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Date 10 February 2017

[redacted]

By email to [redacted]

Dear [redacted]

Freedom of Information request

Thank you for your request for information under the Freedom of Information Act (FOIA), which was received by the Human Tissue Authority (HTA) on 20 January 2017. Your email outlined the following request:

> Enquiry details: 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 2016, where they took place and when?
>
> 2) Please also provide a description of each incident and the classification given to each incident.

Response

I can confirm that 83 post-mortem HTARIs were reported during 2016. The location, month of the incident, a description and the classification of each incident is set out in the table below.

Case Number	Name of Licensed Establishment	HTARI Month 2016	HTARI Classification	Description of Incident
CAS-33527-Z1T4	East Surrey Hospital	January	Accidental damage to a body	Mechanical trolley failure resulted in accidental damage to a body.
CAS-33639-M3B7	Central Manchester University Hospitals	January	Release of the wrong body	Due to human error, the wrong body was released to the funeral director.
CAS-33640-S4T8	St George's Hospital	January	Major equipment failure	Temporary failure of the fridges in the mortuary. No damage to bodies occurred.
CAS-33689-H6G0	Huddersfield Royal Infirmary	January	Serious security breach	Human error resulted in serious security breach
CAS-33695-M9C5	St George's Hospital	January	Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services	Delay of PM examinations due to flooding and loss of hot water supply in the mortuary.
CAS-33721-S9T8	Northampton General Hospital	January	Accidental damage to a body	Human error resulted in accidental damage to a body.
CAS-33746-B8M3	Peterborough City Hospital	January	Discovery of an organ or tissue following post-mortem examination and release of body	Human error resulted in retention of blocks and slides following PM and release of body
CAS-33753-T8G1	Lister Hospital, Stevenage	January	Post-mortem examination of the wrong body	Human error resulted in a post-mortem examination being carried out on the wrong body where two individuals had similar names.

CAS-33889-R8P8	King's College Hospital	February	Disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family	Human error led to a delay in the funeral arrangements of a fetus
CAS-33937-Q4Q2	Chesterfield Royal Hospital	February	Viewing of the wrong body	Human error resulted in viewing of the wrong body
CAS-33983-S6Q7	Arrowe Park Hospital, Mortuary	February	Release of the wrong body	A bank of fridges failed in the mortuary. Bodies were moved while the fridge was repaired. No damage to bodies occurred
CAS-34041-N7J3	Birmingham Women's Hospital	March	Discovery of an organ or tissue following post-mortem examination and release of body	Human error resulted in body release prior to return of an organ
CAS-34049-H6V7	Hammersmith Hospital	March	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Human error resulted in release of body without PM examination
CAS-34075-G7Y5	Dorset County Hospital	March	Accidental damage to a body	Human error resulted in accidental damage to a body.
CAS-34110-K6V5	Royal Derby Hospital	March	Viewing of the wrong body	Human error resulted in viewing of the wrong body
CAS-34137-Y1J2	Royal Berkshire Hospital	March	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Fetus (14 Week gestation), could not be found following delivery.

CAS-34190-S7C6	Birmingham Women's Hospital	March	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 resulted in disposal of pregnancy remains
CAS-34198-Q2H7	University Hospital of North Midlands	March	Accidental damage to a body	Human error resulted in accidental damage to a body.
CAS-34266-B1Z6	Central Manchester University Hospitals	March	Major equipment failure	A bank of fridges failed in the mortuary. Bodies were moved while the fridge was repaired. No damage to bodies occurred.
CAS-34312-M6L4	Royal Stoke University Hospital	March	Accidental damage to a body	Minor accidental damage caused during PM examination
CAS-34370-Z1T3	Manchester Royal Infirmary	April	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Human error resulted in chest clamp not being removed before release for burial
CAS-34409-Z3K9	Norfolk and Norwich University Hospital	April	Release of the wrong body	Human error resulted in the release of the wrong body.
CAS-34451-R8X6	Hull Royal Infirmary	April	Accidental damage to a body	Accidental damage to a body occurred following a post mortem examination.
CAS-34458-H0P2	Southport & Formby District General Hospital	April	Release of the wrong body	Wrong body released and cremated
CAS-34475-P5B2	Watford General Hospital	April	Major equipment failure	Failure of fridges led to accidental damage to a body

CAS-34509-L6P4	Uxbridge Public Mortuary	April	Discovery of an organ or tissue following post-mortem examination and release of body	Failure to follow documented procedure resulted in discovery of additional tissue
CAS-34555-Y9F1	Royal Stoke University Hospital	April	Accidental damage to a body	Minor damage found on the arm of a deceased individual, investigation underway to try to establish where and how the incident happened
CAS-34563-J2N6	Bedford Hospital	April	Viewing of the wrong body	Due to human error, the wrong body was viewed by the family.
CAS-34618-X5W4	Leighton Hospital	May	Major equipment failure	Fridge alarm did not alarm as expected following a failure of the fridge. No adverse consequences on bodies but reported as equipment failure.
CAS-34654-Y2N1	Hemel Hempstead Mortuary	May	Post-mortem examination of the wrong body	Due to human error a PM examination was performed on the wrong body.
CAS-34703-Z7K0	Brighton & Hove City Mortuary	May	Accidental damage to a body	Human error led to accidental damage
CAS-34721-G4L4	Countess of Chester Hospital	May	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 resulted in inadvertent retention of fetus
CAS-34825-J4M6	Gloucestershire Royal Hospital	June	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Staff action resulted in unauthorised access to the body store area

CAS-34874-S1C6	Poole Hospital Mortuary	June	Accidental damage to a body	Human error led to accidental damage to a body
CAS-34918-Q5H8	King's College Hospital	June	Accidental damage to a body	Human error resulted in accidental damage to a body
CAS-34970-D1D2	Barnsley Hospital Mortuary	June	Removal of tissue from a body without authorisation or consent	One block of retained tissue discovered during an audit, without appropriate consent.
CAS-34972-F3B9	Victoria Hospital, Blackpool	June	Viewing of the wrong body	Human error led to the viewing of the wrong body.
CAS-35011-M3K6	Leicester Royal Infirmary	June	Accidental damage to a body	Minor damage to a deceased person noted prior to post mortem examination.
CAS-35083-S5N3	Darent Valley Hospital	July	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Fetus misplaced.
CAS-35094-M5J0	Dorset County Hospital	July	Accidental damage to a body	Ineffective systems lead to accidental damage of a deceased individual.
CAS-35105-W5X3	Newcastle upon Tyne Hospitals NHS Foundation Trust	July	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Memory stick containing unencrypted images from two post mortem examinations, left on public transport.
CAS-35121-N9V2	Flax Bourton Public Mortuary	July	Post-mortem examination conducted was not in line with the consent given or the post-mortem examination proceeded with inadequate consent	Due to error in paperwork the post-mortem examination was not in line with the consent given.

CAS-35279-W8Y7	Southmead Hospital Bristol	July	Disposal or retention of an organ against the express wishes of the family	Brain kept/disposed of, contrary to the wishes of the family.
CAS-35297-B2R2	University Hospitals of North Midlands NHS Trust	July	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Brakes on trolley were not applied and tray moved when touched by family member.
CAS-35298-G6T1	John Radcliffe Hospital	July	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Human error resulted in mix-up of brains.
CAS-35344-Y6N7	Leicester Royal Infirmary	July	Accidental damage to a body	Human error led to accidental damage
CAS-35393-J5K6	Royal Wolverhampton NHS Trust	July	Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	Inadvertent disposal of fetal remains against family wishes.
CAS-35402-G0T9	Broomfield Hospital	July	Accidental damage to a body	Human error led to accidental damage
CAS-35417-C3K8	Leicester Royal Infirmary	July	Accidental damage to a body	Incorrect hoist used while admitting a body and accidental damage was caused to the body
CAS-35418-G4C9	Countess of Chester Hospital	August	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Missing pregnancy remains, presumed to have been disposed of in error.

CAS-35507-N6B5	Bedford Hospital	August	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Release for burial of container believed to contain fetus as well as placenta. Subsequent to burial fetus confirmed to be present in mortuary. Later confirmed that casket buried contained placenta only. Further funeral undertaken to rebury fetus.
CAS-35512-K0X5	Cheltenham General Hospital	August	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Body positioned incorrectly on the refrigerator tray causing discolouration to the face of the deceased.
CAS-35543-M1R9	John Radcliffe Hospital	August	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	A fetal brain used by a medical student in a research project, despite no consent for use for research being in place. Consent was given for use for education, medical record and genetics.
CAS-35563-V4H8	Royal Surrey County Hospital	August	Viewing of the wrong body	Due to human error, the wrong body was viewed by the family.
CAS-35578-X3K0	Wrexham Maelor Mortuary	August	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Delay in informing the family of baby's return from consented PM at another Mortuary resulting in delays to the release and funeral of the infant

CAS-35592-Q0J6	William Harvey Hospital, Ashford	August	Accidental damage to a body	Human error led to accidental damage
CAS-35610-F2K9	Central Manchester University Hospitals	August	Removal of tissue from a body without authorisation or consent	Human error resulted in removal of tissue without consent
CAS-35652-Y3F6	Royal Stoke University Hospital	August	Viewing of the wrong body	Due to human error, the wrong body was viewed by the family.
CAS-35675-S6D8	Leeds General Infirmary	August	Release of the wrong body	Human error resulted in the release of the wrong body.
CAS-35681-H4K2	Bedford Hospital	August	Discovery of an organ or tissue following post-mortem examination and release of body	Due to an administrative error, the body was released to funeral directors without histology samples being repatriated.
CAS-35703-N1K1	Manchester Royal Infirmary	August	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	The deceased was released with devices still in place. Staff did not note their presence so the funeral director was not offered the option of removal.
CAS-35818-Z1L3	Sheffield Children's Hospital	August	Post-mortem examination conducted was not in line with the consent given or the post-mortem examination proceeded with inadequate consent	Due to a transcription error the post-mortem examination was not in line with the consent given.
CAS-35819-D8C4	Royal Liverpool University Hospital	August	Accidental damage to a body	Human error led to accidental damage
CAS-35982-W4V4	Royal Victoria Hospital Mortuary	September	Accidental damage to a body	Human error led to accidental damage
CAS-36021-K9G3	Addenbrookes hospital	September	Accidental damage to a body	Human error led to accidental damage

CAS-36047-C6X5	Royal Devon & Exeter Hospital Mortuary	September	Accidental damage to a body	Human error led to accidental damage
CAS-36053-B8Q7	Leighton Hospital	September	Major equipment failure	Failure of the bariatric fridges but no signs of any detrimental effects or deterioration of bodies as a result.
CAS-36287-L7X5	Chesterfield Royal Hospital	October	Accidental damage to a body	Accidental skin tear damage during dissection.
CAS-36314-C6V5	Leicester Royal Infirmary	October	Accidental damage to a body	Accidental damage to body when admitting into fridge
CAS-36498-T3R9	Royal Liverpool University Hospital	October	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Unintentional retention of tissue slides and blocks
CAS-36507-S5M3	Princess Alexandra Hospital	October	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	HTA conducted a non-routine inspection of an establishment licensed in the post mortem sector, in order to review the premises following a CQC inspection.
CAS-36530-L8P4	The James Cook University Hospital	October	Release of the wrong body	Due to human error, the wrong body was released to funeral directors.
CAS-36621-Y1S2	Worcestershire Royal Hospital	October	Discovery of an organ or tissue following post-mortem examination and release of body	Tissue taken from a post mortem was discovered after the release of a body.
CAS-36722-H1B4	The Royal Oldham Hospital	November	Accidental damage to a body	Accidental damage to body.

CAS-36826-S4S5	Leicester Royal Infirmary	November	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	Loss of a specimen following post mortem examination
CAS-36906-D5S3	Royal Albert Edward Infirmary Wigan	November	Accidental damage to a body	Accidental damage to a body due to staff training
CAS-36918-N9R1	Ipswich Hospital	November	Release of the wrong body	Due to human error, the wrong body was released to funeral directors.
CAS-36947-Q3F8	Worcestershire Royal Hospital	November	Serious security breach	Mortuary closure procedure not followed correctly.
CAS-37146-N5K2	Queen Elizabeth Hospitals Birmingham	December	Accidental damage to a body	Minor damage to body during routine procedure.
CAS-37207-V5N0	Dorset County Hospital	December	Accidental damage to a body	Inappropriate storage of body.
CAS-37264-T4J1	University Hospital of North Tees	December	Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	A review of organ / tissue holdings in the mortuary discovered some tissue had not been returned.
CAS-37294-Z8V2	University Hospital of North Durham	December	Accidental damage to a body	Accidental damage to body when admitting into fridge.
CAS-37295-T7T4	New Cross Hospital Wolverhampton	December	Accidental damage to a body	Skin tear damage to deceased arm on admission to body store.

Further information

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

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

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

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

Yours sincerely