HTA
Human Tissue Authority

Sharing learning

Lessons learned from HTA reportable incidents in the post mortem sector, 2012/13

Introduction

The Human Tissue Authority (HTA) regulates organisations that remove, store and use human tissue and organs for research, medical treatment, post-mortem examination, education and training, and display in public. We also give approval for organ and bone marrow donations from living people.

In England, Wales and Northern Ireland, mortuaries where post-mortem examinations take place are licensed and inspected by the HTA. We help mortuaries improve the standard of services they provide, so the public can be confident that deceased people and their families are treated with dignity, respect and sensitivity.

The HTA is committed to supporting the post mortem sector by providing advice and guidance to all those working in and connected with post mortem services. Part of this is sharing learning gained from our inspections of mortuaries and reviews of serious incidents that are reported to us.

Our work with the post mortem sector is informed by our Histopathology Working Group (HWG), which meets twice a year to share information, consider current issues and contribute to the development of HTA policy affecting the sector. Membership of the HWG includes representatives from key stakeholder groups, including The Royal College of Pathologists, The Association of Anatomical Pathology Technology, the Home Office and the Coroners Society of England and Wales.

HTA-licensed establishments in the post mortem sector are required to notify the HTA of any reportable incidents, including 'near misses', within five days of the incident being discovered. This report contains information about HTA Reportable Incidents (HTARIs) that were notified to the HTA during the 2012-13 business year. It includes statistical data on the numbers and types of incident, as well as a number of hypothetical case studies based on incidents reported during the period. The report also provides 'lessons learned' and advice and guidance for establishments where post mortem activities take place. Finally, for information and to reinforce our commitment to supporting licensed establishments, the report provides an explanation of how we manage HTARIs when they are reported to us.

We are grateful to all those establishments that have submitted detailed HTARI notifications, not least because they have provided valuable information about how things can go wrong and what can be done to make sure that they and others get things right. We encourage sharing of this report with colleagues who may be involved in the care of the deceased, as well as coroners, their officers and funeral directors.

Background

Establishments licensed in the post mortem sector have been required to report serious incidents to the HTA since 1 May 2010. Until 31 March 2013, these were known as 'Serious Untoward Incidents' (SUIs). We began using the term 'HTA Reportable Incident' on 1 April 2013 at the request of the HWG and following a small survey of Designated Individuals who had reported incidents to us. The change in terminology was to distinguish incidents that should be reported to the HTA from those that fall within the reporting framework of the NHS National Reporting and Learning System (NRLS).

In the past year we have also reviewed our internal procedures for the administration and management of incident notifications and introduced online reporting via the HTA's web Portal. The Portal facilitates robust and auditable record-keeping of communications and document submissions from notification through to the conclusion of an incident investigation. It also enables greater analysis of data, in particular trends in contributory factors, which will improve our ability to identify and feed back the lessons learned from serious incidents. We hope that this will help reduce the likelihood of incidents occurring in licensed establishments.

Our intention is to produce similar reports on an annual basis. We would welcome feedback about this document, either via the general enquiries email address (enquiries@hta.gov.uk) or to any member of the HTA Regulations team. Further contact details are on the final page.

HTA Reportable Incidents (HTARIs), 2012-13

Incidents are reported under 16 different classifications (see the incident classification table on next page). These were revised in 2012 to include two new classifications:

- Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family
- Viewing of the wrong body

We introduced these new categories because HWG members felt they may indicate failures in systems governing HTA-licensed activities, while not being strictly in line with the HTA's remit in relation to post mortem services.

The HTA received 92 incident notifications during 2012/13. Not all of these were reportable incidents, meaning that on review they were deemed not to fall within one of the reportable incident types or were considered not to be of sufficient severity to warrant consideration by the HTA.

Of the 92 submitted, 73 (80%) met our reporting criteria and were classed as HTARIs, two were 'near misses' and 17 were not considered reportable incidents, although they were serious in nature. While not reportable to HTA, we expect any serious incident that does not fall within our reporting classifications to be investigated by establishments in line with their internal governance and incident reporting procedures and to be escalated appropriately. This is an aspect of governance that we review routinely during inspections.

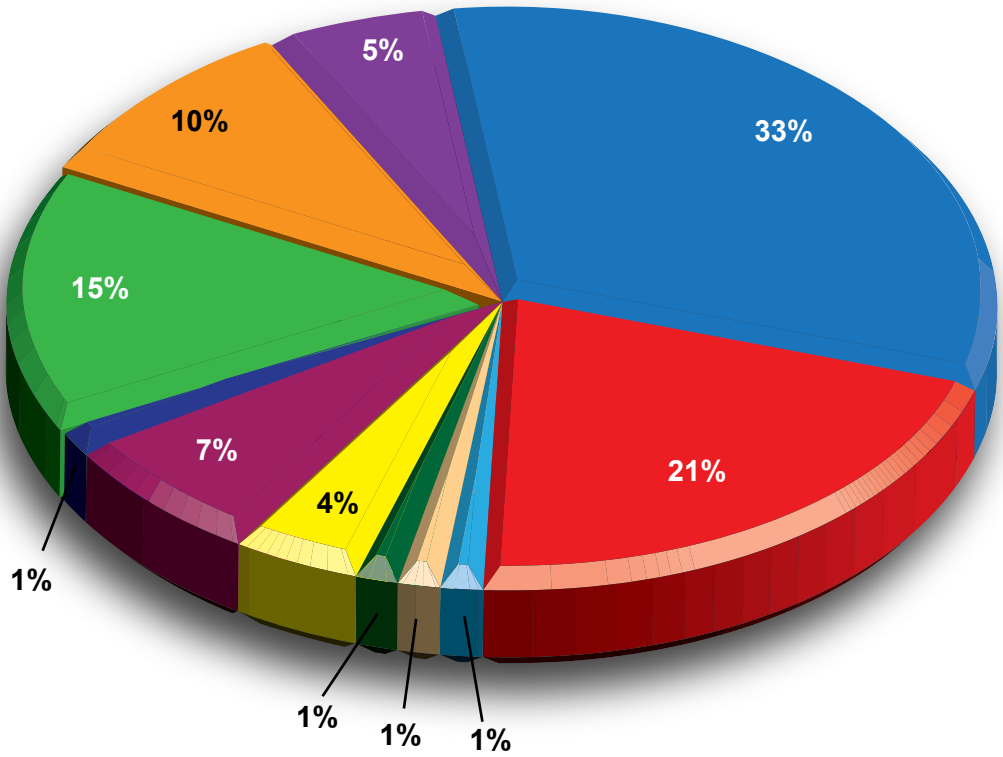
Set against the total number of post-mortem examinations conducted each year (around 95,000 in England and Wales), 73 serious incidents is clearly a very small number. However, in each of these cases, there was the potential for significant distress to the family of the deceased and a reputational risk to the establishment concerned, with the ensuing damage to public confidence.

While we cannot determine whether all incidents are reported to us, we regularly remind mortuary staff of their reporting obligations. We also encourage those who are in doubt about whether an incident should be reported to contact us for advice so that we can work with them to clarify their obligations and, where necessary, resolve any issues.

The table on the next page shows the numbers and types of HTARIs reported in 2012-13.

Incident Classification	Number of Incidents
Accidental damage to a body	24
Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence	15
Discovery of an additional organ(s) in a body on evisceration for a second post-mortem examination	0
Discovery of an organ or tissue following post-mortem examination and release of body	1
Disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family	0
Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family	1
Inadvertent disposal or retention of an organ against the express wishes of the family	1
Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services	3
Loss of an organ	0
Major equipment failure	5
Post-mortem examination conducted was not in line with the consent given or the post-mortem examination proceeded with inadequate consent	1
Post-mortem examination of the wrong body	0
Release of the wrong body	11
Removal of tissue from a body without authorisation or consent	0
Serious security breach	7
Viewing of the wrong body	4
Total	**73**

A pie chart of the incident types which occurred at least once is on the next page, showing each as a percentage of the total.



- Viewing of the wrong body
- Accidental damage to a body
- Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence
- Discovery of an organ or tissue following PME and release of body
- Major equipment failure
- PME conducted was not in line with the consent given or the PME proceeded with inadequate consent
- Release of the wrong body
- Serious security breach
- Disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family
- Inadvertent disposal or retention of an organ against the express wishes of the family
- Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services

Emerging themes

Two categories of incident occurred much more frequently than others: 'accidental damage to a body' and 'release of the wrong body'. In addition, we received 22 notifications of the category 'any incident not listed here that could result in adverse publicity that may lead to damage in public confidence', 15 of which were determined to be HTARIs. These covered a range of serious incidents, including loss of belongings of the deceased, significant damage to storage facilities by extreme weather and excessive decomposition of a body in storage.

Our review of establishments' investigation reports highlights a number of key contributory factors which come up regularly:

- **Human error, usually as a result of a failure to follow documented procedures**
- **Poor communication between mortuary staff and other employees**
- **Technical failures such as equipment or security system failures**
- **Inadequate labelling of bodies**
- **Ineffective systems for highlighting same or similar name**
- **Lack of risk assessments for mortuary procedures**
- **Lack of out of hours contingency arrangements**

There have been several occasions when the actions of individuals not directly employed by the establishment have contributed to the incident. We recommend strongly that anyone entering the mortuary for work-related reasons should receive a local induction and be required to read relevant procedures and, if considered necessary, be subject to supervision while in the mortuary. This applies to police officers, funeral directors, porters and external contractors.

In addition, we have found that in some cases low staffing levels may have been a contributory factor. While the HTA does not make recommendations about mortuary staffing levels, we advise that identification checks are always carried out by two people. Risk assessment of mortuary activities should consider staffing requirements and where staffing levels are of concern, the Designated Individual should undertake a staffing needs analysis and, if necessary, highlight any staffing shortage as an organisational risk to the establishment.

There follows a series of scenarios developed from incidents that were reported to us during 2012-13. They are hypothetical, but illustrate what can go wrong in a mortuary setting and what can be done to prevent something similar happening.

After each scenario we list possible contributory factors, actions taken in mortuaries to prevent similar incidents happening again and advice from the HTA on what more can be done to prevent reoccurrence.

Scenario 1: Accidental damage to a body

Portering staff bring to the mortuary the body of a bariatric patient who has died in hospital during the night. Mortuary staff are occupied in the post-mortem room and therefore the porters transfer the deceased into a standard fridge without their assistance. They identify an available space at the top of one of the refrigerated units and, using the hydraulic trolley, begin to place the body into the space.

However, due to the weight of the body and uneven weight distribution, the tray tips back causing the two porters to reach up and push the tray into position. They are unaware that the deceased's arm has come free from its shrouding and is in contact with the side of the fridge.

When the anatomical pathology technologist (APT) comes to do the normal admissions checks later that day, they pull the tray out of the fridge. Due to the body's size and positioning on the tray, the arm is caught in the door-jam as the tray is removed. Examination reveals two significant breaks in the skin over the right arm.

Contributory factors

- Incorrect positioning of body on tray
- Instability of tray/trolley
- Inadequate equipment or poor practice when handling very large or heavy bodies
- Incorrect transfer technique
- Lack of training for porters

Actions to reduce future risk

- Review of risk assessments of body transfers to inform procedures
- Regular training and re-training of portering staff, APTs and funeral directors on body handling
- Review and update of procedures for the transfer of bariatric bodies, to include minimum staff requirements when transferring patients above a specific weight and the use of lower fridge spaces where possible

HTA advice and guidance

- Establish training and guidelines for the receipt of deceased with unusual body morphology, including out of hours contacts
- Consider separate storage for bariatric bodies
- Ensure that bodies are shrouded sufficiently tightly when placing them into the fridge to prevent arms coming lose and being at risk of damage

Key learning point

Procedures for body handling and body storage need to recognise and reflect the risks to bodies of unusual morphology or weight, and staff should be trained in what actions to take in these circumstances.

In a small number of cases reported under this classification, there was decomposition of a body due to fridge failure.

Scenario 2: Release of the wrong body

In a very busy mortuary, a funeral director arrives to collect a body at the same time as two other funeral directors. The funeral director checks the mortuary whiteboard for the deceased's name to locate the fridge number, while the other funeral directors are informed by the APT that they need to wait for their collections.

The body is removed from the fridge space identified by the funeral director. The details on the body's identification tag have been slightly blurred, but the surname of the deceased is still clear on the label and matches the name of the deceased on the funeral director's form. The mortuary register is signed by the APT and the funeral director, in line with the mortuary's body release procedure, and the body is removed from the premises. Meanwhile, the waiting funeral directors are checking the white board for fridge numbers and reviewing the paperwork for their collections, while talking to the APT.

Later that day, a fourth funeral director arrives to collect the body of a deceased person with the same surname as the first body released. When the deceased is removed from the fridge, it is evident that the details on the release form (full name and date of birth) do not match those on the identification tag, and that the body to be collected had been released earlier in the day in error.

Contributory factors

- No system or inadequate system for flagging up same or similar name
- Insufficient identification information on identity tags on bodies
- Failure to follow mortuary release procedures, possibly as a result of the presence of several funeral directors in the mortuary at the same time

Actions to reduce future risk

- Implementation of a new system for flagging up bodies of the deceased with the same or similar names using coloured tags, highlighted names (on whiteboard, in mortuary register and on fridge doors) or a grid system (see next page)
- Set times for funeral directors to attend to collect bodies and a system of queuing
- New minimum requirements for the labelling of bodies: first name, surname, date of birth and mortuary number
- A new release procedure, setting out the minimum paperwork and information required, shared with all relevant internal staff and funeral directors

HTA advice and guidance

- Periodic audit of release procedures, documented in a schedule of audits
- Risk assessment of storage of bodies with same or similar names
- Establishment's release procedure to require the mortuary register to be signed by those individuals who have undertaken an identity check

With regard to the 'same name' procedure, an effective system has been introduced by one establishment, which may help others mitigate the risk of wrongful release.

A whiteboard in the body storage area is marked with the letters of the alphabet on the y axis and a number of columns extending along the x axis headed alternately 'Name' and 'Fridge location'. When a body is received into the mortuary, the name of the deceased is recorded in the appropriate row corresponding to the capital letter of their surname, along with the number of the fridge space.

When the body of a deceased person with the same or a phonetically similar surname is received and their name is added in the next column of the row relating to the capital letter of their surname, a scan across the rows highlights similarities. Those names are then highlighted in red marker and an alert notice is applied to the relevant fridge doors and to the shrouds in which the bodies are wrapped.

	Name	Fridge	Name	Fridge	Name	Fridge	Name	Fridge
A	Anderson	1	Ames	4	Anderton	3		
B	Brown	12	Burns	8				
C	Carr	17	Collins	6	Campbell	9		
D								
K	Kent	21	Knight	14	Kerr	15		
L								
M								

Key learning points

1. An effective system of flagging up same or similar names is crucial to minimising the risk of body mix-up.

2. Relying on the deceased's name is not enough and there should be at least one other unique identifier.

3. Identification checks should always be made by two people.

Scenario 3: Serious security breach

A mortuary is undergoing building improvements undertaken by external contractors. The contractors are advised of the need for confidentiality and the importance of maintaining the security of the premises to ensure the safety and dignity of the deceased.

A member of mortuary staff is escorting the contractors from the mortuary as work is completed for the day, when the telephone rings in the office. The member of staff leaves the contractors at the external door of the body store to answer the phone. When they return to the body storage area, one of the contractors has opened a fridge door and is looking at the bodies contained in the fridge.

Contributory factors

- The mortuary door was left unlocked giving open access
- The area was not secure
- 'Morbid curiosity'
- Failure to follow security procedures

Actions to reduce future risk

- Retraining of staff on security risks within the mortuary
- Enhanced induction for contractors and others entering mortuary areas
- Review of security systems, including implementation of security key pads
- Review of access arrangements for non-hospital staff
- Review of out of hours access procedures

HTA advice and guidance

- Risk assessment of mortuary premises to further improve security
- Risk assessment of lone working and of contractors working in the mortuary
- Consideration of installation of CCTV

Key learning point

The mortuary can be a vulnerable area and needs to have adequate security arrangements in place to ensure the safety of those working there and the deceased. Particular attention should be paid to controlling access by non-establishment staff.

Scenario 4: Any incident not listed here that could result in adverse publicity that may lead to damage in public confidence

In a busy general hospital, fetal tissue, fetuses and deceased neonates are stored in a fridge in the maternity ward before being transported to the histology laboratory or to the mortuary. A fetal tissue specimen does not arrive at the histology laboratory as expected, and cannot be found. It is unclear from interviews with staff or from CCTV pictures when, or how, the specimen was misplaced.

Contributory factors

- Inadequate lines of communication between maternity staff and the Designated Individual responsible for HTA-licensed activities
- The risks to security and traceability of tissue had not been assessed
- Procedures for the transfer of fetal tissue were not documented clearly and there was poor staff awareness of them

Actions to reduce future risk

- Making a senior member of staff on the maternity ward a Person Designated on the HTA licence, who meets regularly with the Designated Individual
- Risk assessment of the premises, in particular:
  - The security of the ward room where the fridge is located
  - The potential for fridge breakdown and contingency arrangements
  - Fridge temperature monitoring
- Introduction of a logbook on the ward to record the storage and movement of fetal tissue and neonatal bodies
- Daily checks on tissue and bodies stored in the fridge
- Monthly audits of fetal tissue stored in the histology laboratory
- A procedure on what to do if fetal tissue is received in the laboratory with incomplete or missing documentation
- Nominated staff members to transport specimens from the ward to the mortuary or laboratory

HTA advice and guidance

- Audit of the new processes to ensure they are effective in mitigating identified risks

Key learning point

Areas outside the mortuary may be involved in the storage of tissue for use for scheduled purposes and subsequent disposal. To ensure compliance with HTA requirements, and to ensure that the wishes of the deceased's family are carried out, it is prudent to have a named contact (Person Designated) in each of these areas, who can oversee these activities and provide assurance to the Designated Individual that suitable practices are being carried out.

Scenario 5: Major equipment failure

A mortuary's refrigerated storage units are alarmed and trigger a call to the hospital switchboard in the event of an increase in temperature above a set limit. The storage fridges are also connected to the hospital's essential power supply.

A power supply failure affecting part of the hospital site occurs in the early hours of the evening, once all staff have left the mortuary. Upon returning to work the following day, mortuary staff notice that the fridge temperature readout is not working. Upon further investigation it is discovered that the bank of fridges has no power supply, the temperature has risen overnight to 10°C and the alarm has not sounded. Fortunately, there is no sign of decomposition of the bodies being stored in the fridges.

Internal investigation of the incident finds that although the fridges are linked to the hospital's essential power supply network, this was not activated as the power failure only affected a small part of the hospital site, including the area housing the mortuary. The alarm did not sound as it too had no independent power or battery back up, so although the temperature rose above the set limits, the alarm did not alert the hospital's switchboard.

Contributory factors

- The mortuary was not aware of the hospital's emergency power supply protocol and that the emergency power supply was not activated unless a major power failure affecting the whole site occurred
- The fridge temperature monitoring alarm system did not function independently of power to the fridges

Actions to reduce future risk

- Installation of a new alarm system which is triggered both by deviations in temperature and power supply failure. The new alarm has a battery back up to ensure it can still be triggered in the event of a power outage
- Review of the fridge alarm testing procedure to ensure the alarm is triggered and sounds due to temperature deviations and also sounds should there be a failure of the fridge's power supply
- Amendment of the establishment's procedure on what to do in the event of a power shortage, in particular to include a physical check of the fridges

HTA advice and guidance

- Fridges should be subject to a programme of routine maintenance
- Introduction of a system for checking and monitoring fridge temperatures, including out of hours
- Procedures for identifying and dealing with fridge failures
- Fridges should be alarmed, and the alarms should be tested regularly. Where fridges are not alarmed, there should be arrangements for manual temperature checks out of hours

Key learning points

1. Fridge alarms should not be powered from the same source as the fridges but should operate independently.

2. Establishments' emergency power supplies may only be triggered in the event of a site-wide power failure, so it is important to check power supply arrangements.

Scenario 6: Major equipment failure

During routine temperature checks of the mortuary body storage fridges, it is discovered that the temperature of one bank of fridges has risen over the weekend to 11°C. The alarm is not sounding locally and the alarm linked to the hospital's switchboard has not activated.

Three bodies are being stored in the affected fridges, one is scheduled for a post-mortem examination that morning and shows visible signs of decomposition. The storage fridges have been installed within the last six months and have operated without fault until the incident.

Contributory factors

- The compressor had failed due to refrigerant leakage
- The fridge temperature monitoring alarm system had not been linked correctly to the hospital's building management system, meaning that only local alarms sounded and no alert of the temperature deviation was sent to the estates department
- The local audible alarm had been muted following false alarms resulting from leaving fridge doors open during body release and receipt procedures
- The local visual alarm, a strobe light, had failed so there was no visual warning of the temperature deviation

Actions to reduce future risk

- Alarm system reinstalled and linked to the building management system
- Alarm strobe light replaced
- Implementation of a fridge alarm testing procedure to ensure the alarm is triggered and sounds due to temperature deviations; tests to include the audible and visual alarms in addition to the alert sent via the building management system
- Purchase of a data logger linked to on-call mobile phones to provide fail safe back up for the fridge alarm system
- Updates to all standard operating procedures relating to fridge monitoring

HTA advice and guidance

- Retraining of staff in mortuary storage procedures
- Regular maintenance checks to ensure that leaks of refrigerant or alarm failures are identified and rectified
- Creation/review of standard operating procedures for contingency plans to manage fridge failure within the mortuary

Key learning points

1. Contractors or estates departments responsible for installing or maintaining key equipment should leave signed records with the mortuary confirming that the necessary checks have been carried out before leaving the area.

2. Mortuary staff should test alarms regularly to ensure they are working to specification.

Scenario 7: Viewing of the wrong body

A patient (deceased A) dies in hospital and is taken to the mortuary out of hours. The following morning, mortuary staff check that all bodies brought in during the night have been booked in correctly.

In the afternoon, a trainee APT receives a phone call from the bereavement officer to say they have been contacted by the deceased's daughter who wants to view the body. The trainee APT contacts the daughter and makes arrangements for her to visit, making a note of this on a piece of paper as the viewing appointment book is not to hand.

Later that day, the senior APT receives a phone call from the bereavement officer about another viewing request. The senior APT contacts the next of kin who wants to view her husband (deceased B) at the same time as the viewing for deceased A.

The senior APT checks the viewing appointment book and books the appointment at the requested time.

The trainee APT is off sick on the day of the viewings and the senior APT and a colleague check the viewings appointment book and prepare deceased B for viewing. In the meantime the bereavement officer receives a phone call from the wife of deceased B to say that she will be half an hour late for the viewing. This information is not conveyed to mortuary staff. Deceased B is placed in the viewing room and the daughter of deceased A arrives at the mortuary.

The senior APT asks her to confirm that she is here to see deceased B, which she does. She is escorted into the viewing room to discover that the deceased is not her father.

Contributory factors

- Lack of accessibility to the viewing book, which had been temporarily misplaced by mortuary staff
- The trainee APT had not booked in a viewing before and was not familiar with the procedure
- Lack of communication between bereavement and mortuary staff, who were not aware that deceased B's wife would be late for the viewing
- Lack of communication between trainee and senior APTs
- Inadequate procedures for checking with the next of kin who they have come to view

Actions to reduce future risk

- Training of trainee staff in booking viewings
- Viewing appointment book attached to the table so it cannot be removed or misplaced
- A minimum of three points of ID (forename, surname, date of birth) to check when confirming who families have come to view
- New guidance on what to ask families visiting for a viewing: 'Who are you here to see? Please confirm their full name and date of birth?', rather than 'Are you here to see…?'

HTA advice and guidance

- Formally document changes to viewing procedure and share these with staff
- Ensure that all staff are fully trained in procedures, including staff in the bereavement office
- Ask families to state who will be attending to view and make a note of their names, to check on their arrival
- Review of security procedures and pre-viewing identification checks

Key learning points

Preparing the wrong body for a viewing may not always be a matter of misidentification of the body, but may be the result of inadequate booking procedures for viewing the body or a failure to meet them. Asking families to confirm who they are and who they have come to see should help to mitigate the risk.

HTA management of incident reports

When a new incident report is received, it is assigned to a Regulation Manager who carries out an initial assessment and informs the Communications Team if it is felt that the incident has the potential to impact on public confidence or generate adverse publicity for the establishment or the family. The Regulation Manager considers the following points:

- what immediate actions have been taken to limit the adverse effects of the incident?
- has the deceased's family been informed?
- has the incident been reported to the HTA within the required timeframe?
- has a formal investigation to identify root causes been instigated?
- is there any action the HTA can take to support the establishment in its investigation?

If a notification is received late, the Regulation Manager assigned to the case reminds the establishment of the reporting timeframe and asks for the reasons for the delay.

Delay is often because the establishment was unaware of the reporting requirements. The HTA regularly raises awareness of these requirements in communications with licensed establishments.

Establishments are encouraged to telephone us to discuss potential incidents and 'near misses' before they report them where there is uncertainty which could cause delay. The five working day reporting requirement is also reinforced during HTA inspections and through written communication with the sector, such as the HTA's e-newsletter. Repeated late incident reporting is factored into an establishment's risk rating in the HTA's licensing system.

Within two to three months of the incident, Designated Individuals are expected to provide a detailed investigation report setting out the root causes that have been identified and the actions that have been taken to mitigate the risk of reoccurrence.

Review of this report by the HTA is an important part of our process. It provides an opportunity for the HTA to determine whether more could be done to mitigate the risk and to share with the establishment examples of lessons learned from similar incidents.

In reviewing the final report, the Regulation Manager will check that:

- the incident has been escalated appropriately
- all avenues of investigation have been explored
- the root causes have been identified
- the actions that have been identified mitigate the risk of reoccurrence
- all actions have been completed or are subject to appropriate planned deadlines

An HTARI is only considered closed when the HTA is satisfied that the investigation has been thorough and resulted in effective mitigating actions that will prevent a similar incident happening in future.

If the follow-up report and other actions taken by the establishment fall short of HTA expectations, the Regulation Manager will ask the establishment to provide evidence of completion of all actions. If the HTA has serious concerns about the establishment's management of an incident, we may arrange a non-routine inspection of the licensed premises.

Freedom of Information requests

The Freedom of Information Act (FoIA) enables anyone to ask a public sector organisation for the information it holds on a particular subject. Individuals can also ask for information held about them under the Data Protection Act (DPA). Making information available under Freedom of Information is a legal duty under the FoIA and DPA.

The HTA has developed a publication scheme in accordance with guidance from the Information Commissioner's Office, and we currently publish quarterly anonymised statistics about incidents reported to us in the post mortem sector in our Regulatory Activity Report. This is reviewed at HTA Authority meetings and can be found within the Authority meeting papers on our website.

We occasionally receive requests for information about incidents in the post mortem sector. In responding to these requests we are obliged to follow the principles laid out by the FoIA and must consider every information request on its own merits. We seek to maintain the confidentiality of establishments and patients, and aim only to provide the following high level information:

- dates
- names of licensed establishments
- licence numbers
- incident classifications
- brief descriptions of incidents reported to us
- summaries of follow up actions, advice and guidance

We inform establishments about any information requests we receive regarding them, and give them the opportunity to comment on the information we intend to send to the information applicant before it is provided.

HTA contact details

If you would like to comment on any aspect of this report, or if you would like further information about the HTA's reportable incident system, please contact us. Your feedback is important.

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