For discussion on
31 March 2006

LC Paper No. CB(2)1568/05-06(01)

Special Legislative Council Panel on Health Services

Fu Shan Public Mortuary Incident

Introduction

This note seeks to brief Members on the findings and recommendations of the report of the Independent Committee on the incident of the Fu Shan Public Mortuary.

Background

2. On 7 March 2006, the Fu Shan Public Mortuary under the Department of Health (DH) found that a dead body was missing and it was suspected to have been released to another family and cremated. The Director of Health promptly appointed an Independent Committee on 8 March to conduct a thorough investigation into the incident and a review on the relevant procedures. The Committee completed the investigation on 21 March and handed a report to the Director on 23 March.

Terms of reference

3. The three-member Committee comprises Mr. WAN Chi-keung as convenor and Ms Nora YAU and Ms Jasminia CHEUNG as members.

4. The terms of reference of the Independent Committee are:

- To conduct a thorough investigation into the incident of missing dead body from the Fu Shan Public Mortuary,

- To review the procedures and practices on identifying and claiming dead bodies in public mortuaries, and

- To make recommendations to the Director of Health on measures to

prevent the occurrence of similar incidents in the future.

The Report

5. The Executive Summary of the report is attached at Annex 1[1]. DH accepted the findings and recommendations of the Committee. The Department is committed to implementing the recommendations of the Committee to prevent recurrence of similar incidents and to improve the operation of public mortuaries.

Department of Health
March 2006

[1] Owing to its bulkiness, the full report is not attached. Soft copy of the Chinese Version is submitted to the Panel Secretary.

[Translation]

Annex 1

Executive Summary

On 7 March 2006, the Fu Shan Public Mortuary under the Department of Health found that a dead body was missing and it was suspected to have been released to another family and cremated. The incident has aroused grave concern among the public. Taking the incident very seriously, the Director of Health promptly appointed an Independent Committee on 8 March to conduct a thorough investigation into the incident and a review on the relevant procedures. The three-member Committee comprises Mr. WAN Chi-keung as convenor and Ms Nora YAU and Ms Jasminia CHEUNG as members. As regards public mortuaries, immediate improvement measures have been taken by the management to enhance identity verification of dead bodies.

The Committee commenced its work on 13 March, including reading through operational documents of public mortuaries, examining dispatch records of dead bodies, conducting site visits to all public mortuaries under the Department of Health and the mortuary of the Queen Elizabeth Hospital under the Hospital Authority, interviewing parties concerned and consulting relevant government departments as well as a scholar and expert in the field concerned.

Investigation was completed on 21 March. Results showed that on 4 March, two Mortuary Attendants failed to follow the working guidelines in that the identification bracelet and the Dead Body Card of the deceased were not checked for identity verification before releasing the dead body for identification. As a result, the dead body kept on Body Rack B112, which is believed to be that of the late Mr. WONG Fong-ho, was erroneously released to the family of the late Mr. WONG Yin-chau whose body was in fact kept on Body Rack A112. When realising their wrongdoing, the two Mortuary Attendants, instead of reporting the incident to their superiors, went so far as to move the body of the late Mr. WONG Yin-chau kept on Body Rack A112 to Body Rack B112 and then even throw away the bracelet, which could be used for identification purpose, on the body of the late Mr. WONG Yin-chau, with the intention of covering up their mistake. On 7 March, the family of the late Mr. WONG Fong-ho came to claim the body of the deceased, and it was found that the dead body kept on Body Rack B112 was not that of

the late Mr. WONG Fong-ho.

The Committee is of the view that the incident was mainly caused by human error. Although working guidelines in public mortuaries have been clearly set down, the two staff members involved failed to follow them. Furthermore, they even attempted to cover up their mistake when they realised the mistake that had been made. The Committee considers that they have been seriously derelict in their duty and should be held primarily responsible for the incident.

During investigation, the Committee found that another staff member had also failed to follow the guidelines. When releasing the dead body on body rack B112, the staff member found no identification means on the deceased, as a result the crucial step of checking the identify of the deceased before identification by family members as stipulated in the Public Mortuary Staff Working Manual could not be fulfilled. Despite that, the staff member still asked the family to identify the dead body. As this may lead to wrong release of dead bodies, the staff member is considered to have committed serious dereliction of duty.

Based on the information provided by the families concerned and the circumstantial evidence available, the Committee has reasons to believe that the dead body released to the family of the late Mr. WONG Yin-chau on 4 March and cremated is very likely to be that of the late Mr. WONG Fong-ho. The Committee is aware that the ash sample in question has been sent to the authority concerned for scientific identification and laboratory results are still pending.

In this incident, the families concerned have to bear, in addition to the grief of losing their beloved ones, unnecessary worries and uncertainties, resulting in an overwhelming feeling that their late family members may have been disappointed and aggrieved. Many of the relatives who showed up at the funeral held on 4 March for the late Mr. WONG Yin-chau could not attend the subsequent funeral on 12 March whereas the family of the late Mr. WONG Fong-ho is still unable to hold a ceremony to pay last respect to the deceased. The immense shock, rage and sorrow experienced by the two families are absolutely understandable. Apart from the extra time, effort and money spent on handling and

following up on the incident, there was wide media coverage and public concern on the issue. Under such circumstances, it is hard for the families to overcome their sadness. They are worry-stricken day and night. The Committee feels deep sympathy for their suffering.

The extensive coverage and follow-ups of the media on the incident reflect that it has not only shocked the community but also aroused fear and uncertainty among the public towards the standard of services provided by public mortuaries. No one can avoid death in life. For cases where the cause of death has to be ascertained, such as sudden deaths and deaths caused by accident, murder and suicide, regardless of the social stratum the deceased belonged, the relevant services are provided by public mortuaries. Therefore, public mortuaries under and the forensic services provided by the Forensic Pathology Service of the Department of Health are indispensable in our society. Such facilities and services are so important that no error could be tolerated, as they serve as the last gatekeeper in our life journey. Their qualities directly and significantly affect whether or not the deceased could eventually rest in peace with justice and dignity and whether or not the mourning families could overcome their grief. Since death is a taboo in the culture of our society, the plan of building and expanding public mortuaries cannot be implemented due to objections in local communities and various other reasons. Furthermore, the operational needs of public mortuaries have all along been neglected. For those mortuary staff who still work dedicatedly to serve the public despite the obnoxious nature of their jobs and the shortage in resources, they should be given recognition, affirmation and respect. This indispensable service should be provided with sufficient resources to make its operation and service meeting expectations of the general public. The Victoria Public Mortuary and the Fu Shan Public Mortuary, built years ago, could hardly cope with the needs of the increasing and aging population, nor could the supporting facilities to families meet public expectations. Moreover, the long waiting time for cremation service puts public mortuaries under additional pressure. Outdated architectural design makes it difficult to set apart the working area from the public area, which is undesirable to occupational safety and poses a higher risk of community infection. There is an imminent need to allocate additional resources to tackle these problems.

Subsequent to the incident, the Department of Health has taken immediate improvement measures as follows:

A. Strictly comply with working guidelines
B. Enhance procedures for identity verification
C. Explain relevant procedures to families
D. Step up monitoring of the CCTV surveillance system
E. Step up security at the rear entrance of the public mortuary

In order to prevent recurrence of similar incidents in the future, the Committee recommends improvement measures in the following areas:

A. Short-term measures

(i) Staff establishment, training and management

(a) Create clerical posts to handle duties at registration counters

- Make sure that the family of the deceased has made a positive identification of the dead body before signing the Certificate of Body Collection
- Avoid frequent rushing in and out of Mortuary Attendants between the lobby and the infection control areas

(b) Strengthen middle management

- Mortuary Officers and Mortuary Technicians should be well aware of their duties of enhancing supervision over the work of Mortuary Attendants
- Mortuary Officers should be mainly responsible for assisting the supervision of the overall performance of all levels of subordinates while Mortuary Technicians should focus on supervising the technical standard of staff
- Provide management training so that strict requirements and assessments can be made on frontline management

(c) Review the duty roster of staff

- Ensure that staff arrangements meet the demand in different time periods while attending to employees' right and need of taking leave

- Special attention should be paid to the period from 5pm to 9am the following morning as there is only one frontline staff member on duty with no support or supervision

(d) Enhance staff training

- Enhance on-the-job training for frontline staff
- Arrange briefing activities when notices and guidelines are promulgated
- Before computerisation is implemented in all public mortuaries, staff training and practice should be strengthened with appropriate assessments so as to ensure that they are equipped with the necessary skills

(e) Enhance internal audit

- Frequent surprise checks should be arranged by the Internal Audit Team
- Monitor the operation in public mortuaries through the CCTV surveillance system
- Review staff establishment and facilities of public mortuaries on a regular basis to ensure that they have sufficient resources to provide services meeting public demands

(ii) Facilities and services

(a) Reform the numbering system of body racks

- Reform the numbering system of body racks to ensure that all three-digit numbers for the racks in the cold rooms do not duplicate (e.g. A001-A032 for Cold Room A, and B033-B066 for Cold Room B)
- Use different colours for the doors of and the floors and walls inside different cold rooms for easy identification
- Use different colours for the labels on the Body Rack Laminated Record Sheet of body racks to indicate different cold rooms

(b) Prevent access to controlled areas in public mortuaries by unauthorised persons

- Step up security measures in controlled areas such as corridors outside cold rooms, passageways leading from the working area

to the lobby and the rear entrance leading to the body identification and release area, in order to prevent unauthorised entry and damage as well as reducing the risk of infection and virus transmission

- Provide an additional exit in the encoffining room on the wall leading outside for use by family members claiming dead bodies and funeral personnel; restrict the rear entrance previously shared by mortuary attendants, funeral personnel and families to mortuary staff only
- Strictly forbid entry into controlled areas in public mortuaries by non-mortuary staff and unauthorised persons
- Personal particulars of trespassers should be recorded clearly by mortuary staff
- Inform staff formally that they should strictly follow the above measures and that non-compliance will be subject to disciplinary action

(c) Expand the coverage of the CCTV surveillance system

- The CCTV surveillance system should cover all areas of security concern including entrances, working areas and the lobby; adjust the camera lens so that the facial appearance of subjects can be clearly filmed
- Install the CCTV control unit in a locked room
- Strengthen communication with staff to make them understand that the CCTV surveillance system is installed for preventing the entry of unauthorised persons and vandals on the one hand and safeguarding the personal safety of staff on the other, in particular during the 16-hour period from 5pm to 9am the following morning when only one staff member is on duty. Moreover, in the event of unreasonable complaints, the CCTV surveillance system can provide video clips to prove innocence and uphold justice for dedicated and loyal staff

(d) Provide bereavement counselling service

- Appropriate area should be allocated in public mortuaries for volunteer organisations invited to offer bereavement counselling service to families of the deceased. Such organisations can provide the families with assistance in handling emotional and

social problems arising from the loss of their beloved ones and also explain to them basic funeral procedures and relevant information

(e) Provide facilities for holding simple funeral ceremonies

- In order to cater for the needs of families of the deceased (such as those who will not hold the mourning ceremonies in funeral parlours but will take the dead bodies directly from public mortuaries to crematoria or cemeteries for various reasons, such as insufficient time in organising the funeral ceremony, few number of relatives attending the ceremony or financial difficulties), the Department can provide additional facilities in public mortuaries for holding simple yet dignified ceremonies of last rites for the deceased after collection of dead bodies
- Existing related facilities in hospitals under the Hospital Authority, such as the facilities and operational arrangements of the Hall of Eternal Peace in the Queen Elizabeth Hospital, are useful reference for the Department
- Currently, staff can hardly stop the families of the deceased from holding ceremonies after collection of the dead bodies in the external passageway outside the rear entrance of public mortuaries. Apart from obstructing the receipt and release of dead bodies, it causes inconvenience in the use of the rear entrance by other families members who come for body identification. The Department should allocate appropriate areas for simple funeral ceremonies to enable its staff to carry out the instructions by advising bereaved families to observe the rules.

(iii) Procedures

(a) Improve procedures on body identification

- Make fingerprint records when dead bodies are received
- Take a photograph of the dead body upon its receipt at the public mortuary and put such photograph in the plastic bag holding the Dead Body Card for identity verification
- Allow claimers of dead bodies to be accompanied by other relatives during identification

(b) Set up an alert system on the utilization rate of body racks

- Set up an alert system which will give alert signals when the body racks in cold room of public mortuaries are about to exhaust so that the Food and Environmental Hygiene Department can be notified in advance to take relevant measures to transport new dead bodies found to other public mortuaries

(c) Put identification bracelets on the dead bodies at the scene where they are found

- Since several dead bodies may be found in one case, identification bracelets should be attached to the dead bodies with the process witnessed by the most senior police officer at the scene when they are found
- For the above cases where several dead bodies are involved, the Police will use the same station report number for different bodies. For identification purpose, the Police may consider adding letters like A, B, C at the end of the station report number

(d) Improve the design of identification bracelets

- Before implementation of computerisation, wider identification bracelets should be used to make the handwritten information on them more legible

(e) Require endorsement for record updating and revision

- If an officer updates or revises any records in the Mortuary Body Registration Book, he or she should make an endorsement and mark the date and time concerned

(f) Set up an inter-departmental working group

- The Hong Kong Police Force, the Food and Environmental Hygiene Department as well as the Department of Health should form an inter-departmental standing working group with a view to enhancing mutual communication and exchanging views regularly on the arrangements on transportation and receipt of dead bodies. Besides, various departments should inform all frontline staff of such mechanism and encourage them to express their opinions via their superiors or in anonymous ways for better

coordination among these departments.

(iv) Public education

- Enhance public education so as to enable members of the public to address the issues of hospice matters and bereavement with relevant basic information in hand. As the facilities of public mortuaries fail to keep up with our growing and aging population, additional resources should be injected as soon as possible to build or improve mortuary facilities for ensuring smooth operation and continuous upgrading in public mortuaries so that expectations of the general public can be met.

B. Medium-term and long-term measures

(i) Improve facilities in the lobby

- Play briefing videos for families waiting at the reception area to introduce procedures on body identification
- Recruit customer service officers to answer public enquiries
- Install the public address system to call families into the meeting room to undergo relevant formalities so that manpower can be saved

(ii) Strive for professionalism

- The Committee agrees with Prof. Philip S L BEH, Associate Professor of the Pathology Department of the University of Hong Kong, that mortuary service has to be improved thoroughly. In the long run, we should make reference to overseas experience and establish a professional grade to undertake the management and daily operation of public mortuaries. The grade structure proposed by Prof. BEH is as follows:

Mortuary Head
↑
Mortuary Technologist
↑
Mortuary Technician
↑
Mortuary Technician Trainee

- Staff should be promoted only if they pass the relevant examinations. Enhanced service conditions and employment packages should be offered if employees of higher quality are to be recruited. Upon appointment, new recruits should be provided with structured training, including human anatomy, occupational safety, bereavement counselling and legislations on coroner's inquest and organ transplant.

- The Committee looks forward to due recognition, respect and regard among the general public for mortuary work as this will promote the building up of a good service culture and ensure the provision of services fulfilling public expectations. In the long run, the public mortuary should not be a place of death alone and can be transformed into a place of hope and health promotion. Take the Victorian Institute of Forensic Medicine in Melbourne, Australia as an example. The Institute is not only a public mortuary, it also provide tissue and organ donation and harvest facilities, genetic counselling, bereavement counselling and a site for the coroner, thus enabling the provision of more comprehensive services to the public. Developing visions and directions of a similar nature will help attract talents and promote professionalism and professional advancement. As a result, employees at different levels will develop pride for their contribution at work to our society, thus establishing a sense of self-realisation and the capacity for self-improvement.

On 23 March 2006, the Committee submitted its report to the Director of Health and announced the investigation results and recommendations to the public.