For discussion on
8 November 2010

Legislative Council Panel on Health Services

Fu Shan Public Mortuary Incident

Purpose

This paper briefs Members on the incident in which autopsy was mistakenly performed on the body of a 77 year-old lady in Fu Shan Public Mortuary on 19 October 2010.

Background

2. A major function of the Forensic Pathology Service (FPS) of the Department of Health (DH) is to provide support to the Coroner in his enquiry into causes and circumstances of deaths. Of particular relevance is the provision of autopsy service in public mortuaries.

3. FPS runs four public mortuaries, namely Fu Shan Public Mortuary (FSPM), Kowloon Public Mortuary (KPM), Kwai Chung Public Mortuary (KCPM) and Victoria Public Mortuary (VPM). KPM is reserved for contingency use as a storage depot only.

The FSPM incident

4. On 17 October, a 77-year-old lady (the Lady) with history of ischemic heart disease collapsed at home. She was admitted in emergency status into Kwong Wah Hospital, but subsequently certified dead.

5. Relatives of the Lady requested waiver of autopsy during the body identification interview at FSPM the next morning. This was supported by the Senior Medical Officer (SMO) who conducted the

identification interview as the Police raised no suspicion and external examination of the body did not reveal anything suspicious. Wavier of autopsy was granted by Coroner in the same afternoon.

6. Later on that afternoon, when a Mortuary Officer made preparations for autopsies to be performed the following day, he mistakenly prepared labels with the Lady's name and personal particulars, and attached them to the case file of a decomposed male body which required autopsy. In other words, all the documents in the case file were those of the decomposed male body except for the labels on the top.

7. The Mortuary Officer had prepared three documents. First, it was a wrongly prepared toxicology request form, meant for the decomposed male body, but bore the name and case history of the Lady instead because of the wrong label. This toxicology request form was kept in FSPM's General Office together with the toxicology request forms of the other five cases which required autopsy examination on 19 October. Second, there was the wrongly labeled action slip which mortuary staff and doctors used as checklist for each autopsy case. Lastly, the Mortuary Officer, based on Coroners' autopsy orders, had to prepare an autopsy list for bodies to be examined the next day.

8. The next morning, mortuary attendants picked up the female body for autopsy instead of the decomposed male body as they referred to the wrongly labeled action slip.

9. A mortuary attendant in fact spotted the mismatch before autopsy because he discovered discrepancy in information between the labeled action slip and the autopsy list. He immediately alerted a medical officer on the spot.

10. The medical officer checked the number of autopsies needed to be performed on 19 October against the number of bodies in the autopsy room and also the names on the action slips against the bracelets of all six bodies which were to undergo autopsies. No mismatch was noted.

11. The next stage saw another acting Senior Medical Officer (SMO) going through the case histories of all six cases to be autopsied that morning through the toxicology request forms placed in the General Office.

12. Moreover, before starting the autopsy, the acting SMO checked the information on the Lady's bracelet against that on the label affixed to the action slip. Again, they matched as both bore the information of the Lady.

13. The incident came to light after the acting SMO had completed the autopsy on the Lady's body and started labeling the toxicology specimens collected. He found that the type of specimens required to be collected as specified on the specimen labels bearing the Lady's name were those for a decomposed body. As the body of the Lady was not decomposed, he immediately logged into the Mortuary's computer system, only to find out that the autopsy of the Lady had already been waived by the Coroner. The matter was reported to the Service's management.

Procedural guideline for public mortuaries

14. The FPS procedural guidelines for verification of dead bodies before autopsy stipulate that verification should be done twice, first by mortuary staff when the bodies are laid on autopsy tables, and then re-checked by the medical officer responsible for autopsy.

15. However, in this incident, mortuary staff relied on labels affixed to the action slips and the autopsy lists to verify identities of bodies instead.

Remedial measures

16. DH is committed to improving mortuary operations to minimise chances of errors and having an effective monitoring system to prevent recurrence of similar incidents.

17. Immediately following the discovery of this incident, Mortuary Officers have been reminded that in preparing autopsy case bundles, utmost care should be taken to check all received and prepared documents and labels, against autopsy orders received from the Coroners.

18. All public mortuaries staff will be regularly reminded to follow the procedural guidelines. FSPM has also aligned its body verification processes to follow closely the requirements of the guidelines as has been the case in KCPM and VPM, i.e. mortuary staff to check identity of bodies on autopsy tables against autopsy orders, and medical officers to recheck identity of bodies against autopsy orders before performing autopsies.

19. In addition, a medical officer has been assigned as duty officer for the autopsy rooms to handle any contingencies related to autopsies, including the removal of dead bodies from cold rooms to autopsy rooms.

20. To better ensure that public mortuaries comply with the requirements of the guidelines, all public mortuaries are required to obtain accreditation from ISO accrediting agencies. In the interim, the three public mortuaries will conduct crossed procedure auditing among themselves.

21. The acting SMO who performed the autopsy has been temporarily posted out of FSPM, pending further investigation. Disciplinary actions will be taken against relevant staff according to standing protocol.

Advice Sought

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

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