Department for Health and Wellbeing

Review of the Port Pirie Regional Health Service Mortuary Processes

Findings and Recommendations

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Government of South Australia

SA Health

This document contains material of a highly sensitive nature including pregnancy loss, miscarriage, death and dying, and may not be suitable for some individuals.

In addition, whilst the clinical term of fetal remains (FR) is used throughout the document, it is recognised that families refer to the loss of a baby.

Contents

List of Acronyms

BDP	Body Donation Program
DHW	Department for Health and Wellbeing
FR	Fetal Remains
LHN	Local Health Networks
PPRHS	Port Pirie Regional Health Service
WCHN	Women's and Children's Health Network

Executive Summary

In November 2023, the Minister for Health and Wellbeing commissioned a high-level review of mortuary processes at Port Pirie Regional Hospital.

The review followed the reporting of two specific incidents which had occurred at the hospital mortuary in November 2021 and in January 2022.

The review was led by Department for Health and Wellbeing Chief Executive, Dr Robyn Lawrence, who was supported by Mr Stephen Nygaard, Head of Unit, Royal Adelaide Hospital Mortuary / SA Tissue Bank, SA Pathology and Ms Alison Tanner, Mortuary Manager, Women's and Children's Hospital, SA Pathology.

Between November 2023 and January 2024, Dr Lawrence and her review team investigated the two specific incidents which had occurred at Port Pirie Regional Hospital as well as the mortuary and body handling (inclusive of autopsy/coronial case referrals) processes and practices at Port Pirie Regional Health Service more generally.

A key finding of the review was that all fetal remains were handled and contained appropriately, given the age of the fetus (<20 weeks), with the use of a secure biocontainment receptacle.

While some sensationalist media reports incorrectly referred to the biocontainment receptacle as a 'bucket', the review has confirmed that appropriate containment equipment was employed at all times.

The review makes 13 recommendations to enhance Port Pirie Regional Hospital's policy, procedures and practices. The key recommendation to revise, finalise and publish the "Notification and Care of the Deceased Procedure" is already well underway.

Purpose of the Review

On Wednesday, 1 November 2023, the Minister for Health and Wellbeing announced that the Chief Executive, Department for Health and Wellbeing (DHW) would lead a high-level hospital review to include all mortuary processes at Port Pirie Regional Health Service (PPRHS). This followed the reporting of two incidents involving the hospital's mortuary.

The overarching purpose of the Review was to:

- Review the mortuary and body handling (inclusive of autopsy/coronial case referrals) processes and practices at Port Pirie Regional Hospital.

- Investigate the two publicly reported mortuary incidents to:
    - Understand what occurred at the time of the incident
    - Understand how these incidents occurred
    - Outline what changes are required so similar incidents do not occur again

- Identify any necessary changes or improvements to ensure that deceased patients at Port Pirie Regional Hospital are treated with the utmost care, dignity and respect.

Process

Stephen Nygaard, the Head of Unit Royal Adelaide Hospital Mortuary and SA Tissue Bank, SA Pathology and Alison Tanner, Mortuary Manager, Women's and Children's Hospital provided support and advice to Dr Lawrence throughout the review. Dr Lawrence visited PPRHS on 29 November 2023 meeting with the Chief Executive Officer of the York and Northern Local Health Network, Mr Roger Kirchner, and a range of PPRHS staff.

Note of thanks

I am thankful to both Stephen and Alison for their support and guidance throughout the review. I would also like to recognise the hardworking, dedicated staff I met with at PPRHS – I appreciate your time and transparency in supporting this review.

Dr Robyn Lawrence,
Chief Executive

Summary of Findings

Perinatal incident – December 2021

The review team found that fetal remains was handled appropriately given the age of the fetus (<20 weeks). An appropriate, secure biocontainment receptacle was employed and labelled.

No consent was received for the post-mortem examination, so the fetus (FR1) was appropriately returned to PPRHS in the same receptacle.

Relevant, loose-leaf register forms from the PPRHS mortuary register were missing or incomplete, including the tracking of FR1 to WCHN Pathology and subsequent receipt back to PPRHS.

Identification procedures were not adhered to at the time of the intended collection of a second fetus (FR2) by the funeral director and hospital staff. FR1 was transferred in error. The error was corrected in a timely fashion by the funeral director, and FR1 was returned to the mortuary. FR2 was collected from the ward, however there is no record of this transfer.

Unclaimed body – November 2021

The review team found that the mortuary met the current guidelines for short-term body storage.

The procedure in place at the time of the incident did not include the delegation of a responsible staff member to monitor the length of stay for deceased patients.

There was no obvious escalation pathway in the event of an unclaimed body.

There was a significant gap in correspondence, or attempted contact, with the next of kin and PPRHS, lasting over nine weeks before concern was raised.

Recommendations

1. PPRHS finalise and publish the “Notification and Care of the Deceased Procedure”. SA Health’s Rural Support Services should give consideration to whether this Procedure should be adopted across all regional Local Health Networks (LHN). Each LHN adopting the procedure should also develop an implementation plan.

2. Fetuses and babies of any gestation / age are handled with the same respect, rigor and attention as any deceased body.

3. Identification checks when releasing a body from the mortuary (or ward) are mandatory regardless of the age of the deceased. This must be completed with both the hospital representative and the funeral director.

4. For perinatal cases (in which there is not an individually assigned medical record number), the mother’s hospital patient label, with the addition of B/O (Baby of), along with Baby/fetus date of birth should be used, either on the appropriate specimen container or outer wrappings. Where a fetus is over 12 weeks in gestation an identification tag should also be attached to the fetal remains.

5. The mortuary register must include a section for the release or transfer of bodies. This must include recording date and time of release, as well as the name and signature of the person removing the body and the person authorising removal.

6. The register should be of a type where pages are not readily removable without evidence i.e. not a ring binder where pages can simply be removed.

7. A register on all wards/other sites where storage of remains occurs should be maintained to record evidence of collection of deceased (including fetal) remains for cases where families do not wish for them to go to mortuary.

8. Families are offered an autopsy and provided comprehensive information and counselling (as per *South Australian Perinatal Practice Guidelines: Perinatal Loss*) by staff trained in this area. Processes and discussions with the mother/family are completed in a timely manner and where possible prior to the mother’s discharge. Staff must ensure correct autopsy consent paperwork is discussed and completed before sending fetal remains to Pathology.

9. Ensure discussion regarding wishes of the family for handling of fetal remains is completed with the family at time of admission or follow up to ensure the discussion occurs in a timely manner.

10. The procedure pertaining to body handling includes delegation of an existing appointment to be responsible for the monitoring of deceased persons in the hospital environment e.g. the Director of Nursing.

11. The procedure pertaining to body handling describes an escalation pathway which is time dependant and includes instructions for recording attempts at contacting next of kin, contact with Public Trustee, when indicated, as well as any correspondence with the Coroner’s Office, in the event that the case has been referred.

12. The procedure pertaining to body handling describes a contingency plan for delayed funeral arrangements that includes transfer of deceased patient's remains to an alternative site with the capacity for storage at -20°C, as per National Pathology Accreditation Advisory Council guidelines. Recommended for consideration during the fourth week after the date of death.

13. Rural Support Services should consider the need for -20^{O}C freezer including a cost benefit analysis, noting the vast area of regional SA and long term storage requirements maybe very infrequent events at disparate locations.

Next Steps

It is necessary to note that both incidents resulted in local investigations and appropriate corrective action was subsequently put into place. This has manifested in the reassessment of body handling processes as per the design of a revised procedure "Notification and Care of the Deceased", instigated by PPRHS Consumer Safety and Incident Manager. It is the view of the review team that this document would serve as an appropriate template for other regional health centres that require a standardised approach, albeit the document should be scaled to be fit for purpose.

The procedure "Notification and Care of the Deceased" is to be completed and endorsed by the LHN's Clinical Effectiveness Committee. The review team have had the opportunity to review the document and provide input.