.
186	St Thomas' Hospital	Oct-15	Viewing of the wrong body	Human error led to viewing of the wrong body.
187	Stepping Hill Hospital	Nov-15	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Tissue blocks and slides were disposed of in error, against the family's instructions.
188	Uxbridge Mortuary	Nov-15	Any incident not listed here that could result in adverse publicity that may	Complaint from family regarding post mortem changes occurring during storage.

HTA ref. no.	Reporting establishment	Month HTARI occurred	Incident classification	Summarised description of HTARI
			lead to damage in public confidence	
189	Frimley Park Hospital	Nov-15	Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services	Replacement of mortuary floor took longer than expected leading to unplanned closure of mortuary for PM examinations.
190	Stepping Hill Hospital	Dec-15	Accidental damage to a body	Accidental damage to a body during post-mortem examination.
191	James Paget University Hospital	Dec-15	Accidental damage to a body	Accidental damage to a body during trolley transfer.
192	Wednesfield Public Mortuary	Dec-15	Accidental damage to a body	Human error resulted in the accidental damage to a body.
193	St Thomas' Hospital	Dec-15	Release of the wrong body	Human error led to the wrong body being released.
194	North Tyneside General Hospital	Dec-15	Viewing of the wrong body	Human error resulted in viewing of the wrong body.
195	Tunbridge Wells Hospital	Dec-15	Viewing of the wrong body	Human error led to the wrong body being removed for viewing.

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]