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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 9 March 2009

The Pamela Youde Nethersole Eastern Hospital mortuary incident

Purpose

This paper gives an account of the past discussions by the Panel on Health Services (the Panel) on the incident in which the dead body of a baby boy was found missing from the mortuary in the Pamela Youde Nethersole Eastern Hospital (PYNEH).

Background

2. On 15 December 2008, a baby passed away at the PYNEH. On 17 December 2008, a large-size adult dead body was placed in the same compartment with the deceased baby's body. On 2 January 2009, a Mortuary Technician (MT) conducted a bi-weekly routine checking of the number of bodily parts and discovered that the baby boy was missing. The MT and the Mortuary Attendant (MA) started a search for the body in the mortuary but to no avail. At 4:45 pm on 5 January 2009, the MT reported the baby boy missing incident to the hospital management, which subsequently reported the incident to the Hospital Authority (HA) Head Office and the Police. 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.

Deliberations of the Panel

3. The Administration and HA briefed the Panel on 12 January 2009 on the preliminary investigation of the PYNEH mortuary incident, actions taken by the PYNEH after the incident, and the additional measures that would be implemented by HA to minimise risks in hospital mortuary operations.

Preliminary investigation of the incident

4. Members noted that the occupancy rate of the PYNEH mortuary on 17 December 2008 was about 75%. Hon Albert CHAN asked how prevalent was the sharing of two deceased bodies in the same compartment in HA mortuaries.

5. HA advised that in general, the shared use of one compartment by more than one bodies was not allowed. Only under special circumstances, such as when the utilisation of the mortuary had exceeded 100%, would two deceased bodies be considered to be placed in the same compartment. The PYNEH management was not aware that a large-size adult dead body was placed in the same compartment with the deceased baby's boy, until after the mortuary staff had reported the baby boy missing incident to the management.

6. Dr Hon LEUNG Ka-lau asked why the mortuary staff still put the baby body and the large-size adult body in the same compartment when the utilisation had not reached full capacity.

7. HA responded that the staff concerned believed they had followed the proper procedures for storing the bodies. There were three special compartments for storing either a large-size dead bodies or baby bodies in the PYNEH mortuary. In the absence of additional special compartments, the staff concerned chose to put the baby body and the large-size adult body together in the same compartment. The reason why the staff concerned did not consider moving the baby body to another compartment was because they were concerned about the additional risks of body mix-up carried by transfer of body to another compartment. HA, however, pointed out that these were only speculations on why the staff concerned did what they did. Inquiry into what went wrong was being conducted by the Police and the independent investigation panel set up by PYNEH to further investigate the incident.

Actions taken by PYNEH after the incident

8. Members noted that the PYNEH had 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 had been set up to further investigate the incident and to recommend to the

hospital management to take necessary follow-up actions, including disciplinary actions.

9. Concern was raised about HA only putting the blame on the frontline staff and not the management.

10. HA responded that in accordance with HA's human resources policy, the hospital management would take appropriate disciplinary actions upon findings of the independent hospital investigation team set up by PYNEH to further investigate the incident. In the meantime, the duties of the MA concerned had been temporarily suspended as he had become emotionally unstable after the incident. HA staff had been telephoning the MA concerned daily to see how he was coping. Arrangements would be made for the MA concerned to work in other areas in the Department of Pathology after his condition had stabilised. As regards the MT, he had been temporarily taken off his supervisory duties to carry out frontline work. Nevertheless, the decisions on how to deal with the incident, including disciplinary actions, would hinge on the findings of the independent hospital investigation team and their recommendations to the hospital management.

Measures to minimise risks in hospital mortuary operations

11. Members noted that in the light of the findings from the PYNEH incident, HA would implement additional measures to minimise risks in hospital mortuary operations. These included -

(a) daily verification of deceased bodies against mortuary records;

(b) installation of CCTV in mortuaries for better monitoring; and

(c) half-yearly audit on compliance with established standard operation procedures.

12. Members further noted that in PYNEH, all dead bodies (whether adult or baby) were put inside adult-size plastic body bags which were silver in colour by nursing staff in the in-patient areas. Following the incident, HA decided that the colour of body bags should be standardised across all mortuaries in public hospitals. In the long run, HA would source small body bags for dead bodies of babies. In the interim, HA would use transparent plastic bags for keeping bodies of dead babies and put these bags individually in semi-transparent plastic boxes. HA clarified that garbage bags were never used to store dead bodies, albeit black plastic bags were used in some HA mortuaries to store aborted foetus from pregnancies before 24 weeks, amputated body parts and body tissues. After review, the use of black body bags to store aborted foetus, amputated body parts and body tissues had been banned across the board in HA.

13. Hon Audrey EU was of the view that HA should cross-check all operation procedures for body collection and identification to ensure complete compliance, and

install a sound-emitting electronic device to the wristband of the deceased so as to avoid a dead body from leaving the mortuary without the knowledge of mortuary staff as had happened in the PYNEH incident.

14. HA advised out that in addition to conducting daily verification of deceased bodies against mortuary records, mortuary staff had been instructed not to put two dead bodies in one body bag and not to put one large-size body and one small-size body in the same compartment. Nevertheless, HA agreed to examine whether it was necessary to cross-check all operation procedures for body collection and identification. HA further advised that installing an electronic tag to the wristband of the deceased was certainly one area which HA would be looking at to prevent a dead body from leaving the mortuary without the knowledge of mortuary staff.

15. Concern was raised as to whether the lack of sufficient mortuary staff was one of the main contributing factors to the PYNEH incident. HA did not believe that staffing level played a role in the PYNEH incident. While HA would examine whether it was necessary to introduce a cross-checking system for the release of deceased bodies, it should not require two persons to discharge a body properly and accurately.

16. Some members, including Hon WONG Kwok-hing, were of the view that the root cause of the PYNEH incident was due to the lack of respect paid by HA staff to the deceased patients.

17. HA advised that all mortuary staff had been provided with training on the updated procedures for body collection and identification and the use of the new Mortuary Information System in 2007 and 2008, to ensure staff vigilance and compliance with the procedures. One other focus of the training was on the importance of clear documentation and correct use of label to indicate sharing of compartment. HA would also stress the importance of paying greater respect to the deceased in future training for mortuary staff. Following the PYNEH incident, HA would conduct a comprehensive review on mortuary management and explore measures to strengthen mortuary operation. Staff training and work culture, as well as the accountability and responsibility issues, would be among the various areas covered by the review.

Recent developments

18. The investigation panel set up by PYNEH released its report on 17 February 2009. The hospital management accepted the investigation findings and the Head of the Pathology Department has been instructed to take immediate actions to follow up and implement improvement measures as recommended in the investigation report.

19. In accordance with HA's human resources policies, a Committee of Inquiry (COI) has been set up by PYNEH to look more specifically into the performance of the MT and the Administrative Assistant to decide on the appropriate disciplinary

actions. On 19 February 2009, PYNEH announced that having studied the COI's report on its inquiry on the MT, it decided to terminate the employment of the MT with immediate effect. COI will continue with its inquiry regarding other staff's role in the incident and will deliver their findings and recommendation as soon as practicable.

Relevant paper

20. Members are invited to access the Legislative Council website (http://www.legco.gov.hk) for details of the relevant paper.

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