

**For Information  
on 9 March 2009**

**Legislative Council Panel on Health Services**

**Update on the  
Pamela Youde Nethersole Eastern Hospital Mortuary Incident**

**Purpose**

This paper briefs Members on the investigation findings of the Pamela Youde Nethersole Eastern Hospital (PYNEH) mortuary incident (the Incident) and the follow-up actions taken, as well as other enhancement measures on mortuary services in the Hospital Authority (HA).

**Background**

2. At the meeting of the Panel on Health Services on 12 January 2009, the Administration and HA briefed Members on the mortuary enhancement measures introduced since 2007 and gave a preliminary report on the PYNEH Incident vide LC Paper No. CB (2)607/08-09(01).

**The PYNEH Investigation into the Incident**

3. Following the Incident, the hospital management has set up an investigation panel (the Panel) for full investigation and review of the incident. The Panel comprises of two HA staff and three non-HA staff including a member of the PYNEH Hospital Governing Committee, a member of the HA Public Complaints Committee and a representative of patient group respectively. The investigation was completed and the Investigation Report (the Report) was made public on 17 February 2009. A copy of the Report is attached at the **Annex**.

Findings and conclusion of the Panel

4. From the information provided by the interviewees, the Panel was

of the opinion that the baby body had been lost some time between 17 and 19 of December 2008 due to human errors. Possible factors leading to the event included :

- (a) ineffective management of the mortuary, from the Head of the Pathology Department down to the middle managers, which resulted in communication failure, lack of direct supervision and support to frontline mortuary staff; and
- (b) lack of written departmental instruction against placing more than one body in the same tray/compartment, and avoidance of relocation of body, which created confusion and different understanding among staff, and hence, variation in practice.

5. The Panel questioned the credibility of the three mortuary staff implicated in the Incident, who had given inconsistent and unreliable evidence, in particular about what they did on the most critical days between 15 and 19 of December 2008.

6. The Panel concluded that the frontline mortuary staff have committed a number of mistakes at different stages of the Incident. The mistakes, nevertheless, have arisen partially from a poor system of work resulting from insufficient supervision and management in the mortuary.

#### Recommendations of the Panel

7. The Panel made a number of recommendations for the PYNEH hospital management (summarized in Section 8 of the Report), including :

- (a) to apologize to the parents for the loss of the baby body and provide the necessary support;
- (b) to improve the management of the mortuary through a number of measures, such as to prohibit storing more than one body in the same compartment before the mortuary is full; to enhance the security of mortuary; to provide staff training and cultivate a culture of care and respect to the bodies of the deceased; and to review the mortuary organization, management, workforce and

workflow; and

- (c) to consider appropriate disciplinary actions against the relevant staff.

### Actions taken by the PYNEH

8. The PYNEH hospital management accepted the findings of the Panel and implemented the recommendations with regard to improvement measures. The hospital management also proceeded with disciplinary actions against the staff concerned immediately. Five staff received disciplinary actions ranging from written counseling to summary dismissal. One staff is still undergoing the disciplinary proceedings. In addition, the PYNEH has added a supervisory grade position to enhance the supervision of mortuary service.

### **HA-wide Mortuary Enhancement**

9. As highlighted in paper LC Paper No. CB (2)607/08-09(01), HA has taken a number of measures to enhance mortuary operations since 2007. In terms of mortuary capacity in the HA, it has expanded considerably from 1,532 compartments in 2007 to about 2,335 compartments currently, representing a 52% increase.

10. Following the PYNEH incident, HA has taken/will take the following immediate remedial measures to further enhance the mortuary operations :

- (a) central procurement of standardized bags for small bodies;
- (b) installation of CCTVs in mortuaries;
- (c) further enhancement to the Mortuary Information System to bar the sharing of compartment unless the storage capacity was exceeded;
- (d) reviewing the workflow and guideline for body handling;
- (e) auditing on staff compliance with established guidelines; and
- (f) providing staff training and culture building activities.

11. The review of guideline in paragraph 10(d) has been completed while improvement measures in paragraph 10(a) and (b) are targeted for

completion in May 2009. Implementation of the other measures is in progress.

12. To complement the immediate measures taken, HA has set up a task force to follow-up on the implementation of the remedial measures; explore the use of radio-frequency identification technology to safeguard against mortuary errors; and to review and advise on the organization and management of mortuary services.

### **Advice Sought**

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

**Hospital Authority**  
**March 2009**

**Investigation Report**  
**on Missing Baby Body from the Mortuary of**  
**Pamela Youde Nethersole Eastern Hospital (“PYNEH”)**

**1. Background Information of the PYNEH Mortuary**

The PYNEH Mortuary (the “**Mortuary**”) stores dead bodies, aborted foetus from pregnancies before 24 weeks, amputated body parts and body tissues. It provides a central autopsy service for the Hong Kong East Cluster (“**HKEC**”).

**1.1 Capacity of the Mortuary**

The capacity of the Mortuary has been increased over the past years, as set out in Table 1 below.

*Table 1 – Increase of Mortuary Capacity*

Year	Capacity	Cumulated Change
October 1993	92	
<b>May 2007</b>	<b>114</b>	+22
February 2009 *	154	+62

*\* Mortuary Extension Project from September 2008 to end of January 2009*

As of December 2008, the Mortuary had a capacity of 114 spaces to house 114 trays. They include 22 compartments with five trays each and one compartment with four trays, designated as the ‘Special Compartment’ to store the following as shown in Table 2. There is a single door to each of the compartments.

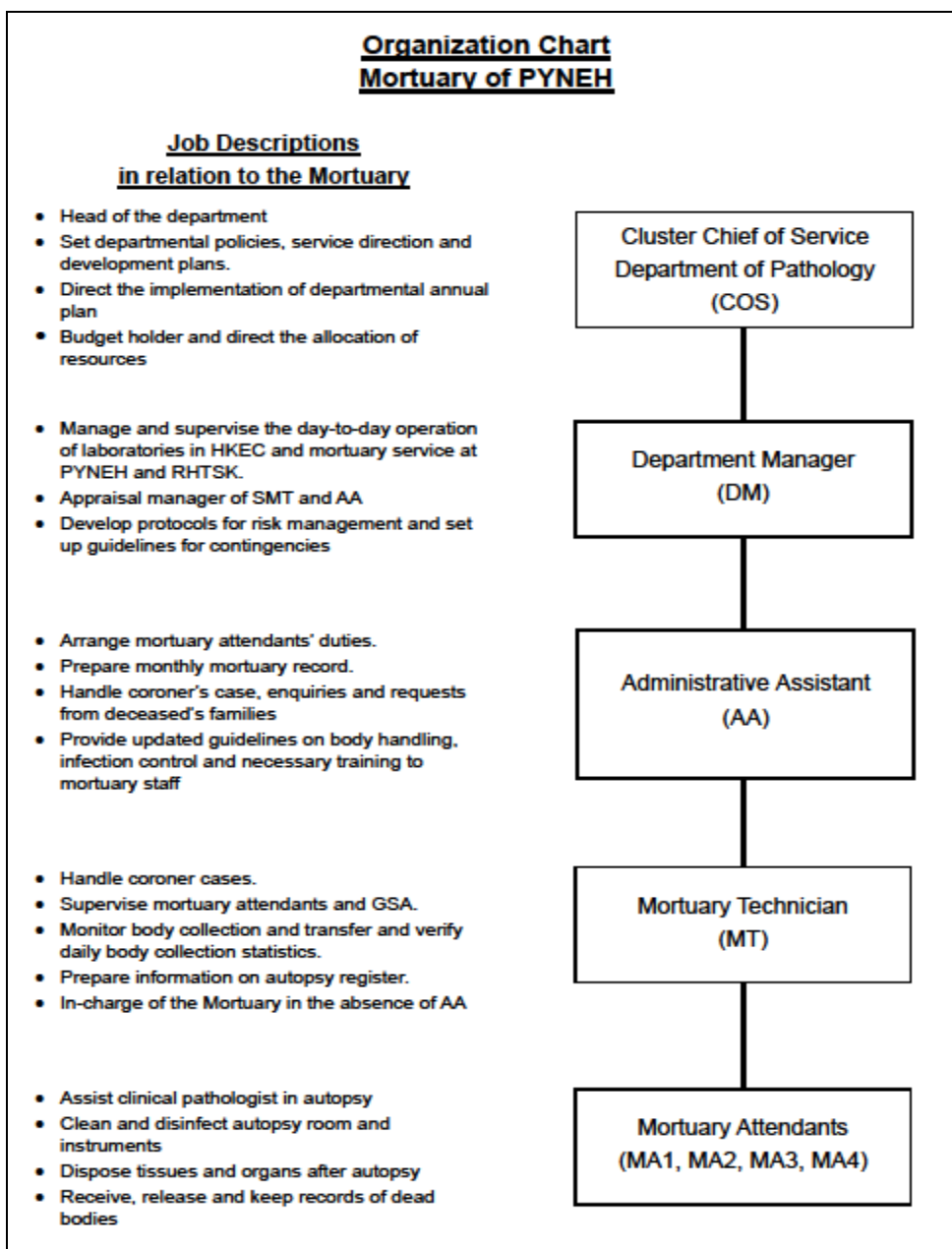
*Table 2 – Designated Storage Purpose of Special Compartment*

Tray No.	Designated Storage
1	Aborted foetus before 24 weeks
2	Aborted foetus before 24 weeks
3	Either large-size dead bodies or baby bodies
4	Amputated body parts and formalin-fixed surgically removed specimens which are pending disposal.

## 1.2 Organisation

The Mortuary is one of the services operated by the Department of Pathology managed by the Cluster Chief of Service (“**COS**”) as the overall in-charge. He is assisted by a number of staff to supervise and manage the day-to-day operations of the Mortuary. The organization chart and their job descriptions are shown in Table 3.

Table 3 – Organisation Chart of the Mortuary and Job Descriptions of the Staff



### 1.3 Policies and Procedures

#### (a) Packaging of Dead Bodies, Aborted Foetus, Amputated Body Parts and Tissues and Availability of Empty Trays

In HKEC, all dead bodies (whether adult or baby) are put inside standardized adult-sized plastic body bags that are silver in colour by nursing staff in the in-patient areas. Aborted foetus from pregnancies before 24 weeks, amputated body parts and body tissues are packed in yellow bags to be collected at regular intervals for incineration.

It is the normal practice of the Mortuary staff to make available at least 10 empty trays to receive bodies transferred from the wards after 17:00 hours everyday.

#### (b) Transportation of Dead Bodies

Transportation of dead bodies from the wards to the Mortuary is performed by porters of the Central Transportation Team in accordance with the HKEC's standard procedures.

#### (c) Mortuary Operation

##### (i) Standard Operating Procedures for Body Collection and Identification in HA Mortuaries effective from September 2007 ("HA SOP") (Appendix I)

The procedures for body receipt and release in HKEC are in accordance with HA SOP.

##### (ii) Mortuary Information System

The Mortuary has four systems to manage and document day-to-day operations. They are as follows:

- Mortuary Information System ("**MORIS**") has been implemented in PYNEH since 22 May 2008 to ensure correct identification of dead bodies from the time of receipt to release. The Mortuary staff have been instructed to use a 2-D bar-code scanner to match the information on the Unique Patient Identification label ("**UPI label**") on the wristband of the body with the necessary documents for the

receipt and release of bodies, such as the Last Office Form (“**LOF**”) and Body Collection Form (“**BCF**”), etc. All transactions from receipt to release of bodies must be registered in MORIS. This computer system, MORIS, is operated by the Mortuary staff.

- To complement MORIS, a “Mortuary Register” is concurrently maintained to enable the Mortuary staff to manually record all transactions of dead bodies.
- There is also a large white board (“**White Board**”) on which the names of the deceased in each tray is written for easy reference and updating by all Mortuary staff.
- A manual ‘Dead Body Receipt Register’ is routinely used by the porters of the Central Transportation Team for registration of all the bodies they transfer to the Mortuary. The information will be subsequently entered into MORIS by all Mortuary staff.

## **2. The Missing Baby Body**

A baby (“**Baby**”) was delivered in critical condition at 11:07 hours on 15 December 2008. He was resuscitated and transferred to the Neonatal Intensive Care Unit (“**NICU**”) in Ward E7. The baby was baptized and eventually certified dead at 13:24 hours.

In the late afternoon of 5 January 2009, the Hospital Management received a report from the Department of Pathology that the body of the Baby (“**Baby Body**”) was found to be missing from the Mortuary (the “**Incident**”). The Hospital Management made a thorough search to ascertain the loss and reported the Incident to the Police. The Hospital Management then disclosed the Incident to the family of the deceased baby, and afterwards repeatedly and thoroughly searched the Mortuary at the request of the Baby’s parents (the “**Parents**”) but all searches ended in vain. Subsequent to this, the Hospital Management decided to establish an Investigation Panel to ascertain the facts of the Incident and recommend improvement measures.

## **3. Investigation Panel**

The Investigation Panel on the Incident of the missing Baby Body in PYNEH (the “**Panel**”) was appointed on 14 January 2009. It is composed of the following members:



Chairman: Dr. LAU Chor-chiu, Deputy Hospital Chief Executive and Chief of Service (Accident and Emergency), PYNEH

Members: Rev. CHU Yiu-ming, Member of Hospital Governing Committee, PYNEH and Principal Pastor, Chai Wan Baptist Church

Mr. CHEUNG Tak-hai, Chairman of Alliance for Patients' Mutual Help Organizations

Ms. Virginia WU, Member of Public Complaints Committee, Hospital Authority and Patient Group Representative

Dr. David LAM, Hospital Chief Executive, Ruttonjee Tang Shiu Kin Hospital and Tung Wah Eastern Hospital

The Terms of Reference, Objectives and Guiding Principles of the Panel are enclosed in [Appendix II].

#### 4. **Investigation Procedures**

4.1 The Panel conducted interviews, paid three visits to the Mortuary and collected documentary evidence in order to reconstruct the facts of the Incident. The Panel had interviews with the following 22 persons.

*Table 4 - the number of interviews conducted with each of these interviews.*

<b>Interviewees</b>	<b>No. of Interviews</b>
Parents of the deceased baby	1
2 Nurses from NICU	1 (concurrent)
1 Porter	1
MT	3
MA-1	3
MA-2	2
MA-3	3
MA-4	1
DM	1
AA	2
Death Documentation Officer (DDO)	1
COS, Department of Pathology,	2
Personal Secretary to COS	1
2 Cluster General Managers	1 each

<b>Interviewees</b>	<b>No. of Interviews</b>
Executive Manager, HKEC	1 <i>(via telephone)</i>
Hospital Chief Executive, PYNEH	1
3 Staff of the Contractor Working on the Mortuary Extension Project	1 (concurrent)

4.2 The Panel has referred to the following:

- Organisation chart of PYNEH Mortuary and Job Descriptions of the COS, DM, AA, MT and MA
- Accounts of the Incident given by the following staff to the Department Management, Department of Pathology:  
MT, MA-1, MA-2, MA-3, MA-4, DM, AA
- Account of the Incident given by a Hospital Administrator
- Mortuary Register
- Copy of Dead Body Receipt Register
- Review of the MORIS
  - to confirm that the Baby Body was received but not released
  - to obtain information on occupancy
- Mortuary SOP, Work Instructions & Protocols
- Standing Committee Meeting Notes (Pathology) (July 2004 – Present)

4.3 The Deputy HCE of PYNEH had conducted investigation into the Incident before he was appointed as Chairman of the Investigation Panel. He also gave his accounts to the Panel.

4.4 The Panel carried out investigation and compiled this report from 22 January 2009 to 16 February 2009.

## 5. **The Incident**

The Panel reconstructed the sequence of events of the Incident as follows:

### 5.1 **From the Ward to the Mortuary**

*15 December 2008*

According to the NICU Nurse, she had performed Last Office for the Baby at about 15:00 hours. She placed the Baby Body inside an

adult-sized silver-coloured body bag, which was folded into a smaller size of about 52 cm X 40 cm. She inserted a label with "B/O XXX" (Baby of Name of Mother) written into the plastic pouch on the body bag.

According to the Hospital Porter assigned to collect the Baby Body from NICU in Ward E7 on 15 December 2008, he had taken the Baby Body in the silver-coloured body bag from the nurse at about 15:45 hours. He delivered it to the Mortuary on a trolley covered with a white cloth. On arrival at the Mortuary, the Porter was directed by the MT (in accordance with the usual practice in the Mortuary) to place the Baby Body in Tray No. 3 of the Special Compartment ("**Tray No. 3**"). After that, he attached a UPI label of the Baby Body on a yellow card and inserted it as a nametag into the slot on the Special Compartment door, and made a new entry in the "Dead Body Receipt Register" before leaving, in accordance with the usual Mortuary practice.

*16 December 2008*

According to the Hospital Administrator in-charge of the Central Transportation Team, a large adult body (the "**Adult Body**") was sent to the Mortuary by four porters at 17:40 hours on 16 December 2008. The large size of the Adult Body could not be accommodated in an empty space of a 5-tray compartment, so the body was placed on an autopsy table in the Autopsy Room, in accordance with the usual Mortuary practice.

## **5.2 Transfers Inside the Mortuary**

*17 December 2008*

According to MA-1, he noted the Adult Body on the autopsy table and the corresponding entry in the Dead Body Receipt Register when he returned to work before 08:00 hours. At about 08:00 hours, MA-1 transferred the Adult Body from the autopsy table to the Special Compartment with the assistance of MA-2. As there is a threshold between the autopsy room and the Special Compartment, MA-2 assisted the transfer of the Adult Body over the threshold, and MA-1 placed an empty tray from another compartment on a trolley to collect the Adult Body ("**New Tray**"). MA-2 then left.

MA-1 took out Tray No. 3 with the Baby Body. He placed the Baby Body on the thighs of the Adult Body in the New Tray and inserted it in the space for Tray No. 3.

According to MA-1, he had inserted the nametag of the Adult Body in the slot on the Special Compartment door containing the New Tray and written the name of the deceased adult above the entry of B/O XXX on the White Board.

### **Issue (1) - Sharing of Tray**

The COS of Department of Pathology stated a department policy of “no sharing” of tray unless all trays are full.

The Mortuary staff stated they had knowledge about previous incidents in other mortuaries and had received subsequent briefings from AA to heighten their awareness. They knew it was undesirable, though not absolutely forbidden, to hold more than one body in one tray. At that moment, there were 27 trays available.

### **Issue (2) - Relocation of Bodies**

The COS confirmed that all along staff are reminded to minimize body transfer as far as possible.

All Mortuary staff acknowledged and understood that relocation of bodies to different trays carry additional risks.

MA-1 claimed that he put both Adult Body and the Baby Body together in the New Tray to save storage space and to avoid possible risks associated with body relocation, and that November to February is normally the peak season for the Mortuary. MA-1 said that he was aware of the “no sharing” and “no relocation” policies of the Department.

The Panel came to the view that the Department had given instructions on these issues to the Mortuary staff, although not in writing. Hence, when faced with a situation such as the one in this Incident, MA-1 had to make his own judgment because the Department had not specified the priority of these instructions relative to each other.

The Panel also noted that according to the MORIS data, the peak season for the Mortuary is January to March.

*19 December 2008*

### **Issue (3) - Change of Identification**

A Death Documentation Officer (“**DDO**”) had acknowledged the legal birth certificate presented by the father of the Baby at about 14:33

hours on 19 December 2008. She brought a new wristband with the updated name of the Baby, a sheet of corresponding labels and a "Major Key Change" Form to the Mortuary for updating between 16:00 and 17:00 hours. With this updating, the Baby should thereafter be referred to as "(Name YYY)" instead of "B/O XXX".

In accordance with the HA practice, the Mortuary staff who received such a request should put the new wristband on the Baby Body, replace the nametag on the door to the compartment, and file the Major Change Form with deceased Baby's Last Office Form.

The MT was the person who received the request in this Incident. In an earlier account given to the Police and the COS, the MT claimed that he had last seen the Baby Body on 19 December 2008. The MT later told the Panel that he had put the "Major Change Form" with the deceased Baby's Last Office Form on 19 December 2008 in the file. He had not put the new wristband on the Baby Body nor replaced the nametag on the door to the Special Compartment.

The Panel found that even Mortuary staff with the shortest duration of service is aware that updating of changed identification of deceased bodies must be done as soon as they receive documented information about the changes.

The MT admitted that the change of identification had not been taken place. He failed to give an account for the whereabouts of the new wristband and claimed that he might have thrown it away unintentionally.

#### **Issue (4) - Release of Adult Body**

At 15:29 hours on 19 December 2008, MA-3 stated that he had performed the release of the Adult Body. He had taken out the New Tray with the Adult Body and conducted body identification procedures. To expose the wristband of the deceased to scan the bar-code for verification, he had unzipped the body bag of the Adult Body down to the knee position for the identification procedure and to tidy up the body. Following that, he wheeled the Adult Body to the Viewing Room and covered it with a blanket for viewing by the relatives. He then invited the next-of-kin into the Viewing Room, accompanied by staff of the Funeral Home. After the body identification procedure, MA-3 said that he had taken away the blanket covering the Adult Body, afterwards the Adult Body was transferred to the Funeral Home by the Funeral Home staff with his assistance.

MA-3 initially told the Panel that only the Funeral Home staff was present when he took away the blanket. He later changed his account to the Panel stating that both the next-of-kin and the Funeral

Home staff were present when he removed the blanket. With either version, he claimed that any additional bag on the thighs of the Adult Body would have been seen by all those present.

The two Funeral Home staff also told the Executive Manager, PYNEH that they had only seen the Adult Body on that day in the Viewing Room, and when handling it in the Funeral Home.

The COS informed the Panel that he had contacted the next-of-kin of the Adult Body. She told him that she had not noticed other items on the Adult Body or anything dropped on the floor during the body identification procedure.

MA-3 admitted that, on 19 December 2008, he had only performed the release of the Adult Body while the MT had performed the documentation. MA-3 also admitted that he had not erased the name of the Adult Body from the White Board after the Adult Body was released because he thought it was the responsibility of the person performing the documentation. However, the MT claimed that he had not erased the name either. No staff admitted to the erasing the name on the White Board.

MA-3 also claimed that he had only seen the Adult Body in the tray, and the corresponding nametag on the door when he removed the nametag of the Adult Body.

The other Mortuary staff claimed that different workers have their own practices on release of dead bodies. Body receipt and release may be performed by one worker or two at the same time. When two workers are involved, the staff gave different answers with regard to the responsibility of each one in the body release process. According to the MT and all the MAs except MA-3, when body release is performed by two workers, it is the responsibility of the staff who releases the body to take out the nametag from the door of compartment, to erase the deceased's name from the White Board and to handover all the papers to the staff performing the documentation.

*31 December 2008*

MA-1 stated that, he had returned an aborted foetus to the Special Compartment after post-mortem in the afternoon of 31 December 2008. At that time he found the New Tray to be empty. Because he knew the Baby Body had not yet been released, he reported to the MT that the Baby Body was missing. MA-1 said that MT asked him to search for it. MT did not report the Incident to the Department Management.

MA-1 searched the Mortuary and contacted a staff of the Funeral

Home by phone to check if the Baby Body had been accidentally transferred together with Adult Body to the Funeral Home on 19 December 2008. He received a reply in the negative.

*1-4 January 2009*

MA-1 informed the Panel that he and the MT had continued to search for the Baby Body in all compartments and all body bags but in vain. He was instructed by the MT to wait for clarification from MA-3 who would return from leave in the afternoon of 5 January 2009.

MT claimed that he had not phoned MA-3 for more clues at this juncture because he thought that MA-3 was having some family problems.

*5 January 2009*

#### **Issue (5) - Failure to Report the Incident Immediately**

On his return from leave, MA-3 stated that he had informed the MT that he had not seen the Baby Body when he released the Adult Body on 19 December 2008. At about 14:30 hours on 5 January 2009 the MT reported the Incident to his supervisor, the AA, who in turn relayed the Incident to the DM.

The DM stated that he had conducted another search in the Mortuary with the Mortuary staff but again in vain. The Incident was therefore reported to the COS and the Hospital Management at about 16:00 hours.

#### **Issue (6) – Provision of Misleading Information**

The Panel noted that, when the MT reported the Incident to the AA, he had given wrong information about the date that the Baby Body was found missing. He initially claimed that it was found missing on 2 January 2009, when in fact MA-1 had reported this to him on 31 December 2008.

MT admitted to the Panel that he lied about having seen the Baby Body on 19 December 2008 and having discovered the Baby Body to be missing on 2 January 2009. He was willing to apologise to the Parents, Hospital Management and the public for the problems consequent to the misleading information he had given.

#### **Issue (7) - Other Aspects of Mortuary Operations**

(a) Management of the Mortuary by COS

COS informed the Panel that he is responsible for the policy, development and direction of the Mortuary. While he personally attends to the autopsy service, he has delegated the management of the Mortuary to the DM. He chairs a Standing Committee in the Department of Pathology to discuss service issues with department staff.

The AA is of the view that this Standing Committee only serves the purpose for COS to distribute work to staff.

(b) Supervision by the DM

A Cluster General Manager informed the Panel that, when she went with the Parents to visit the Mortuary for the first time on 7 January 2009, the DM appeared to be unfamiliar with many aspects of Mortuary operations, including workflow and the storage of materials.

When asked by the Panel, however, the DM claimed that he expects the AA to be in the Mortuary very often to supervise the staff, although it might not have to be on a daily basis.

(c) Supervision by the AA

The Mortuary is functionally headed by the AA who is also in charge of the General Registry of the Department of Pathology. His office is located in the Pathology Block while the Mortuary is located in the Main Block. He informed the Panel that he had only gone to the Mortuary for specific tasks, including Coroner's cases and difficult cases of clinical postmortem.

According to the AA, he is the direct supervisor to the Mortuary staff but he has other duties in the Department. He admitted that he went to the Mortuary mostly for Coroner's cases. He had given briefings to the Mortuary staff to raise their awareness to the importance of body identification, and the risks of relocating bodies and putting two bodies together in one tray. However, he only realized after the Incident that the staff have not practised according to his instructions.

(d) Nametag Counting

All MAs informed the Panel that there is a daily routine of nametag



counting in the Mortuary.

MA-3 initially informed the Panel that he had performed nametag counting in December 2008, but later stated that he relied on MORIS as to the number of bodies in the Mortuary.

(e) Management Control over the Designated Use of the Special Compartment

From data collected in MORIS and manual records (including the Incident) in 2008, the Panel found five instances in total where large adult bodies were placed in Tray No. 3. There was one other instance when an adult body was kept together with a baby body when the occupancy was 141% on that day. On three occasions, however, baby bodies had been kept in trays other than those in the Special Compartment.

(f) Staff Relationship

The MAs admitted that they had occasional disagreement over their work but the relationship among them was not bad. For example, the staff were willing to share the workload when other staff had to take long leave.

**5.3 Extension Works of the Cold Chamber and Security Measures for Contractor Workers**

The Panel noted the extension works in the Mortuary during this period. The contractor workers informed the Panel that, from September 2008, the contractor had started an extension project in the Mortuary by installing an additional cold chamber with 40 trays opposite to the compartments in use, and this was completed at the end of January 2009. Since the works from 15 December 2008 onwards were only confined to assembly of pre-fabricated panels and installation of chiller, there were no construction wastes in the Mortuary at the time of the Incident. The workers stated that they had removed the packaging materials from the panels at the Mortuary corridor before bringing the panels into the Cold Chamber for installation. The workers claimed that they had taken the wastes back to the contractor's office for disposal, and that they are experienced in working on Mortuary projects. They also knew that

dead bodies in PYNEH are packed in silver body bags.

Every morning when contractor workers come to the Hospital, they have to report to the Foreman Office to register for “Permits to Work”. Contractor workers normally completed their daily work after the operation hours of the Mortuary. Since there would not be any Mortuary staff on site, they would call the Foreman Office again and wait for the Foreman to lock the Mortuary door, after which they would return their permits before they left.

#### **5.4 Hospital Management**

The Panel interviewed the HCE PYNEH (HCE) and noted the Hospital Management had put efforts in the Mortuary in terms of communication, risk management, facilities improvement and manpower provision in the past few years. The Panel found that at various time periods, improvement works had been completed for the establishment of the Farewell Rooms with donations, and for the ventilation at the Autopsy Room and the extension of cold storage with the hospital’s budget. Moreover, Members noted that recently security installations had been completed as planned. There had been Senior Executive Walk Arounds to the Mortuaries in HKEC led by the Cluster Quality and Risk Management Office with the participation of the CCE. Regarding manpower provision, HCE also informed the Panel that the manpower provision of the Mortuary was about average of 8 large regional hospitals in the Hospital Authority. A new post of Mortuary Officer which would be created in the coming financial year would further improve the situation.

### **6. The Panel’s Observations**

#### **6.1 Credibility of the Staff**

The Panel Members found that the MT, MA-1 and MA-3 had given inconsistent and unreliable evidence, in particular about what they did on the most critical days between 15 December 2008 and 19 December 2008.

The MT, who is in-charge of the daily operations of the Mortuary, gave the most unreliable evidence. He had failed to comply with the

HA-SOP to update the changed identification of the Baby Body and this is a breach of duty. Because he did not immediately report the Incident to his superiors, the Panel is of the opinion that he was attempting to cover up the facts.

Although the Mortuary staff had claimed that different workers had their own practices, the Panel has concerns about the transfer of the Adult Body on 17 December 2008. The Panel considers that, if MA-1 had intended to place the Adult Body in Tray No. 3 of the Special Compartment, he could have used this tray directly to collect the Adult Body. Instead, he used the New Tray which had unnecessarily increased the number of transactions in the workflow.

The Panel cannot totally eliminate the possibility that MA-3 had unintentionally lost the Baby Body when releasing the Adult Body.

The Panel noted that the AA and the DM had little knowledge about the day-to-day operations of the Mortuary. Though their accounts were credible, they did not impress the Panel as having been effective supervisors of the Mortuary staff.

The Panel was given to understand by the AA that he has to oversee both Mortuary and General Registry in the Department. He seldom went to the Mortuary and he delegated a significant proportion of his work in the autopsy room to the MT. The Panel found neither written departmental instruction to be in place, nor were adequate monitoring and control exercised by both AA and DM to ensure that the Mortuary operation complies with all requirements, even in the absence of a dedicated full-time supervisor. This situation left the Mortuary staff unsupervised, resulting in individualized practices that pose high risk to the Mortuary service.

The COS only attended in person to the autopsy service of the Mortuary but did not control the management of the Mortuary which he delegated to the DM.

The Panel, however, could not find any motives from the Mortuary staff of having acted with malicious intent.

## **6.2 Procedures and Guidelines**

Even though the Mortuary staff were knowledgeable about the procedures, the Panel found written departmental instructions to be lacking. The Panel is of the opinion that the Mortuary staff have been operating with mostly verbal instructions from the supervisors. They often have to make their own judgment according to their experience and the situation. With regard to the act of putting 2 bodies in the New Tray on 17 December 2008, the Panel is of the view that MA-1 has followed one of the prevailing instructions, i.e. to avoid relocation of bodies, even though he was also aware of the other instruction that sharing of bodies in one tray is undesirable and the Mortuary capacity was not full on that day.

The variations in practices among the Mortuary staff reflect the absence of an effective communication between the staff and their supervisors. Had the communication been effective, the supervisors including the AA and DM would have opportunities to give the staff advice and feedback on the best practice to be followed. They could also have performed on-site checking of compliance to instructions given.

### **6.3 The Management Control over the Designated Use of the Special Compartment**

The Panel found that the department had not exercised control over the use of the Special compartment. The Panel agrees that Tray No. 3 is more convenient to store large-sized bodies but could not perceive the reason for the said tray being also designated for small-sized baby bodies.

### **6.4 Staff Attitude**

The Panel is of the opinion that the Mortuary staff are not aware about the need of risk management to sustain a high quality of service, and efforts of the Department Management had not been apparent towards the cultivation of a caring culture in the Mortuary.

### **6.5 Staff Relationship in the Mortuary**

The Panel did not find any motives among the staff to sabotage the Mortuary operations as a result of poor staff relationship.

## **6.6 Management of On-site Contractors in the Mortuary**

While the Panel Members are satisfied that the Baby Body was unlikely to have been mixed up with construction wastes and thus taken away, it considers that the security in the Mortuary could be tightened whenever there is increased flow of non-Mortuary staff.

## **6.7 Hospital Management**

The Panel found that the Hospital Management is committed to the Mortuary service. Besides resources which are injected to improve the facilities in various time periods, risk management in the Mortuary is on the Senior Management's agenda.

## **7. Conclusions**

The Panel Members regret that the Baby Body still could not be recovered at the time of writing the report. This is a most unfortunate incident in which the Parents have suffered multiple traumas, from learning about the difficulty for their baby to survive, the grief at the death of their new born, the unfortunate loss of the Baby Body and the unpleasant experience of visiting the Mortuary. The Panel Members wish to express their deepest condolences to the Parents for their great loss.

The Panel appreciates the openness of the Hospital Management in the prompt disclosure of the Incident to the Parents and to the public, as well as the prompt establishment of the Investigation Panel with participation of patient representatives.

From the information provided by the interviewees, the Panel is of the opinion that the Baby Body had been lost unintentionally due to human errors. It was lost sometime between 17 December 2008 and 19 December 2008. The Panel has identified two critical time points/events that might have been related to the loss of the Baby Body. The first was when the Adult Body was transferred to share the same tray with the Baby Body on 17 December 2008. The second was when the Adult Body was released on 19 December 2008.

The Panel has identified the following possible factors leading to the loss of the Baby Body:

- 7.1 Leadership in the Mortuary from the Head of the Department of Pathology to the Middle Managers does not appear to be effective. The Panel is of the opinion that the communication chain down to the front-line Mortuary workers was broken. There was no direct supervision of the Mortuary staff who were therefore used to solving problems in their own ways.
- 7.2 The Panel found no written departmental instructions against placing more than one body in the same tray and avoidance of relocation of body. This has led to confusion and disagreement among the staff in interpretation and eventually resulted in variable practices, non-compliance and errors.

Based on the investigation, the Panel concludes that the front-line workers have committed a number of mistakes at different stages in this Incident. However, the mistakes have at least partially arisen from a poor system of work resulting from insufficient supervision and management in the Mortuary.

## **8. Recommendations**

The Panel recommends to the PYNEH Hospital Management to apologise to the Parents for the loss of the Baby Body and provide such support as is necessary.

The Panel also recommends the Hospital Management of PYNEH to improve the management of the Mortuary in the following aspects in order to achieve a quality Mortuary service.

- 8.1 To prohibit placing more than one dead body on a single tray before the storage capacity is full.
- 8.2 To respect baby bodies as individuals and store them in the same manner as adult bodies.
- 8.3 To improve the security of the Mortuary.
- 8.4 To cultivate a culture of care and risk management by providing training and development programmes to the staff
- 8.5 To review operational workflow, guidelines and procedures
- 8.6 To implement a quality management system with regular auditing
- 8.7 To review organizational and staffing structure, and manpower provision

Finally, the Panel recommends the Hospital Management to consider appropriate disciplinary actions in respect of the relevant staff of the Department of Pathology, who failed to effectively perform their roles, resulting in this unfortunate Incident.

Date: 17 February 2009



**STANDARD OPERATING PROCEDURE**  
**For Body Collection and Identification in HA Mortuaries**  
*(Barcode Version – for hospital with barcode scanning system)*

w.e.f.. 1 Sep 2007

v1.0 (dated 31 July 2007) Subject officer: COC (Path)

**A. On arrival of the body at the mortuary**

- (1) The body and the Last Office Form (LOF B1.i) with Part 1 completed by ward staff are collected from the ward and taken to the mortuary. Mortuary staff / transport team should assign a compartment for the body and record the compartment number on Last Office Form Part 2a and sign the Part 2a with date and time.
- (2) As soon as possible, and NOT later than the next working day, mortuary staff must enter details in the Mortuary Register according to the information shown on the Last Office Form. The mortuary staff should scan the barcode on the wrist band or body identification tag (HA234)<sup>1</sup> attached on body and the barcode shown on the Last Office Form Part 2b.
- (3) A confirmation label will be generated immediate after the barcodes are verified. Mortuary staff should then attach the confirmation label to the Last Office Form Part 2b and sign this part. The compartment number should be entered into the Last Office Form Part 2b and the Mortuary Register.
- (4) Mortuary staff should attach a body identification tag / Name Card bearing the name and ID on the respective compartment door.
- (5) If compartment sharing is required, a letter “A” should be added to the compartment number and placed on the compartment door holding the additional body, e.g. 12A. The criteria for selection of bodies for sharing a compartment are listed in Appendix I for reference.

**B. Relative or authorized representative presenting to mortuary**

Relative or authorized representative presenting to the mortuary should bring along the following documents:

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<sup>1</sup> It is preferable to use the wrist band unless it cannot be accessed due to the wrapped body / the body is classified as a Cat. 2 or 3 case. Then, the identification tag attached to the outside of the mortuary sheet / body bag may be used.



(1) Normal Circumstances

- a. Body Collection Form [Form BCF(B)]
- b. Certificate of Registration of Death (Form 12)
- c. I.D. Card of the relative or authorized representative
- d. I.D. Card of the deceased

(2) Coroner's Cases

- a. Body Collection Form [Form BCF(B)]
- b. Certificate of Order Authorizing Burial / Cremation of Body (Form 11)
- c. I.D. Card of the relative or authorized representative
- d. I.D. Card of the deceased

If the person who collects the body is not the one who was shown on the Body Collection Form, an authorization from the person claiming the body, as stated in the Body Collection Form, is required. The "Authorization" part in the Body Collection Form can be used for this purpose.

**C. Checking of documents by mortuary staff**

- (1) Mortuary staff must check the documents carefully:
  - I.D. Card and name of the deceased against the particulars stated in the Body Collection Form and the Hospital Mortuary Register
  - I.D. Card and name of the relative / authorized representative against the details stated in the Body Collection Form and the Authorization (if needed)
  - Certificate of Registration of Death (Form 12) or Certificate of Order Authorizing Burial / Cremation of Body (Form 11)

**D. Identification of deceased by relatives / representatives**

- (1) Mortuary staff will take the Body Collection Form and the Last Office Form to the body storage compartment.
- (2) After removing the body from the compartment, the mortuary staff should scan the barcode on the wrist band<sup>2</sup> and the barcode shown on the **Body Collection Form** to make sure the two barcodes are matched.
- (3) Then, a confirmation label will be generated and attached onto the Last Office Form Part 3a. Mortuary staff will also record the date, time and compartment number of the released body on the Last Office Form Part 3a.
- (4) Mortuary staff should prepare the deceased body by exposing the face and the limb

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<sup>2</sup> It is mandatory to use the wrist band unless the body is classified as a Cat. 2 or 3 case when the identification tag attached to the outside mortuary sheet / body bag may be used.

with a wrist band\* before presenting the deceased to the relatives / authorized representatives for identification. (\*unless the body is classified as a Cat 2 or 3 case).

- (5) Mortuary staff will lead the relatives / authorized representatives and the funeral parlour staff to the room for body identification. Relatives / authorized representatives will be asked to identify the deceased in person.
- (6) Together with relatives / authorized representatives, the mortuary staff will check and read out the particulars (ID and Name) on the wrist band<sup>3</sup> of the deceased against the details on the Body Collection Form. If all the details of IDs and Names match, then a “✓” should be put against the boxes in Part 3b of the Last Office Form to indicate the identification procedure is completed.
- (7) Upon completion of the proper identification procedures, relative / authorized representative and the responsible mortuary staff who release the body should sign on the Last Office Form Part 3b to confirm the identification information is correct. Relative / authorized representative should also sign the confirmation on the Body Collection Form and Mortuary Register with the company chop of the funeral parlour placed on the Body Collection Form and the Mortuary Register.
- (8) Mortuary staff should clip the following three items together to facilitate the subsequent counter-signing procedure NOT later than the next working day:
  - (a) Last Office Form
  - (b) Body identification tag / Name Card removed from the storage compartment door
  - (c) Body identification tag removed from the outside of the body bag / mortuary sheet.

#### **E. Releasing the body to a funeral parlour**

- (1) When all the above procedures are completed, the funeral staff is then allowed to remove the body from hospital mortuary.
- (2) Both Last Office Form and the Body Collection Form should be kept and properly filed in the mortuary.

#### **F. Counter-signing**

- (1) After the body is released, counter-signing of the Last Office Form Part 4 should be done by a mortuary staff NOT later than the next working day for the purpose of stocktaking each body release episode.

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<sup>3</sup> It is mandatory to use the wrist band unless the body is classified as a Cat. 2 or 3 case when the identification tag attached to the outside mortuary sheet / body bag may be used.

- (2) The counter-signing staff is required to verify that the IDs and Names on all documents (a), (b) and (c) as listed in Item D (8) match. If all the IDs and Names match, then this mortuary staff should put a “✓” against the boxes for checking the information and sign on the Last Office Form Part 4 with date and time.
- (3) When the counter-signing procedure is completed, the Last Office Form should be properly filed in the mortuary.

**Additional information: DURING CMS DOWNDOWN ON THE WARD**

- (1) Body will arrive at the mortuary with a hand-written version of the Last Office Form (LOF B1.ii)
- (2) For mortuary, only step 2b will have to be modified, i.e. instead of using barcode scanner to verify the barcode for producing the confirmation label, mortuary staff will need to manually copy the name and ID from the wrist band or body identification tag to the Last Office Form Part 2b.
- (3) Steps for Last Office Form Part 3a,b,c, and 4 will not be affected.

**Documents related to this Standard Operation Procedure**

Form LOF (B1.i) - Last office Form (Barcode version)

Form LOF (B1.ii) - Last office Form (Barcode version) during CMS downtime

Form BCF(B) - Body Collection Form (Barcode Version)

Appendix I - Criteria for selection of bodies for sharing compartment

Frequently Asked Questions and Answers (FAQ) on Procedures on Body Collection and Identification in HA Mortuaries

*For any issues in doubt / problems encountered regarding the identification procedures and identity of the body, appropriate assistance from mortuary senior staff must be sought and extra checking measures should be required, e.g. double checking by 2 staff (including one senior mortuary staff).*

## **Terms of Reference, Objectives and Guiding Principles** **Investigation Panel on Missing Baby Body PYNEH**

### **Terms of Reference**

1. To investigate into the incident in which a baby body was found missing from the Mortuary of Pamela Youde Nethersole Eastern Hospital (AIRS reference 5922).
2. To recommend improvement measures where appropriate.

### **Objectives**

Pursuant to the above terms of reference, the objectives of the Panel are as follows:

1. To obtain relevant facts whether documentary or oral, and for this purpose, to interview such witnesses as the Panel may consider appropriate;
2. To review the relevant information obtained, and study deficiency in the workflow, facilities, environment, organisation and competence of staff that may lead to the incident;
3. To prepare and submit an investigation report, together with recommendations for improvement measures, to the Cluster Chief Executive of Hong Kong East Cluster.

### **Guiding Principles**

The following principles are listed for the guidance of the Panel:

**Nature of the investigation** – This is not a disciplinary investigation but an internal one within the Hong Kong East Cluster. The Panel is charged with establishing the facts and circumstances surrounding the incident of missing dead body.

**Confidentiality** – The Panel will observe absolute confidentiality regarding information that may come into its possession during the course of its work.

**Impartiality** -- The Panel will conduct itself in an independent, fair and impartial manner.

**Accessibility** – The Panel will conduct itself in a non-adversarial manner in all its dealings with witnesses, and will operate as informally as circumstances permit. To be consistent with the nature and requirements of an internal investigation, all

interviews should be conducted for the purpose of fact finding and recommendation for improvement action.

**Effectiveness** -- The Panel will endeavour to proceed with its work as efficiently as possible within the limitations of its terms of reference, objectives and guiding principles. The Panel will set its own timetable and deadlines and will do all that it reasonably can to overcome delays which may lie outside its direct control.

**Accountability** – The Panel will hold itself accountable to the Cluster Chief Executive, Hong Kong East Cluster.