Heart of England NHS
NHS Foundation Trust

ROOT CAUSE ANALYSIS INVESTIGATION DOCUMENT (RCA)

Mortuary wrong release January 2015

Signed : ……..

Director

Date : ……..

Signed : ……..

Director

Date : ……..

OVERVIEW

Root Cause Analysis

Root Cause Analysis is an investigative tool used to understand why an incident has occurred. RCA emphasises the critical exploration of underlying and contributory factors. The Trust has adopted the Root Cause Analysis tool for the investigation of claims, complaints and incidents in line with NPSA guidelines.

Purpose

The Trust has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Etc Act 1974 and more specifically in accord with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. It is also a requirement to report certain incidents to a national body (e.g. Medicines and Healthcare Regulatory Agency, NHS Estates, Department of Health, the Strategic Health Authority (St HA) and the National Patient Safety Agency (NPSA)) within a specific timeframe. Currently the timeframe for serious untoward incidents is 45 days.

How to Complete This Document

1. This document is designed to be completed electronically.
2. Complete the right hand column for all sections relevant to the investigation.
3. Review the explanatory guidance text in the right hand column to understand the type of issues to consider and positively enter information. For example, in section 4, even if policies were followed and were in-date, state this otherwise there is no evidence that you have considered the possibility.
4. The examples given in the right hand column are not exhaustive but are provided as examples. Consider whether anything similar might be relevant to your particular incident investigation.
5. If you are unsure about any section, please contact the Risk Management Department on ext 42639 or 40285 for guidance.
6. Once you have entered your text into each section of the right hand column, delete the explanatory guidance.
7. Following completion of the RCA review any areas in which you have ticked “yes”. For each section with a “yes” you should consider an action to prevent or minimise the problem from recurring.

   In developing your actions consider the problem by way of the following hierarchy of controls, in order:

   1. **Eliminate**-can you eliminate the problem, for example stopping a high risk procedure altogether or not using a hazardous piece of equipment?
   2. **Substitute**-can you substitute the problem with something less harmful?. An example is the use of latex free gloves for staff allergic to latex
   3. **Isolate/distance**-can you isolate or distance the problem from people?
   4. **Safe Systems Of Work**-can you create, or improve upon, safe operating procedures to minimise or eliminate the problem?
   5. **Training/knowledge/information/Supervision**-can you provide additional training or supervision to staff to minimise or eliminate the problem?
   6. **Personal Protective equipment**-can you provide protective equipment to staff or patients to minimise harm to them. Examples include hip protectors for patients at risk of falls, eye protectors to prevent splash injuries, sharps boxes to prevent sharps injuries, etc.
8. For any actions identified, which cannot be managed locally, please document that these issues have been included in the Directorate Risk Register.

PID No.	Ref No.MO.195668 HTA Reference Number CAS-30056-FRVN	Incident Date: 06/01/15 – 16/01/15	Date RCA completed: 24/06/15	Lead Investigator: Steve Waller

	Questions	Findings
1	Give a background history and description of the event	**Outline of Incident Detection** **10/02/15** Senior Mortuary Technician (SMT) contacted Funeral Directors 1 (FD1). This was a routine call prompted by an enquiry from the Trust bereavement team to check that no deceased patients from Heart of England NHS Foundation Trust (HEFT) remained at FD1 beyond a reasonable time. **11/02/15** SMT was informed by FD1 that they retained one deceased patient from HEFT who had been there for some time and the details of the deceased (details given; patient name and hospital site they were released from) were given as Patient A (Good Hope Hospital - GHH). SMT telephoned the mortuary technician at GHH Mortuary to liaise with the Bereavement Office to investigate what appeared to be a delay in collection of the deceased patient. GHH mortuary technician confirmed that the deceased Patient A (GHH) had previously been returned from FD1 on 06/01/15. Cremation forms had been completed and the deceased patient released to the undertaker (FD2) on 13/01/15 for cremation. SMT, concerned that a possible wrong release may have taken place, went to FD1 to confirm identity of the deceased patient. The deceased patient was confirmed to have a HEFT printed wrist band for Patient A (GHH). FD1 staff confirmed verbally to the SMT that they had also had a deceased patient of a very similar name Patient B from University Hospitals Birmingham (UHB) in their care. **History of Events** **20/12/14** Patient A (GHH) died at GHH 00:48 hours and was transferred to the GHH mortuary at 02:00 hours. Mortuary register shows last digit of PID missing. **24/12/14** Patient B (UHB) was sent from UHB mortuary to FD1 for dignified relocation. Patient B had a very similar sounding name to Patient A, differing by one letter in the first name and one letter in the surname.

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	Questions	Findings
	Give a background history and description of the event (Contd)	**02/01/15** A verbal request was made by phone by the GHH mortuary technician to FD1 for dignified relocation of four deceased patients from GHH due to reaching near maximum storage capacity. This appropriately triggered the dignified relocation procedure. Form MO.F029 – assessment of mortuary capacity form was filled in for the four deceased patients including Patient A (GHH). FD1 arrived to collect the four deceased patients with no paperwork since none had been issued by GHH. Release occurred based on GHH paper work; a copy of the notice of death was made and given to FD1. FD1 signed the GHH mortuary register (patient ID (PID) for Patient A remains incorrect with last digit missing). **06/01/15** A verbal request was made to FD1 for Patient A (GHH) to be returned to GHH - change from burial to cremation. Cremation forms needed to be completed and as a result the deceased patient needed to be returned to the hospital mortuary to enable the medical staff to check the deceased patient and confirm identity in order to complete the cremation papers. Verbal request to FD1 in all likelihood, only stated patient's name. 15:45 hours Patient B (UHB) (now confirmed as such by registrar) is brought to GHH mortuary from FD1. First section of MO.F011 completed on receipt of deceased patient but surname was overwritten with surname of Patient A (GHH). No age stated on the form. No other patient identifiers at that time were required on the HEFT MO.F011 form. **09/01/15** 15:00 hours the 1st Doctor signs cremation papers- evidence taken from the mortuary cremation register. **12/01/15** 12:00 hours the 2nd Doctor signs cremation papers – evidence taken from mortuary cremation register.

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	Questions	Findings	
	Give a background history and description of the event (Contd)	13:12 hours GHH mortuary technician emails FD1 requesting dignified relocation for further deceased patients and confirms receipt of deceased patient returned to GHH mortuary to facilitate completion of cremation papers. Name quoted is spelt as Patient B (UBH) no other patient details; i.e. address, DOB are given in the email for this patient. **13/01/15** 09:55 Patient B (UHB) released by GHH to FD2 for cremation. The second section of MO.F011 was completed by GHH mortuary technician and two undertakers which is required as part of the process to release a deceased patient. MO.F034 – confirmation of patient's address label – signed by GHH mortuary technician and two FD2 undertakers. **16/01/15** 14:30 hours Cremation took place – confirmed with FD2	
2	Confirm day, date, time of incident	6th January – 16th January 2015	
3	Where did the incident occur?	Good Hope Hospital Mortuary	
4	Did deviation from current systems or processes contribute to the event?	Yes	**See attached barrier analysis** ○ **Procedure for the release of deceased – Dignified relocation (DR)** The Mortuaries across the three hospital sites operate to generic Mortuary Standard Operating ○ Procedures (SOP's) which are in line with both national and professional practice guidance. These documents are distributed electronically and are available in hardcopy on each site. Electronic copies distributed to staff must be electronically acknowledged. Within the directorate it is agreed that acknowledging a document means that staff have read and understood the contents. All the relevant documents have been acknowledged by all the mortuary staff. In addition the directorate perform competency assessments for all mortuary staff and there are internal and external (Clinical Pathology accreditation/UKAS and Human Tissue Authority) audits of mortuary processes to assess knowledge and compliance with SOPs and best practice.

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(Procedure for the release of deceased – Dignified relocation (DR) contd) MO.S005 Body storage and release SOP Version 16 updated 22/12/14 and acknowledged by GHH mortuary technician on the same day. MO.S005 states that there are 98 mortuary spaces at BHH, 25 at Solihull Hospital (SH) and 55 at GHH. 2 spaces at BHH and 1 at GHH have been allocated for the storage of babies/foetuses. This means a maximum storage capacity for other bodies of 96, 25 and 54 respectively. When the occupancy levels at BHH, SH and GHH reach 90, 20 and 48 respectively the Morticians will prepare to arrange for a number of deceased patients to be sent for dignified relocation. This will ensure a minimum of 5 spaces per site are available within the mortuary. When dignified relocation takes place it is normal for the deceased patient to be released from the offsite mortuary directly to the funeral director of choice. To ensure this happens, only cases in which all cremation papers are complete, or burials (that do not require completion of cremation forms) are relocated. In this case, burial was initially identified but subsequently changed to cremation after relocation had taken place. After the dignified relocation, if cremation papers had not been required to be completed, FD2 would have requested the release of the deceased patient directly from FD1. The HEFT process for dignified relocation is to complete form MO.F029 (assessment of mortuary capacity), email FD1 and BHH Mortuary with a list of the deceased patients for transfer (include full name, PID, DOD, address). **This part of the procedure was not followed.** A verbal request was made by phone but this was not followed up with the required email confirmation from HEFT Mortuary staff. The investigation has not been able to identify why the complete procedure was not followed on this occasion by GHH. However, there is no evidence that FD1 was or should have been aware of HEFT process MO.F029. The mortuary technician and FD check the deceased patient (prior to release) including identification details first in the mortuary register and then on the wrist band and the notice of death label for the following mandatory information: Full name of deceased patient, DOD, address and also age or DOB

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(Procedure for the release of deceased – Dignified relocation (DR) contd) if available. The procedure states the Funeral Director must provide details of the deceased's home address which must be checked against the address on the notice of death. **This part of procedure was not followed.** FD1 did not receive an email from the mortuary containing patient details including address. As a result they did not have details of the deceased patient's home address to form part of the checking process. Sticker MO.F034 must be attached by GHH mortuary staff to the email sent to FD1 confirming patient details. Make a photocopy and retain in the Mortuary with form MO.F029. **This part of procedure was not followed.** As no email had been sent to FD1 the MO.F034 sticker was not completed. No documentation was provided by FD1. FD1 procedure 'Branch Operations Manual' for 'transfer into care and identification of the deceased patient' refers to transfer from hospitals and states that FD1 will check identification on the deceased patient with identification provided (by the Funeral Arranger) to check the deceased's name, Dob or DOD, gender and the deceased's home address. **This part of FD1 procedure was not followed** as no email confirmation had been sent to FD1 by GHH mortuary. For each deceased patient going for dignified relocation an entry must be made in the mortuary register as per standard procedure for release of every deceased patient. All labels must be checked together with the undertaker and mortician before signing out in the register. ○ **Procedure for receiving bodies in the mortuary** (including deceased returned from FD1) Procedure MO.S002 Version 13 updated 22/09/14 and acknowledged by GHH mortuary technician on the same day.

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(Procedure for receiving bodies in the mortuary - contd) The procedure states that all deceased patients must have three identifying labels or tags; the wrist band, the toe tag and the notice of death which will contain the patient's address. The procedure states that the address of the deceased patient is now an additional requirement by the mortuary to facilitate an absolute match for subsequent release to an undertaker. There is no specific procedure for receiving deceased patients back from dignified relocation as this is not a routine practice – this was an infrequent event. However there is a procedure for receiving deceased patients' who have not died within the hospital setting. Procedure MO.S002 states 'under no circumstances should a body be sent to the mortuary without a wrist band. The I.D./valuables label and notice of death labels will not be accepted as an alternative. Following patient A's death the procedure followed by the ward staff at GHH in respect of labelling the deceased patient in preparation for sending to the mortuary was correct; however it was identified during the investigation that the patient PID had 1 digit missing on the notice of death form. If a body is received without a tag or the tag is incorrect form MO.F003 must be completed, and the ward informed. Also a Datix online incident report form must be completed. No anomalies were reported to senior staff. A statement from FD1 confirms a verbal request was made on 06/01/15 to transfer Patient A (GHH) – name only was given - back to GHH. The deceased patient was located in their mortuary as identified on a racking system white board which is an identical grid of who and where the deceased patients are located in the refrigerator. Subsequent evidence shows Patient A (GHH) was signed for release in FD1 mortuary register and Patient B (UHB) was returned. **FD1 ID checking procedure on this occasion was insufficient; however the request from the mortuary was a verbal request giving name only and was not followed up with an email containing name, address and DOB.** At the time of this incident FD1 did not have a robust procedure in place to identify deceased patients with similar names.

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(Procedure for receiving bodies in the mortuary - contd) MO.F011- The first section of the 'Body brought in' form MO.F011 was completed on receipt of the deceased patient but surname was overwritten with surname of Patient A (GHH). The GHH mortuary technician stated that this happened when completing the form. The form slipped and the alteration was made to make the name clearer. No age stated, and no other deceased patient details are required on the form as this was usually identified on the attached email. The form was signed by undertaker and mortuary technician – dated and timed (06/01/15 15:45 hours) ○ **Procedure for preparation of cremation papers** MO.S005 Body storage, release and disposal section 7.5 deals with preparation of cremation papers. The procedure states a certificate of medical attendant (form B) and a confirmatory medical certificate (form C) must be completed. Part B must be completed by the doctor who was attending the patient in life and part C by a doctor with no prior knowledge of the patient. The procedure states an entry must be made in the mortuary Cremation Papers register – enter date and time and print and sign name. These records are complete in the mortuary cremation register. The procedure at that time required the mortuary technician and the doctor to 'both check the wrist band to identify the deceased patient'. The Laboratory Medicine SOP states that the mortuary technician and the Doctor should check the identity of the deceased, using the wrist band; however the SOP does not identify what details should be checked to confirm identify of the deceased patient or what this should be checked against. This part of the SOP was not followed by either the mortuary technician or the Doctor; however there is no evidence that the doctors would have knowledge of the SOP. Furthermore the national guidance for Doctors on the completion of cremation papers is not specific on how to check the identity of the deceased. Doctor 1 admitted that he did not check the wrist band and Doctor 2 stated that his normal practice was to check the wrist band and notice of death label but could not specifically remember this case.

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(Procedure for preparation of cremation papers - contd) In practice, the mortuary technician receives a verbal request from the doctor and locates the deceased through the mortuary register and presents the body to the doctor to confirm identification. The mortuary technician on duty for the first cremation form check was covering GHH mortuary (mortuary technician 2). Mortuary technician 2 located a deceased patient based on a verbal request by the doctor and removed him from the fridge to allow the doctor to complete his checks. Mortuary technician 2 confirms that she made no checks of the deceased patient's wrist band. **This part of the procedure was not followed.** The investigation has been unable to identify why this check did not take place. A statement given by the doctor who was completing part 1 of the cremation paperwork said that they did not undertake due diligence with the cremation form checks. The doctor did not check the deceased patient's wrist band and stated that he could not recall what other checks he did to confirm the identity of the deceased patient in line with cremation form completion. The GHH mortuary technician was on duty for the part 2 doctor's checks. The GHH mortuary technician states that usually the doctor will state the deceased's name and will be shown the body; however there is no record of the mortuary technician undertaking an identification check by the wrist band. In this case she cannot recall what, if any, patient identification the doctor brought. A statement given by the doctor (a Trust Medical Examiner) completing part 2 of the cremation form stated that he saw the deceased patient in the mortuary at GHH and the body was identified by the information provided 'such as the wrist band, information sheet on the front chest etc.' Clarification was sought from the part 2 doctor as to the exact information checked on this occasion and by whom. He could not recall any specifics regarding the exact labels other than to confirm labels were present.

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	○ **Procedure for the release of deceased – release to FD2** Procedure MO.S005 states that the undertaker will produce (in this case) the Registrar's certificate for disposal (green form). FD2 statements state green registrar's certificate was produced by FD2. A copy was made and retained in the mortuary with MO.F034 sticker attached 'Confirmation of deceased address' label. This has been signed by the GHH mortuary technician and both FD2 undertakers. The procedure states that they are signing to confirm a full match of patient identification details. The procedure states 'the undertaker will produce the forms and the person releasing the body will check the details first in the mortuary register and then on the wrist band and the notice of death label for the following mandatory information requirements: Full name of deceased, Date of Death, the address, and also when available age or date of birth. The Funeral Director must provide details of the deceased's home address which must be checked against the address on the notice of death label. The procedure goes on to state that the mortuary technician and undertaker will check all labels on the deceased to ensure details – name, DOB or age, DOD and address match those on the disposal certificate. The address on the copy of the disposal certificate stated GHH. GHH mortuary technician states that FD2 came with address identification and this was checked against white cards that had been put on the body containing the address. The procedure states the address must be checked on the notice of death on the deceased. The procedure goes on to state if the details do not match or are missing the body cannot be released until the problem is resolved and documented in the mortuary register. **This procedure was not followed by the mortuary technician as no notice of death was on the deceased patient.** Both undertakers have made statements saying they checked the deceased patient's wrist band. It is unclear as to whether they are aware that the PID, DOB and address need checking on the deceased patient and not just the paperwork. **HEFT procedure was not followed by the undertakers but there is no evidence that they are aware of this procedure. As this is a HEFT procedure Trust staff should have ensured this was followed.** The investigation has

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(Procedure for the release of deceased – release to FD2 - contd) not been able to identify why this did not happen. Two further statements were given by the undertakers at FD2 who sealed the coffin. One undertaker states that he checked the wrist band and that it was a hospital printed wrist band and that all the details matched the workshop instructions. He does not however, say what details were checked. The second undertaker cannot recall if there was any wrist band. He checked the deceased patient's identification by checking the name written in marker pen on the body bag. Both refer to a body bag, one stating white plastic bag. FD2 procedures for 'Bringing a person who has died into care from a hospital or mortuary' state that identification required is full name, address, age (and expected jewellery). FD2 only came with the green form and no other documentation detailing home address. On questioning FD2 stated that they use full name and DOD as identification. DOD is on the green form but would have differed between Patient A and Patient B. Age/DOB checked on the wristband would have been different if correctly identified. **Between FD2 and mortuary staff identification checking procedure on this occasion was insufficient.** ○ **Procedure for selection and monitoring of external suppliers** Procedure GM.S071 v8 for selection and monitoring of external suppliers updated November 2014. The procedure requires the laboratory to evaluate all external suppliers - form GM.F161 has been completed 16/09/14 to provide evidence that all the selection criteria have been considered and the service deemed suitable. ○ **University Hospital Birmingham procedures** Confirmation has been received from UHB that their deceased patients are labelled with: ○ 1 or 2 laser bands barcoded with full PID or written wristband; Name, registration number, date of death, ward, age,

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	Did deviation from current systems or processes contribute to the event? (Contd)	Yes	(University Hospital Birmingham procedures - contd) ○ A card label with name, registration number, date of admission, age, ward, date of death, hour of death, religion, ward sister/nurse in charge & jewellery present. Either attached to the shroud or tied to the patient. No address is contained on the card. ○ Notice of Death (UHB) does contain the address and is usually attached to the deceased but was retained in the mortuary as the deceased had been sent for dignified relocation, as is their practice. It has been confirmed with UHB that there would not have been a patient address on the deceased patient. It has also been confirmed that they use orange shrouds and white body bags.
5	Did staff actions contribute to the event?	Yes	GHH mortuary technician requested the return of Patient A (GHH) from FD1 to GHH by phone. This was not followed up by any formal, written request. Unbeknown to the mortuary technician, FD1 were in possession of two deceased patients with similar sounding and spelt names (Patient A GHH and Patient B UHB). A statement from the GHH mortuary technician states that when the deceased patient was returned from FD1 there was no HEFT hospital wrist band and no HEFT notice of death. The deceased patient was also in a yellow shroud rather than a white one which is normally used by HEFT. This alerted the technician to a potential problem. The mortuary technician recalls there was a handwritten wrist band with GHH on it. There was also an ankle band and 2 white card 'notices of death'. The mortuary technician recalls asking FD1 operative why the deceased was in a yellow shroud. It was thought that this may be due to deceased patient purging. FD1 operative did not recall this conversation. The mortuary technician rationalised the situation assuming that FD1 had cleaned up the deceased patient before he was returned assuming deceased patient had been cleaned whilst at FD1 premises. The GHH mortuary technician did not alert anyone else to the anomalies with identification or report the incident on Datix. • FD1 have stated that on attending GHH mortuary the mortuary technician explained that she had injured herself earlier that day. They cannot recall the mortuary technician making the necessary checks as she was preoccupied with her injury.

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	Did staff actions contribute to the event? (Contd)	Yes	FD1 have stated they do not re-label deceased patients using any card; a wrist band and ankle label only would be added at point of collection i.e. GHH mortuary. • The doctor completing Part 1 of the cremation forms has stated that he did not check the wrist band of the deceased patient. • The procedure for release of deceased patients to FD2 (MO.S005) was not followed by GHH mortuary technician. • It is unclear whether FD2 are aware of the requirement to physically check the deceased patient's body for anything other than name – checks of details of DOB and address are being made but via paperwork as evidence suggests. • MO.R009 – risk assessment for the release of a deceased patient to the undertaker – requires review in light of this incident • No risk assessments for the use of contingency plans for dignified relocation • A review of previous HEFT mortuary HTA reportable incidents has shown procedures have been put in place to ensure correct identification of the deceased patient prior to release – a requirement for funeral directors to produce proof of the deceased patient's address as part of the release procedure. Letters went out to a number of funeral directors but FD2 did not receive this as they are not within our locality. They are however aware of the procedure and bring address identification with them when collecting deceased patients. • Recent audits of the mortuaries across sites has shown some transcription errors in mortuary entries and an audit of GHH mortuary in January 2014 demonstrated that the mortuary technician was not attaching the address check label to the release form although the checks were observed taking place. There are a number of paper based mortuary records that require completing and cross referencing (mortuary register, cremation register, property book, 'brought in dead' form etc.). These may have added to over complicate the process with the unintended consequence of increasing the risk of human error.

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6	Did inadequate staff training/skill contribute to the incident?	No	• Review of records of training, competency and appraisal for the GHH mortuary technician are all up to date.
7	Did inadequate staffing resources contribute directly to the incident?	Unclear at this stage	• There is a question as to the level of direct supervision for the GHH mortuary technician and whether this contributed to the incident occurring. Whilst appraisals and training are up to date, the GHH mortuary technician is the most junior member of the team in terms of role banding. • The GHH mortuary technician is a lone worker but has access to a manager by telephone. A lone worker procedure is in place and a risk assessment has been carried out for all mortuaries including the GHH mortuary. If it is not possible to have 2 staff on duty at all times in all 3 mortuaries. The directorate must identify an escalation procedure to deploy resources quickly in times of higher than normal demand. The Directorate must look at the way in which members of the mortuary staff are supported and supervised and establish that there is a culture which supports team work with across all sites. • A demand and capacity review is one of the recommendations to establish whether adequate staffing is in place for routine activity as well as peaks in activity as was the case here.
8	Did poor communication or information contribute to the incident?	Yes	• Initial request for the return of Patient A (GHH) was made by phone and was not followed up by any written request. The fact that both deceased patients had the same first name (slightly different spelling) and a very similar surname (one letter different) has contributed to the wrong deceased patient being 'returned' to GHH from FD1. • Procedures are in place for release of deceased patients, MO.S005, with mandatory requirements to check full name, DOD, address and when available age/DOB. Address must be provided by the funeral director and must be checked against the address on the notice of death. Letters instructing funeral directors of this requirement were sent out 08/08/14 but did not go to FD2 as they were out of the region. However, FD2 are aware of the requirement to bring address identification and brought address confirmation with them. • Secondary finding – HEFT medical records spelt Patient A's (GHH) name with an additional letter at the end of the surname. This was not identified at any stage whilst under HEFT's care.

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9	Did a malfunction or absence of equipment appear to contribute to the adverse event?	Yes	• Body storage facilities at GHH There are 98 spaces at BHH, 25 at SH and 55 at GHH. When occupancy levels at BHH, SH and GHH reach 90, 20 and 48 respectively contingency plans for dignified relocation are activated. Between Jan 2014 and Jan 2015 contingency plans were triggered as follows: • GHH – 18 times from 1/1/14 to date with 2 of those in January 14 (15 bodies in total)and the other 16 between 22/12/14 and 29/1/15 (92 bodies in total) • BHH – 3 times since 28/12/14 (34 bodies in total) with 22 of those over 2 occasions in January 2015 • SH – 4 times since 10/1/14 (15 bodies in total) with 10 of those over 2 occasions in January 15 • Contingency plans were activated 6 times more often at GHH than at BHH. GHH have approximately half the number of beds of BHH and death rates for Jan 2015 for all sites were all approximately 20% higher compared to Jan 2014 – no exceptional increase at GHH. • A lack of capacity and consequence in this case of dignified relocation has contributed to the cause of the incident.
10	Did controllable environment factors directly affect the outcome?	No	
11	Are there any uncontrollable external factors truly beyond the organisation's control? Give reasons why.	No	• The level of control HEFT has over external mortuaries in regard to identification checks. • There is no national standardised agreed core set of identifiers or documentation to ensure consistent and robust identification of deceased patients. This also includes the transfer of care/custody of deceased patients.
12	Are there any other factors that have directly influenced this outcome?	Yes	**Other supporting Information** • A detailed Barrier Analysis is included in Appendix 3; this was completed following the tool issued by the National Patient Safety Agency. A barrier is defined as 'any barrier, defence or control that is in place to increase the safety of a system'. When using the tool and considering the barriers in place throughout this process they would all fall into the category of either 'Human action barriers', (manual checking) or

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	Questions	Findings	
	Are there any other factors that have directly influenced this outcome? (Contd)	Yes	'Administrative Barriers' (adherence to policies and procedures). It is also apparent that there is a multiplicity of paper systems that further complicate the process. These types of barriers are acknowledged to be the weakest and least effective because they are prone to human error. The purpose of this tool is to identify which barriers have failed or been ineffective and to replace them with a more effective barrier. The most effective barriers are 'Physical barriers' an example of which would be electronic checking using bar codes • A joint assessment of the mortuaries at HEFT by United Kingdom Accreditation Service (UKAS) and Human Tissue Authority (HTA) was carried out in July 2014 as part of on-going regulatory assessment. The assessment found some non-conformances which were addressed and rectified by November 2014. One finding related to mortuary procedures not having sufficient detail to allow the users to consistently conform and allow internal audit to confirm this e.g. identification checks. Confirmation of address has been added since. Another non-conformance related to the mortuary registered not being uniquely identified; again this has been addressed since the assessment. The report also stated the assessment team witnessed several deceased patients being admitted and released, and in each case could confirm that all records were being completed accurately and with sufficient detail. • A statement from FD1 indicates that the identity tags were checked before return to confirm identity. There is no evidence that an incorrect wrist band was placed on Patient B (UHB) containing details of Patient A (GHH) by FD1. Failure to identify correctly, which was not due to wrong labelling outside HEFT/UHB. • There is clear evidence in the statements from FD2 that the name on the wrist band was the only identification that FD2 used on the deceased patient. • There is no requirement in procedure MO.S005 for medics to check anything other than wrist band on the body. However, this was not done by part 1 doctor.

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	Questions	Findings	
	Are there any other factors that have directly influenced this outcome? (Contd)	Yes	• Statement from GHH mortuary technician demonstrates that the technician was aware that, when returned from FD1, the deceased patient's labelling was not HEFT labelling and the HEFT notice of death was not present on the body. • The contingency plan of dignified relocation is being activated far more frequently at GHH than at BHH. **<u>Conclusion</u>** In summary, the wrong deceased patient was released and subsequently cremated. The normal process was complicated by the use of an off-site mortuary and particularly by the return of the deceased patient to the original hospital mortuary. The custody of the deceased patient changed 3 times, • from GHH to FD1 • from FD1 back to GHH • from GHH to FD2 FD1 completed the documentation for the GHH deceased patient A in the mortuary ledger when returning deceased patient to GHH. Patient A (GHH) remained in the care of FD1. However Patient B (UHB) was selected by FD1 and returned to GHH. This was not recognised by the identity checks at subsequent changes in custody or during normal procedures within all three organisations. It has been established that appropriate identifiers were available on both the documentation and the deceased patient but that checking procedures did not recognise that that there was a discrepancy. All documentation and registers were completed using the correct identifiers at every stage by all three organisations; it was the check between the identifiers on the deceased patient with those on the documentation that were not adequately checked. The **root cause** of this incident is complex and multifactorial, from a process and **human factors perspective**. • **Mortuary fridge capacity inadequate** - leading to dignified relocation to an off-site mortuary, which increased the number of custody handovers. • **Return of the wrong deceased patient -** by FD1 to GHH following change of disposal plans from

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	Questions	Findings	
	Are there any other factors that have directly influenced this outcome? (Contd)	Yes	burial to cremation • **Failure of adequate identification and checks** – at multiple points in the process and in all three organisations, which failed to detect the return of the wrong deceased at all subsequent checks. To support the generation of the final report, **Professor Jane Reid**, expert in human factors reviewed the draft documentation and held a round table event on 17th April 2015, meeting with senior Trust staff to discuss the draft RCA documentation. Following that session, the final documentation – version 8 - was carefully reviewed and shared with other report stakeholders (FD1, FD2 and UHB). To support the development of this final report, Professor Reid made a number of high level observations and these are listed at appendix 4 of this report. A number of these actions were already identified by the investigation team and are included in the action plan. Concern was raised in her recommendation 3 that there was a lack of peer review, however the laboratories have external accreditation from Clinical Pathology Accreditation (UK) since the inception of that scheme, and in 2014 were inspected and accredited by the United Kingdom Accreditation Service (UKAS) to ISO 9001 standards. The mortuaries are also accredited by the Human Tissue Authority (HTA). All of these authorities conduct on site inspection of the laboratories using peer reviewers. Robust governance arrangements are essential as observed in recommendation 3, and the Trust is currently engaged in a Board level governance recovery programme under the leadership of the Chief Nurse. Locally, there exists a clinical governance structure within Laboratory Medicine and this is overseen at Divisional level. Wider reference to culture and engagement at HEFT are the subject of the staff engagement plan which is well underway at the Trust: to date there have been 16 staff engagement events which have provided opportunities for all grades of staff to feedback. One event focussed specifically on the needs of AFC bands 2 to 4 and 2 events focussed on the opinion of medical staff.

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	Questions	Findings	
			The HEFT investigation has confirmed the presence of processes and procedures in all organisations therefore concludes that the procedures were adequate but that they were not consistently followed. Evidence from interviews, observations and statements suggest that the reason behind the failure of identification checks throughout all 3 organisations, is an over reliance on name over other data items. At all stages the identifiers on the deceased patient were not reconciled with those on the documentation.

Lead Investigator Name: Steve Waller **Signature:**

Designation Laboratory Medicine General Manager

Date: 24/06/15

A key to abbreviations used within this RCA is held within the hardcopy file in the Quality Manager's office.

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ACTION PLAN

Action	Timescale	Person Responsible	Resource Implications	Local, Directorate or Trust wide	How will the completion of the action plan be measured?
Action point #1 **Interim actions with immediate effect:** ○ Instructions to all mortuary staff that the requirement for three mandatory identifiers on the deceased, one of which must be patients' address, must be adhered to. ○ Any anomalies, however small, must be escalated to bereavement via the senior mortuary manager or the laboratory manager. ○ Mortuary staff have been given the authority to challenge doctors not completing the correct checks and refuse to allow the register to be signed. ○ Reiteration to all mortuary staff that all requests for dignified relocation must be made in writing, confirming patient details to include address. ○ GHH mortuary technician is not to work unsupervised during the course of the investigation into the incident. To work supervised at BHH and be offered support.	Complete 05/03/15	M Collard M Collard M Collard M Collard M Collard		Local	• Verbal and written instruction **Action complete** • Verbal and written instruction **Action complete** • Verbal and written instruction **Action complete** • Verbal and written instruction **Action complete** • Temporary change in arrangements enacted **Action complete** • Temporary

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○ Medics who carried out the cremation paper checks have been suspended from performing these procedures during the course of the investigation.		Clive Ryder		Trust wide	change in arrangements enacted **Action complete**
Action point #2 All doctors completing part 4 or 5 cremation papers now need to fill in a checking requirement form (which has data set of name, address, DOB, PID, sex) and take to the mortuary for identification purposes	Complete 05/03/15	D Chaplin		Trust wide	Document with audit trail in use in normal practice **Action complete**
Action point #3 Establish and implement a mechanism to provide on-going training for new doctors completing cremation papers. Training must ensure medics are aware of the requirement to provide patient details including address (complete the checking requirement form) and to check these against details on the deceased – notice of death.		P Bright		Trust wide	

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Action point #4 Establish and implement a mechanism to provide on-going training for medical examiners completing cremation papers. Training must ensure medics are aware of the requirement to provide patient details including address (complete the checking requirement form) and to check these against details on the deceased – notice of death.		P Colloby		Trust wide	
Action point #5 Figures for the activation of the contingency plan for body storage to be sent to Laboratory Manager every time capacity is reached and dignified relocation is required.	Complete 02/03/15	M Collard		Local	Standard operating procedure in place and in use in normal practice **Action complete**
Action point #6 Devise a capacity plan to cover the Easter period. Additional capacity requirement over the Easter period has been identified and as such there is an immediate need to increase capacity.	Complete 31/03/15	M Collard		Local	Evidence of effective plan that is understood by stakeholders, to manage capacity **Action complete**

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Action point #7 Demand and capacity review of all mortuaries to take place. To include staffing for HEFT mortuaries to reduce lone working, structure and management support as well as physical capacity.	Complete 23/06/15	M Collard		Local	Information available to support a decision on investment in both physical and human resources. Summary of additional resource requirements escalated in HEFT. **Action complete**
Action point #8 Review procedures and devise a system for monitoring on-going capacity.	30/06/15	M Collard		Local	System for proactive understanding of demand and management of capacity.
Action point #9 Collaborate with other hospitals, including UHB, regarding contingency plans for mortuary capacities.	30/06/15	D Chaplin M Collard		Trust wide/ regional wide	Plan to support proactive capacity planning and provide consistent practice between Trusts. June 2015 - Work on-going with UHB and others to improve contingency procedures.

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Action point #10 Review risk assessment for the release of a body and place on the risk register. Carry out a risk assessment of the contingency plans for dignified relocation Review risk assessments for lone workers	Complete 31/03/15	M Collard		Local	Updated risk register with mitigation plans
Action point #11 To investigate the feasibility of introducing a bereavement and mortuary electronic database across all sites replacing the current bereavement paper based procedures in place.	30/09/15	M Collard D Chaplin S Crossfield		Trust wide	Report on a simplified system with better access to information for stakeholders
Action point #12 To investigate the feasibility of using physical barriers as part of the identification process (see barrier analysis).	30/09/15	M Collard		Local	Option appraisal of potential barriers to reduce risk of wrong identification
Action point #13 Long term plan is to investigate the feasibility of incorporating the mortuary into the Trust wide patient identification system being set up across the Trust.	30/09/15	S Waller		Trust wide	Option appraisal of benefits and costs of a single electronic system of electronic ID checking

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Action point #14 Review of the service supplied by FD1 to be undertaken to include: • audit of the premises • contract agreements • Ensure HEFT responsibilities to follow up on DR deceased are clearly defined within contract and HEFT procedures	31/03/15 complete 30/06/15 30/06/15	M Collard L Fallon M Collard		Local	Report included in the Laboratory QMS that will satisfy the Trust and external accreditation bodies that FD 1 is being managed appropriately.
Action point #15 Investigate the feasibility of a pan-Birmingham approach between all organisations (All Trusts, external mortuaries, funeral directors) with regard to documentation used and deceased patient identification. This collaborative approach should consider peer reviews.	31/07/15	S Waller M Collard		Trust wide/ regional	<u>Option appraisal</u> feedback to all at lessons learned session action point 16
Action point #16 Once full RCA complete, feedback lessons learnt to all staff with Laboratory Medicine, the wider Trust and external organisations.	31/10/15	S Waller M Collard		Trust wide/ regional	Programme of feedback sessions following which demonstration that lessons have been applied.

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Action point #17 Feedback to the Department of Health on the recently released consultation on 'releasing a body from hospital authorisation form'.	Complete 06/04/15	S Waller D Chaplin		National	Contribution to Consultation **Action complete**
Action point #18 Load completed RCA onto the HTA portal and track further actions which may be imposed by the HTA.	30/06/15	M Collard		Local	Uploaded and acknowledged by HTA
Action point #19 To undertake a patient safety walkabout to each site's laboratory medicine area within the next year.	30/6/15	A Keogh		Trust wide	Summary of patient safety walkabout presented at Quality and Risk Committee
Action point #20 To consider the introduction of critical peer review (secret-shopper) of process and standards in addition to the national UKAS and regular audit reviews by the pathology services.	30/9/15	A Keogh		Trust wide	Evidence of the outcome

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Appendix 1 Mortuary processes flow diagram – refer to separate document

Appendix 2 Mortuary process pathway – refer to separate document

Appendix 3 Mortuary barrier analysis – refer to separate document

Appendix 4 Recommendations from Professor Jane Reid (based on the draft RCA documentation).

"These recommendations necessarily concentrate on the action needed to address the concerns. They need to be seen as building on the work that has been undertaken to date and the strengths/commitment and drive of a great many good people available to the Trust".

1) Whether perceived or with foundation, the mortuary technician and clinicians involved in this event, are unlikely to feel valued. The mortuary technician is a lone worker, has experienced a serious event, the stress of which, has resulted in absence from the organisation due ill health and she is to face a disciplinary investigation. An immediate and relatively inexpensive means of communicating that she is valued would be for:

   - a senior manager to provide her space to talk and share
   - review demand and capacity to reduce lone working

   For the clinicians involved debriefing should be a provided as an opportunity.

2) The Laboratory Medicine Directorate, should be included as an area of focus for safety walkabouts conducted by NED's and the Executive Team, to properly understand staff concerns regarding the conditions that create error prone situations.

3) Clinical Governance structures, clearer lines of communication, accountabilities and responsibilities must be developed to embrace and support **all** staff. Clinical Governance is everyone's responsibility but appears managerially oriented with a pre-occupation with policies and procedures. Guidance should be developed on quality indicators for safer clinical systems

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The lack of critical peer review needs to be addressed and strengthened. Peer-review (secret-shopper) of processes and standards should be encouraged.

4) An OD approach across the Laboratory Medicine Directorate is required to improve morale, health and wellbeing of those staff, on whom the quality and safety of patient care and operational performance depends.

The Trust has responded to Professor Reid's findings.