For Information

on 12 January 2009

Legislative Council Panel on Health Services
Operation of Mortuaries in Public Hospitals

Purpose

This paper briefs Members on measures implemented since June 2007 enhance mortuary services in the Hospital Authority (HA) and sets out a preliminary report of an incident in which the dead body of a baby was found missing from the mortuary in Pamela Youde Nethersole Eastern Hospital (PYNEH).

Background

2. At the meetings of the Panel on Health Services (the Panel) on 16 April 2007 and 11 June 2007, the Administration and HA briefed Members on the system in place for the operation of mortuaries in public hospitals vide LC Paper No. CB(2) 1587/06-07(02) and LC Paper No. CB(2) 2077/06-07(04).

3. The PYNEH reported on 5 January 2009 an incident in which the dead body of a baby was found missing from its mortuary. The case has been reported to the Police for investigation.

Measures to Improve Mortuary Services in HA

4. Since mid 2007, HA has implemented the following measures across the board to reinforce the mortuary services in its hospitals :

Expansion of capacity of mortuaries across HA

5. As at 6 January 2009, there are 1,916 compartments in the mortuaries in 31 HA hospitals. This represents an increase of 384 compartments (or 25%) as compared with the capacity of 1,532 compartments in April 2007. According to HA's ongoing expansion plan of mortuary capacity, the total number of compartments is expected to increase to about 2,137 (a net increase of about 605 compartments or 39.5% as compared to April 2007) by March 2009. The number of deaths in HA hospitals in 2007 and 2008 were 31,771 and 33,421 respectively (i.e. 5% increase).

Strengthening body collection and identification procedures

6. To strengthen the body collection and identification procedures, the HA Standard Operation Procedures (the Procedures) have been revised to specify

instructions and responsibilities together with standard forms for documentation of the procedures. These were promulgated to all HA mortuaries in August 2007.

7. In addition, since April 2008, 2D bar-coding technology has been implemented in all HA mortuaries to facilitate correct identification of the bodies of deceased patients.

Development of Mortuary Information System

8. The Mortuary Information System, an electronic transaction and inventory management system, was rolled out to all HA mortuaries in June 2008. The system enables mortuary staff, supervisors and management to track body transaction, body location and compartment utilization at real-time, within each mortuary.

Training for mortuary staff

9. All mortuary staff have been trained on the new body identification and collection procedures, and the use of the Mortuary Information System in 2007 and 2008.

Audit on compliance of Standard Operation Procedures

10. A HA-wide audit conducted in the first quarter of 2008 revealed good understanding and compliance of the Procedures. Minor revisions have been made to the standard forms to further improve the Procedures.

The PYNEH Mortuary Incident (The Incident)

Preliminary investigation

11. While the Incident has been reported to and is currently under the investigation by the Police, a preliminary investigation by the PYNEH shows that :

(a) on 15 December 2008, a baby passed away at the PYNEH. The body was wrapped in a dedicated body bag which was clearly labeled and sent to the hospital mortuary. The body was placed in tray number 3 in a special compartment which is designated for deceased babies and large sized adult bodies. Photos taken from the PYNEH showing the typical compartments and the type of body bag used is at the **Annex**;

(b) on 17 December 2008, a large-sized adult dead body was placed in the

same compartment with the deceased baby's body. Two name tags were placed at the door of the compartment concerned to indicate that two bodies were placed in the compartment;

(c) occupancy rate of the hospital mortuary on 17 December 2008 was about 75%;

(d) on 19 December 2008, the adult body was collected by the deceased's relatives. According to the mortuary attendant (MA) who released the adult body, body identification had been performed in accordance with the standard procedures. He could not recall if the baby body was in tray number 3 at the time of releasing the adult body;

(e) on 2 January 2009, a mortuary technician (MT) conducted a bi-weekly routine checking of the number of bodily parts and incidentally discovered that the baby body was missing. The MT and MA started a search for the body in the mortuary but to no avail;

(f) at 4:45pm on 5 January 2009, the MT reported the baby body missing incident to the hospital management, which subsequently reported the incident to the HA Head Office and the Police; and

(g) on 6 January 2009, the parents of the deceased baby were informed of the Incident. Public announcement was made on the same day after informing the parents concerned.

Actions taken by the PYNEH after the Incident

12. The PYNEH management is extremely concerned about the Incident. At the meeting with the parents concerned on 6 January 2009, the hospital management explained in detail the preliminary investigation and also sent their apologies and deepest condolences to the parents concerned. At the same time, the PYNEH has taken the following actions after the Incident :

(a) suspended immediately the duties of the MA concerned and warned the MT on the seriousness of the delayed reporting to the hospital management;

(b) established a multi-disciplinary team to support the family of the deceased baby and undertook to render the utmost assistance and support to the family; and

(c) while assisting police investigation, a hospital investigation team has been set up to further investigate the Incident and to recommend to the Hospital Management to take necessary follow-up actions, including disciplinary actions.

Next step

13. HA has been implementing various measures to enhance mortuary services in its hospitals in the past two years. While not pre-empting the results of Police and the PYNEH's further investigation, HA is concerned about human errors and procedures at the PYNEH mortuary despite all systemic and procedural improvements. Apart from continuing with the committed mortuary service enhancement measures which are on-going, HA will, in the light of the findings from the PYNEH Incident, implement additional measures to minimize risks in hospital mortuary operations. These include -

(a) daily verification of deceased bodies against mortuary records;
(b) half-yearly audit on compliance with established standard operation procedures; and
(c) installation of CCTV in mortuaries for better monitoring.

Advice Sought

14. Members are invited to note the content of this paper.

Hospital Authority
January 2009

Annex

Photos Taken from the PYNEH Mortuary

Photo 1: Typical mortuary compartments

Photo 2: Typical mortuary compartments

Photo 3 and 4 : Special compartments designed for deceased babies and large sized adult bodies

Photo 5: Body bag