

Superior Court Embraces Breadth of Federal Patient Safety Privilege in Fetal Tissue Mix-Up Case

PUBLISHED ON

April 2, 2026

On March 19, 2026, the Pennsylvania Superior Court ("Court") issued a [precedential opinion](#) in the case of *Griffin v. Bryn Mawr Hospital et al*, overruling the Montgomery County trial court's holding that the federal [Patient Safety Quality and Improvement Act](#) ("PSQIA") did not apply to three documents generated in connection with the hospital's investigation of the events leading to the lawsuit.

Background

In the fall of 2018, Plaintiff Tiffany Griffin, 18 weeks pregnant at the time, learned that the fetus she was carrying had a genetic condition which would likely cause it to be stillborn or die shortly after birth. Shortly after receiving this news, Ms. Griffin began to bleed heavily and presented to the hospital for care. While there, she delivered an "intact but deceased fetus." At Plaintiff's request, the fetal remains were sent to a funeral home and cremated. A few days after receiving the ashes from the funeral home, Plaintiff received a call from the Vice President of the hospital, who reported that there had been a mix up, and the ashes she received were not from the fetal remains Ms. Griffin had delivered but rather were likely her placenta. The correct remains were later located and provided to Plaintiff who had them cremated. Suit was filed alleging negligent and intentional infliction of emotional distress and other claims, although no claims were made pertaining to the medical care Ms. Griffin received.

PSQIA Privilege Holding

In acknowledging the expansive breadth of the PSQIA, the Court noted that the Senate report on PSQIA makes clear that the "unambiguous language of the statute reflect the legislature's intent for a broad definition of patient safety work product[.]" The Court held that this plain language means that in order for the privilege to apply, "the document in question must simply contain deliberations or analysis of, or reporting pursuant to, a patient safety evaluation system." The Court also noted that the PSQIA protected such "work product" of a patient safety evaluation system regardless of whether it was actually reported to a patient safety organization.

MCARE Privilege Holding

Of interest is the Superior Court's holding that the MCARE Privilege did *not* apply to the form (PA-PSRS) the hospital submitted to the Pennsylvania Patient Safety Authority, as it thought was required under the MCARE Act. The Court noted that the statutory definitions of both reportable "incidents" and "serious events" required the events at issue to involve "clinical care of a patient," and that the mishandling of the fetal remains did not meet this definition. The Court further noted that the fact that the hospital apparently thought it was a reportable event does not make it so.

Takeaways for Health Care Providers

This opinion underscores the importance of having a robust patient safety system in place and ensuring that your organization's professional liability defense attorneys are familiar with the PSQIA's application to sensitive documents that may constitute patient safety work product commonly sought in litigation.

It also highlights the limits of the MCARE privilege, particularly in non-clinical scenarios, and the importance of carefully evaluating whether an event is reportable under the Act. In unique situations such as this, counsel may need to be consulted before a report is made to the Patient Safety Authority. Barley Snyder will follow the appellate process for this case and report any changes to these holdings.

For now, this decision represents binding precedent in Pennsylvania, unless and until it is modified on further appeal. If you have questions about this decision or how it may impact your organization's patient safety reporting and litigation strategy, please reach out to partner [Katherine Kravitz](#) or any member of Barley Snyder's [Health Care Industry Group](#).

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