Independent Inquiry
into the issues raised by
the David Fuller case

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Phase 2 Report

Sir Jonathan Michael, Chair of the Inquiry

15 July 2025

HC 1092

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Return to an Address of the Honourable the House of Commons dated 15 July 2025 for

Independent Inquiry into the issues raised by the David Fuller case

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Chair's introduction

When I was asked in 2021, by the then Secretary of State for Health and Social Care, the Rt Hon. Sir Sajid Javid, to chair the Independent Inquiry into the issues raised by the David Fuller case, I was clear that my responsibility in the role was significant, as the safety and dignity of the deceased are matters of relevance to us all. Despite the lack of legal status for the deceased, we all expect that our loved ones would be treated with the same dignity and security after death as they would when alive.

David Fuller's crimes were totally shocking and showed that the arrangements to protect the security and dignity of the deceased in the hospitals where he worked were inadequate. This Independent Inquiry was established to examine, in the first place, what happened in Maidstone and Tunbridge Wells NHS Trust, and then to consider the broader national picture.

In November 2023, the Inquiry completed Phase 1 of our work, in which we considered how David Fuller was able to offend undetected for so long in the mortuaries in hospitals in Tunbridge Wells. I made 17 recommendations to Maidstone and Tunbridge Wells NHS Trust (some of which also applied to Kent County Council and East Sussex County Council) to prevent anything similar happening there again.

My findings in Phase 1 of the Inquiry were in respect of Maidstone and Tunbridge Wells NHS Trust. I made no comparison with the management and assurance of mortuaries in other NHS trusts. My assessment of the arrangements in place to protect the security and dignity of deceased people in other NHS trusts is in this Phase 2 Report, alongside my assessment of current arrangements in other hospital and non-hospital settings where people are cared for after death.

In conducting Phase 2 of the Inquiry, it has become obvious to me that the arrangements for the care of deceased people are both complex and interconnected. There are multiple organisations, with different governance and operating models, in each of the sectors that are in scope for Phase 2. The sectors I have considered are large – for example, in England, there are around 4,500 funeral directors, 204 NHS trusts, 317 local authorities and over 200 hospices. I believe that this is the first time that the security and dignity of people after death have been considered at scale in England.

The inadequate management, governance and processes that contributed to the creation of the environment in which David Fuller was able to offend are not solely confined to Maidstone and Tunbridge Wells NHS Trust. I found examples where these were lacking in other hospital and non-hospital settings, as I conducted this second phase of the Inquiry. I found that the security and dignity of people after death were not considered in the governance arrangements of many of the organisations we reviewed in the Inquiry.

My overall conclusion is that the current arrangements in England for the regulation and oversight of the care of people after death are partial, ineffective and, in significant areas, completely lacking.

I have asked myself if there could be a recurrence of the appalling crimes committed by David Fuller. Based on what I have found in Phase 2 of the Inquiry, I believe it is currently possible that such offences could happen again, particularly in those sectors that lack any form of statutory regulation.

The Inquiry has come across a number of recurring themes during our work. These include the following:

- Abuse of the deceased can be deliberate or can result from neglect or incompetence.
- Organisations and individuals have a tendency to view any threat to deceased people as most likely to come from outside the organisation.
- There is an over-reliance on trust and a long period of employment as a mechanism for internal governance and control.
- There is a reluctance to explore systemic risks or to 'think the unthinkable'.

I urge all those involved in the care of people after death to challenge themselves on these issues; to question whether they uphold the same standards in caring for someone after death as they would if that person were alive. The deceased are at least as vulnerable as the living and worthy of the same level of protection.

In this Report, I make a number of recommendations to protect the security and dignity of people after death. Some of my recommendations are to specific sectors; some have wider relevance. My overarching recommendation is that there should be statutory regulation in place to protect the security and dignity of people after death, whichever setting or institution they are in. The recommendations I make work together. They all need to be implemented to ensure that the deceased are protected. The recommendations also need to be applied to any new or emerging places and processes in which people are cared for after death.

These recommendations are designed to make sure that all organisations with responsibility for the care of our deceased enact that care in a manner that ensures security and dignity in death.[1]

In conducting this Inquiry, it has become apparent that policy responsibility for deceased people falls across several government departments. This has the potential to stand in the way of swift action on my recommendations. I urge the government to make sure that organising action across these many different departments does not obstruct or delay the implementation of my recommendations. They are necessary

1 Where recommendations are allocated to NHS England, the Inquiry expects whichever organisation or body takes over the relevant activity to become responsible for the recommendation, from the point at which that responsibility is transferred from NHS England.

and, as a society, we owe it to everybody to ensure that they and their loved ones are cared for safely and with dignity after their death.

The type of harm inflicted on David Fuller's victims and the hurt and trauma experienced by their families must never be repeated. At present, I am not assured of this.

I would like to thank everyone who has contributed to the work of this Inquiry, including the families of Fuller's victims, who bravely shared their experiences with us in Phase 1. I am grateful to the more than 1,200 people and organisations that participated willingly and generously in Phase 2 of this Inquiry. We held 223 evidence sessions, analysed 855 questionnaire responses and over 2,300 documents, held four seminars and visited 15 sites as part of five locality visits. In conducting this Inquiry, I have met very many people who are committed to doing their utmost to provide a high standard and caring service that treats people with dignity after death.

Three organisations did not respond to the Inquiry's request for information. While participation was voluntary, not responding to the Inquiry's request demonstrated a disappointing lack of social conscience or support for the Inquiry's work. I was clear from the outset that I would name all those who did not cooperate with the Inquiry without good reason, and therefore I have named these three organisations in Appendix 4.

The findings and recommendations in this Report are mine and mine alone, but I am indebted to others who put in much of the work of the Inquiry. I would not have been able to deliver this without the support and dedication of the members of the Inquiry secretariat and the specialist advisers listed in Appendix 3.

Sir Jonathan Michael
Chair

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Background

In November 2021, the then Secretary of State for Health and Social Care, the Rt Hon. Sir Sajid Javid, announced an independent inquiry into the issues raised by the actions of David Fuller. Fuller was an electrical maintenance supervisor who sexually abused more than 100 deceased women and girls in the mortuaries at Kent and Sussex Hospital and Tunbridge Wells Hospital between 2005 and 2020.

The Inquiry was established as a non-statutory inquiry and was conducted in two phases. Phase 1 focused on matters relating to Maidstone and Tunbridge Wells NHS Trust and its system partners. Phase 2 focused on the procedures and practices in place to safeguard the security and dignity of deceased people in other settings across England. It also reviewed the adequacy and effectiveness of the regulatory arrangements for the care of people after death.

This is the first time that there has been an inquiry focused on the processes and procedures to safeguard the dignity and security of people after death in all settings across England.

Phase 1 Report

At the end of November 2023, the Inquiry published the Report on Phase 1 of its work.[1]

The Report made 17 recommendations: 16 for Maidstone and Tunbridge Wells NHS Trust and one for Kent County Council and East Sussex County Council.

The government responded to the Report in October 2024.[2] The response referred to an assurance statement published by the Trust in February 2024, setting out the progress made to implement the Inquiry's recommendations.[3] This included: requiring non-mortuary staff and contractors always to be accompanied by another staff member when visiting mortuaries; controlling access to mortuaries using individual swipe cards; mandating contractors to renew security clearances every three years; and installing CCTV to monitor access to and from mortuary areas. It also set out how the Trust Board would provide greater oversight and assurance of licensed activity in mortuaries.

The government's response also stated that NHS England's south-east regional team had held monthly oversight meetings with the Trust between November 2023 and April 2024 – in partnership with NHS Kent and Medway Integrated Care Board – to ensure progress against the Inquiry's recommendations and to review evidence of the

1 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023.

2 UK Parliament, House of Commons, Secretary of State for Health and Social Care, Fuller Inquiry: Response to Phase 1 Report, Hansard, Volume 754, Column 48WS, 15 October 2024.

3 Maidstone and Tunbridge Wells NHS Trust Board meeting papers, February 2024.

Trust's progress in delivering its action plan. It stated that ongoing compliance with the Inquiry's recommendations would be monitored by NHS England through regular regional oversight meetings with the Trust, and through other channels as appropriate.

The Inquiry made a recommendation that Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that these were effective in protecting the security and dignity of the deceased. In its response, the government stated:

> *"[The councils] have reviewed contractual arrangements with the trust and confirmed that the contracts include terms requiring that licensing and regulatory requirements are met to ensure the deceased are at all times treated with dignity and respect."*[4]

Seventy-nine of the deceased women and girls that David Fuller sexually abused were coronial cases, being stored at the Trust under the contracts with the councils. The Inquiry is not satisfied that this recommendation has been implemented, and urges the government to ensure that Kent County Council and East Sussex County Council assure themselves of the effectiveness of their contract arrangements with the Trust.

Phase 2 Report

This Report presents the findings and recommendations of Phase 2 of the Inquiry.

Throughout this Report, the terms 'the Inquiry' and 'we' are used interchangeably. However, the findings and recommendations in this Report have been decided by the Chair of the Inquiry. A description of the Inquiry's methodology can be found in Appendix 1.

The Inquiry's Report contains information that is distressing and difficult to read.

The settings the Inquiry considered in its Phase 2 work included NHS hospitals, independent hospitals, medical education settings, hospices, ambulances, local authority mortuaries and body stores, care homes and the funeral sector. The Inquiry also considered how different faith organisations safeguard the security and dignity of the deceased when facilitating burials or funerary ceremonies.

The Inquiry expedited its work on the funeral sector in light of reports of cases of neglect of the deceased in some funeral homes and the growing calls for regulation of the sector. The Inquiry published its Interim Report on the funeral sector on 15 October 2024.[5]

We begin the Report with this brief introduction to the work involved in Phase 2. The Inquiry divided Phase 2 into modules, covering each of the sectors it examined, to be able to systematically investigate the arrangements in each of them to protect the security and dignity of people after death. The Inquiry's findings on, and

4 UK Parliament, House of Commons, Secretary of State for Health and Social Care, Fuller Inquiry: Response to Phase 1 Report, Hansard, Volume 754, Column 48WS, 15 October 2024.

5 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Interim Report – Funeral Sector*, October 2024.

recommendations to, each sector are in Chapters 1 to 9, followed by its findings on the adequacy and effectiveness of the regulatory and oversight arrangements that are in place (Chapter 11). In undertaking the Inquiry, it has become apparent that the sectors are linked to each other and that people are often transported across and between these various settings after death. This is examined in more detail in Chapter 10.

Finally, this Report presents the Chair's conclusions and summarises his recommendations to minimise the risk of anything similar to Fuller's offending, or other forms of abuse or neglect of the deceased, happening in the future.

The Inquiry used a range of methods in carrying out its work, including: questionnaires; interviewing or obtaining statements from those responsible for caring for people after death and those with an oversight or regulatory role; reviewing documents; and visiting a sample of sites where deceased people are cared for or stored. The methods used in each of the modules are set out in the individual chapters of this Report.

David Fuller clearly had no respect for the dignity of the deceased women and girls he abused. Despite the regulations in place, he was able to freely access the mortuaries unaccompanied to commit appalling acts for 15 years. This only stopped when the police arrested him at his home, in December 2020, for the historical murders of Wendy Knell and Caroline Pierce in 1987. Wendy Knell had been battered, sexually assaulted and strangled. She was found naked. Caroline Pierce was also found naked, with injuries similar to Wendy Knell's.[6] When the police searched his home at the time of his arrest, they found images of David Fuller sexually abusing deceased women and girls in the mortuaries.

There is no question that the scale and nature of David Fuller's crimes are horrific, but it is sadly not the case that his actions are unthinkable. There are other cases where the deceased have been abused while in the care of an organisation that should have protected their security and dignity.

The Inquiry's Interim Report on the funeral sector[7] described two convictions:

- In February 2019, Kasim Khuram was sentenced to six years' imprisonment for burglary and the sexual penetration of a corpse at the Central England Co-operative funeral directors in Birmingham.[8]
- In May 2022, Nigel Robinson-Wright was sentenced to 25 years' imprisonment for sharing indecent images of children, extreme pornographic images and images taken at Martin's Funeral Directors in Preston where he worked. He posed for photographs next to open coffins and naked deceased people and offered to supply a man with crystal meth to facilitate sexual activity in the chapel of rest at the funeral home. The two also shared sexual fantasies about the deceased people at the funeral home.[9]

6 'The double murderer who sexually abused the dead for decades', BBC News website, 4 November 2021.

7 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Interim Report – Funeral Sector*, October 2024.

8 'Birmingham burglar who had sex with corpse jailed', BBC News website, 1 February 2019.

9 Crown Prosecution Service website.

There have also been cases of abuse of the deceased in the hospital sector:

- In January 2003, bacon rashers were found placed on the body of a Muslim woman at Hillingdon Hospital mortuary. Officers also discovered that another deceased person was allegedly defiled at the same mortuary in 1996, when a woman's body had been marked with a pen.[10] No charges were brought in relation to either case.
- In May 2003, the police arrested an employee at the same hospital over the theft of contraceptive devices allegedly taken from deceased women at the hospital. At the employee's home they found over 2,000 photographs of deceased people taken in the mortuary over the preceding ten years, although none depicted desecrations.[11] It does not appear that charges were brought in relation to this case.
- As recently as June 2024, an individual was found guilty of trespassing with intent to commit a sexual offence and sexual penetration of a corpse after he broke into the mortuary at the Diana, Princess of Wales Hospital in Grimsby and sexually abused two deceased men.[12]

The investigation into Jimmy Savile at Leeds Teaching Hospitals was told that Savile had claimed he had *"interfered with the bodies of deceased patients"* in the mortuary at Leeds General Infirmary.[13] While the investigation had no way of proving this claim, it concluded that his interest in the mortuary at the hospital was not within accepted boundaries.[14]

In the local authority sector, in September 2019 a CCTV firm manager and her employee were found guilty of three counts of computer misuse after they admitted illegally accessing CCTV footage of the deceased footballer Emiliano Sala at Holly Tree Lodge mortuary.[15]

Unlike Phase 1 of the Inquiry's work, which was investigating a specific NHS trust, Phase 2 considered the practices and procedures in place to safeguard the dignity and security of the deceased in a range of organisations. The Inquiry was not investigating these organisations, but sought to understand their current policies and practices relating to the security and dignity of the deceased. Although these organisations are listed in Appendix 4, they have not all been named in specific chapters, and some have instead been assigned a cypher.

Where the Inquiry found something of concern or a potential safety issue during the course of its evidence-gathering, which it felt required immediate action, it informed the relevant organisation.

10 'Man suspended in mortuary row', BBC News website, 2 June 2003.

11 'Pictures of mortuary bodies found', *The Guardian*, 3 June 2003.

12 '"Depraved"' man jailed for Grimsby mortuary sex act', BBC News website, 28 June 2024.

13 Leeds Teaching Hospitals NHS Trust, *The Report of the Investigation into Matters Relating to Savile at Leeds Teaching Hospitals NHS Trust*, June 2014, page 96.

14 Ibid.

15 'Emiliano Sala post-mortem CCTV footage pair jailed', BBC News website, 23 September 2019.

Conclusions

People are entitled to be cared for securely and with dignity after death. It is the responsibility of government to ensure that there are systems and processes in place to achieve this.

The Inquiry notes that the concluding sentence of the government's response to its Phase 1 Report states:

> *"The Government are committed to preventing any similar atrocities happening again and ensuring that the deceased are safeguarded and treated with dignity."*[16]

The Inquiry expects the government to deliver on this commitment when it responds to its Phase 2 recommendations.

16 UK Parliament, House of Commons, Secretary of State for Health and Social Care, Fuller Inquiry: Response to Phase 1 Report, Hansard, Volume 754, Column 48WS, 15 October 2024.

Chapter 1: NHS hospitals

1.1 Introduction

The crimes committed by David Fuller took place undetected between 2005 and 2020 in the mortuaries at Kent and Sussex Hospital and Tunbridge Wells Hospital. In Phase 2 of the Inquiry, in order to understand the extent to which the security and dignity of deceased people are protected across NHS hospitals, we reviewed the processes and procedures that are currently in place across NHS trusts. The Inquiry required a different approach for this from that used in Phase 1. We used a range of investigative methods that are described in section 1.2. In Phase 2, we reviewed the procedures and policies governing the security of mortuaries and body stores that are in place across the NHS. This review included security systems in NHS mortuaries and body stores, management arrangements, including the level of influence of the Human Tissue Authority (HTA) Designated Individual (DI), and the governance and oversight of these facilities.

The Phase 1 Report of this Inquiry explored the system-wide response to the crimes of David Fuller in detail. NHS England wrote to all NHS trusts in October 2021, after it had been briefed by Sir Jonathan Michael in his role as Independent Chair of the initial investigation into how David Fuller was able to offend at Maidstone and Tunbridge Wells NHS Trust, alerting them to security risks that might be present at other trusts. NHS England asked all NHS trusts that provided either mortuaries or body stores to ensure compliance with existing guidance from the HTA and ensure implementation of the following actions:

- Review security arrangements and ensure that access points to mortuaries are controlled by swipe card security wherever possible and, if not possible, that sufficient mitigations are in place to ensure facilities are secure and access is auditable.
- Ensure that effective CCTV coverage of 'mortuary areas' is in place and reviewed systematically.
- Undertake a risk assessment of the operation, security and construction of the mortuary or body store.
- Ensure that there is consistent application of the appropriate levels of Disclosure and Barring Service (DBS) checks for all trust and contracted employees.

NHS England requested that NHS trust boards formally reviewed the evidence of compliance with these requirements, that they assured themselves that they had reviewed the evidence in response to each action, and that they confirmed to NHS England, by 16 November 2021, that they were satisfied that they had responded appropriately.

1.2 How we did our work

The Inquiry used a number of different methods to review the practices and procedures in place to protect the security and dignity of deceased people in the NHS. A protocol was developed for each of the methods to ensure that evidence was collected in a manner that recognised the potential for bias and that was proportionate in balancing the requirement to be thorough with the need to progress at pace. The tools developed for each method were piloted with an NHS trust to test the quality of the evidence they produced before they were used widely.

1.2.1 Questionnaire

A questionnaire was sent to all NHS trusts in England. In February 2024, when the questionnaire was sent, there were 210 NHS trusts in England, including ten ambulance service trusts.[1] This questionnaire asked about the processes and procedures in place to safeguard the security and dignity of deceased people. A questionnaire was also sent to Mortuary Managers at NHS trusts; this requested information on the role and responsibilities of Mortuary Managers in the NHS. Copies of these questionnaires are included in Appendix 6.

In January 2025, there were 205 NHS trusts in England.[2] This number encompasses different types of trust, including acute, specialist and community trusts, as well as ten ambulance service trusts.

We did not include Maidstone and Tunbridge Wells NHS Trust in our Phase 2 work, given that the Trust was the subject of an in-depth investigation during Phase 1 of the Inquiry. Our work on ambulance services was approached separately; NHS ambulance service trusts are discussed in Chapter 5.

We received questionnaire responses from 193 NHS trusts and provider organisations[3] during the period February to May 2024. Of the trusts that responded to the questionnaire, 129 had facilities for the storage of deceased people. The 64 trusts that responded to confirm that they did not have facilities are not included in the total numbers for any of the tables or data in this chapter. The Inquiry reviewed the trusts that did not respond to the questionnaire and confirmed that none of these trusts had any facilities for storing deceased people. As discussed above, a questionnaire response was not requested from Maidstone and Tunbridge Wells NHS Trust, and it is not included in the questionnaire figures discussed in this chapter.

1.2.2 Detailed review of a selection of NHS trusts

We selected 24 NHS trusts for a detailed review of the systems and processes in place to safeguard the security and dignity of the deceased. We developed a set of criteria for selecting these 24 trusts that is set out below.

1 Data provided to the Inquiry by NHS England, January 2025.
2 Ibid.
3 This number included three Community Interest Companies that responded as providers of NHS-funded services.

We also reviewed the questionnaire responses from each trust to identify if they contained information that prompted further enquiries. From the questionnaire responses, we identified a further 16 trusts from which we required further information. The follow-up with these trusts was specific and included either asking specific questions in relation to their questionnaire responses or requesting documents from the trusts.

Where the Inquiry found that urgent improvements were necessary in a trust to support the security and dignity of the deceased in their care, we wrote to these trusts to share our findings during the course of our work. These instances are referred to throughout the chapter.

The selection criteria for the detailed review of trusts included:

- a variety of NHS trust types: large university teaching hospitals and small district general hospitals, acute, specialist and community trusts;
- geographical spread across NHS England's seven regions;
- mortuaries or body stores that are licensed by the HTA and those that are not licensed;
- ethnically diverse communities;
- performance against HTA standards as set out in HTA reports, ensuring that both ends of the scale were included;
- Care Quality Commission performance ratings and intelligence;
- intelligence provided to the Inquiry during Phase 1; and
- information provided in the questionnaire that identified a trust as particularly interesting to the Inquiry, such as a large number of facilities.

The methods used to collect evidence from the detailed review of the 24 NHS trusts included:

- review of relevant documentation;
- interviews with key staff, including:
  - Chief Executive Officer;
  - Medical Director;
  - Chief Nurse;
  - Chief Operating Officer or equivalent; and
  - HTA DI;
- selected locality-based visits to facilities storing the deceased;
- a questionnaire specifically for Mortuary Managers in these trusts; and
- interviews with a selected number of Mortuary Managers.

1.2.3 Locality-based visits to facilities storing deceased people

During the course of the Inquiry's work, it became clear that there were some areas of the country where it would be helpful to understand the systems and processes in place to protect the security and dignity of deceased people across and between different settings. In these areas, we sought to understand how local authorities worked with NHS trusts to provide services to deceased people, and the level of oversight that existed across and between the different providers for these services. We also identified that, in some locations, NHS trusts had links with medical education settings with regard to deceased people. As local authorities, medical education settings and NHS trusts are all reviewed in different modules in Phase 2, the Inquiry identified a sample of localities where modules overlapped and developed a schedule of locality-based visits.

The purpose of these visits was to understand the practices and procedures in place across the system to protect the security and dignity of the deceased. The findings of these locality-based visits are set out in Chapter 10.

1.2.4 How we reviewed the evidence we collected in Phase 2

In Phase 1 of the Inquiry, in order to understand the particular circumstances operating at Maidstone and Tunbridge Wells NHS Trust between 1998 and 2020, we undertook a very detailed analysis of evidence in relation to both allegations and proven acts relating to David Fuller's conduct in the mortuary. The Terms of Reference for Phase 2 of the Inquiry required a different approach, not only to collecting evidence but also to analysing evidence. In Phase 2 of the Inquiry, we undertook a thematic analysis of the evidence we collected in relation to the practices and processes in place to protect the security and dignity of deceased people across the NHS.

1.3 Our findings

The Inquiry identified the following themes from the evidence we collected in Phase 2 in relation to the practices and procedures in place to protect the security and dignity of the deceased in NHS trusts:

- security arrangements in NHS hospitals;
- management and governance arrangements;
- executive accountability for mortuary services; and
- safeguarding arrangements.

1.4 Security arrangements in NHS hospitals

1.4.1 Introduction to security

To understand the practices and procedures in place in NHS hospitals to protect the security and dignity of the deceased, the Inquiry drew on evidence from the responses of NHS trusts to the questionnaire and from the document review and interviews with

key senior managers from the 24 NHS trusts selected for a deep dive (a deeper investigation). We reviewed these evidence sources with the Terms of Reference at the forefront of our considerations. Set out in section 1.4.2 are the Inquiry's findings from the evidence we received.

1.4.2 Do the security systems in place in NHS hospitals protect the security and dignity of the deceased?

In this section, we set out the Inquiry's findings on the features of the security systems in place to protect the security and dignity of the deceased during the time when they are in the care of NHS mortuaries and body stores.

The security controls in place for a mortuary or body store have two functions: to prevent access to the deceased for the purposes of abuse or any other inappropriate reason; and to identify any inappropriate access and conduct that has taken place in order to stop it and deal with it as soon as possible. The Inquiry recognises that, when considering these two functions of security in mortuaries and body stores, the security and dignity of the deceased are best protected when security is viewed as a total system, rather than the focus being on individual components of that system. Thus, a facility may restrict access through electronic swipe cards, but if access data is never reviewed the system cannot be judged to be effective. We saw this illustrated at Maidstone and Tunbridge Wells NHS Trust, where David Fuller entered the mortuary 444 times between December 2019 and December 2020. In the Inquiry Phase 1 Report, we set out how unusual and excessive activity was not identified because the Trust did not have a system of audit in place that was designed to identify inappropriate activity. We reviewed the procedures and practices governing individual components of mortuary and body store security, but, in terms of understanding how far these protect the security and dignity of the deceased in NHS hospitals, we looked at the totality of the systems in place.

The individual components that we reviewed included: how access to mortuaries and body stores is restricted; the adequacy of audit arrangements; and the presence and effectiveness of CCTV. To assess how these components work together to protect the security and dignity of the deceased, we reviewed audits of access and CCTV, serious security breaches, recent changes made to security systems, and trusts' understanding of the risk to the deceased while they are stored in NHS mortuaries and body stores.

Restricted access to mortuaries and body stores

From the Inquiry questionnaire, we found that all 129 of the NHS trusts that had a facility for storing the deceased designated the mortuary as a restricted area. Over 96 per cent of respondents (124) said that they restricted access to the mortuary using electronic swipe card systems. Four trusts also identified the use of electronic swipe cards for staff later in the questionnaire. We identified that only one trust did not use individualised electronic means to restrict access to storage facilities for the deceased. This trust restricted access by a physical key. The trust was not licensed by the HTA to undertake post-mortems. From the questionnaire, we also identified different methods to control access to the mortuary or body store; these are set out in Table 1.

Table 1: Different control measures used to manage access to mortuaries and body stores		
How is each facility controlled, e.g. by key, digital lock, electronic magnetic lock?[4]		
Access control measure used	**Number of responses**	**Percentage of responses**
Swipe card/magnetic lock	124	96%
Electronic lock	66	51%
Key lock	52	40%
Digital lock	25	19%
Keypad	5	4%
Code	4	3%
Alarm	4	3%
Personal access control	3	2%
Identification	2	1.5%
Gates	2	1.5%
Shutters	2	1.5%

Source: Inquiry questionnaire 2024.

Twenty-two trusts provided us with Standard Operating Procedures for the mortuary, and 20 of these trusts included details of the individuals and staff groups to whom access was granted.

From the 24 NHS trusts that we selected for the deep dive, 22 trusts provided evidence that access was restricted using individual swipe cards. The document review and interviews confirmed that, in addition to electronic access, other restricted access measures were used, such as digital keypads and alarms, once access to the mortuary or body store had been gained. Most trusts used a variety of methods to control movement once staff were inside the mortuary. The one trust that did not use individualised electronic means as a method of access used either a physical key or a digital keypad at each of its different facilities. This trust did not have a mortuary licensed by the HTA but held the deceased in unlicensed body stores.

The fact that most trusts now restrict access to mortuaries and body stores through the use of individualised electronic mechanisms is a positive development. This is because other mechanisms, such as physical keys and digital keypads, do not provide effective means of controlling and monitoring access.

In Phase 1, prior to Maidstone and Tunbridge Wells NHS Trust moving to its new site in 2012, mortuary access at the Kent and Sussex Hospital was restricted through the use of a key and a digital keypad. There was limited monitoring of the key when it was taken by non-mortuary staff for accessing the mortuary. The limited monitoring made

4 Question was multiple choice; respondents could choose more than one answer per response.

it easy for David Fuller to access the mortuary key unnoticed, without causing suspicion as to the reason he was entering the mortuary so frequently.

In Phase 2, the Inquiry found that two facilities were still using a key as a method of restricting access to body stores; neither facility was licensed by the HTA. Regardless of whether there is a system of monitoring in place, the Inquiry considers that a physical key and a digital keypad do not provide sufficiently robust barriers to prevent inappropriate access to facilities storing the deceased. Keys can be lost, copied or transferred to people who have no legitimate reason to enter a mortuary. There is no reliable method of maintaining a record of key usage. A digital keypad creates similar risks in that codes can be shared if there is no robust audit mechanism to trace who is able to access the facility. We heard during an interview with one of the trusts that used physical keys that this method was regarded as safe because keys were stored in a senior nurse's office, which was locked out of hours: *"The internal door, which staff use to access the body store from the ward has a physical key, which is kept in a ward office in a locked box."*[5]

The Inquiry does not regard this as a secure system for the safekeeping of a key to a mortuary or a body store. It is extremely difficult to ensure that a key always remains secure because of the unpredictable access requirements for these facilities. The inability to identify the person using the key presents a challenge to ensuring that only those with a legitimate reason are accessing a mortuary or body store. This trust also told the Inquiry that there were no audits of who was using the key and that it would not be possible to identify any unusual use:

> *"**Q:** And how would you identify unusual access to the body store?*
>
> ***A:** I'm not sure that we routinely would. I would be reliant on the matrons looking at the in[s] and outs."*[6]

The Inquiry considers that using any system other than an individualised electronic system as a means of restricting access to mortuaries and body stores does not adequately protect the deceased. Not only do keys and digital keypads not provide a sufficiently robust method of preventing illegitimate access, but they also do not allow the identity of those accessing the mortuary to be monitored or audited. Following the interviews, the Inquiry wrote to the trust in question to share its concerns about these practices.

Out-of-hours access to mortuaries and body stores

In the Phase 1 Inquiry Report, we identified that there was minimal supervision of out-of-hours access to the mortuary at Maidstone and Tunbridge Wells NHS Trust. We also identified that there was a system of shared swipe cards in place for maintenance staff. The Inquiry understands that it is necessary for porters to access mortuaries and body stores during the hours when mortuary staff are not present. Electronic shared access cards make it impossible to record the identity of individuals

5 Witness transcript of A312, Chief Executive, July 2024.

6 Ibid.

accessing the mortuary and body store. The Inquiry stated this reasoning clearly in its Phase 1 Report.

In the questionnaire responses, 38 NHS trusts stated that they were still using shared electronic swipe cards for staff to access mortuaries and body stores out of hours. The Inquiry considers that this practice presents a risk to the security and dignity of the deceased.

Audit of access to mortuaries and body stores

The Inquiry is aware that, following the move to the new hospital in 2012, access to the mortuary at Maidstone and Tunbridge Wells NHS Trust was restricted by electronic swipe cards. This restriction did not prevent David Fuller from either accessing the mortuary excessively or committing his crimes. The Inquiry considers that a routine audit of swipe card access would have identified David Fuller's very unusual access profile. Therefore, when reviewing the practices and procedures in place to protect the security and dignity of the deceased, the Inquiry identified the extent to which NHS trusts undertook regular audits of access to mortuaries and body stores.

In the questionnaire, we asked whether NHS trusts ever undertook audits of access to the mortuary or body store. The responses we received indicated that 96 per cent of NHS trusts undertook audits of access. These responses are set out in Table 2.

Table 2: Number of NHS trusts that reported undertaking audits of access to the mortuary or body store

Are audits of access to the mortuary and body store ever carried out?		
Response	**Number of responses**	**Percentage of responses**
Yes	124	96%
No	3	2%
Don't know	2	1.5%

Source: Inquiry questionnaire 2024.

The questionnaire did not identify how regularly these audits were taking place, but, of the 24 trusts participating in the deep-dive document request, 20 confirmed that they undertook regular monthly audits. The most recent HTA inspection reports indicate that this regulator now includes regular audits of access as part of its assurance that there are secure systems in place in HTA-licensed facilities. The Inquiry was told by the HTA that its guidance had become more stringent in relation to security.[7] This issue is also explored in Chapter 11, section 11.5.3.

7 Written statement of Dr Colin Sullivan, Chief Executive, HTA, October 2024.

Monitoring access control privileges

Prior to the then Secretary of State for Health and Social Care establishing the Inquiry in November 2021, Maidstone and Tunbridge Wells NHS Trust commissioned an internal investigation that was independently chaired by Sir Jonathan Michael. Sir Jonathan subsequently became the Chair of the Inquiry when it was established. As Chair of the internal investigation, Sir Jonathan identified that, some time after David Fuller had been arrested, a large number of staff still had access to the mortuary and access rights were not kept under review. Sir Jonathan wrote to Maidstone and Tunbridge Wells NHS Trust in March 2022 in his role as Chair of the Independent Inquiry to escalate his concerns as he considered this to be a risk to the security and dignity of the deceased.[8]

In Phase 2, the Inquiry reviewed which staff groups required access to mortuaries. We asked this question in the questionnaire; the responses are set out in Table 3 and illustrate the wide range of staff requiring access to mortuaries and body stores. As could have been anticipated, porters were the staff group that most frequently required mortuary access: 98 per cent of NHS trusts allowed porters access to mortuaries and body stores. Seventy-one per cent of respondents provided access to maintenance staff. However, this should not be interpreted to mean that maintenance staff were allowed to enter unaccompanied; rather, they required access to undertake legitimate duties. We explored this point further in the questionnaire and set out the responses in Table 4.

8 Letter from Sir Jonathan Michael to Maidstone and Tunbridge Wells NHS Trust, March 2022.

Table 3: Staff groups other than mortuary staff requiring access to mortuaries and body stores in NHS trusts		
Please identify the staff groups, other than mortuary/body store staff, that require access to mortuaries and body stores at your trust.[9]		
Staff group	**Number of responses**	**Percentage of responses**
Porters	127	98%
Maintenance staff	91	71%
Domestics	85	66%
Bereavement officers	68	53%
Site manager	9	7%
Medical examiner	8	6%
Security	7	5%
Funeral directors	4	3%
Nursing staff	4	3%
Pathologists	3	2%
Histology staff	2	1.5%
Police officers	1	0.7%
Site team	1	0.7%
Bereavement staff	1	0.7%
Hospital doctors	1	0.7%
Divisional team	1	0.7%
Infection control	1	0.7%
Waste porters	1	0.7%
Medics	1	0.7%
Retrieval team	1	0.7%
Designated Individual	1	0.7%

Source: Inquiry questionnaire 2024.

9 Question was multiple choice; respondents could choose more than one answer per response.

Table 4: Staff groups allowed unsupervised access to the mortuary		
Are any of these staff groups allowed unsupervised access, e.g. allowed to be in the mortuary on their own?[10]		
Staff group	**Number of responses**	**Percentage of responses**
Porters	89	69%
Bereavement officers	29	22%
None	27	21%
Domestic staff	20	16%
Maintenance staff	16	12%
Security	4	3%
Not applicable or no response	4	3%
Site manager	2	1.5%
Funeral directors	2	1.5%
Pathologists	2	1.5%
Site practitioner	1	0.7%
Nursing staff	1	0.7%
Designated Individual	1	0.7%
Blood and transport team	1	0.7%
Site matrons	1	0.7%
Individuals relating to the coroner	1	0.7%

Source: Inquiry questionnaire 2024.

From the evidence received, the Inquiry found that a wide range of staff groups – and hence significant numbers of staff – still had unsupervised access to mortuaries and body stores in a number of trusts. For 21 per cent of trusts that responded to the questionnaire, no staff groups apart from mortuary staff were allowed to enter the mortuary unsupervised. We were unable to verify whether this included such staff groups as domestics (e.g. cleaning staff), who might normally enter the mortuary outside of working hours when the mortuary was not staffed. However, we considered whether these responses indicated that the staff groups entering the mortuary unaccompanied were not being fully identified.

The Inquiry found that the protocols regarding restricted access were contained within Standard Operating Procedures in all trusts that responded to the document request. However, the details of how access was restricted were very variable. In some instances, there was minimal information regarding the procedures. However, in other instances

10 Question was multiple choice; respondents could choose more than one answer per response.

there were detailed procedures regarding which staff groups were included in access arrangements. The most rigorous procedures included separate Standard Operating Procedures governing access for such staff groups as porters and contractors. These instances were in the minority.

CCTV in NHS mortuaries and body stores

In the Inquiry's Phase 1 Report, David Fuller told the Inquiry that one security measure that would have stopped him abusing the deceased in the Maidstone and Tunbridge Wells NHS Trust mortuary was CCTV with cameras pointing at the body fridges in the post-mortem room.[11] Of course, the Inquiry has no way of knowing whether this is the case, but we do consider that the use of CCTV is a critical part of the security systems of NHS mortuaries and body stores. For this reason, the questionnaire included questions about the presence of CCTV both at the entrances and exits of facilities and inside them. The responses to these questions are set out in Table 5.

Table 5: Summary of responses to the questionnaire questions on CCTV coverage in NHS mortuaries and body stores

CCTV coverage (n=129)	Covering all mortuary entrances?	Inside the mortuary?	Covering the mortuary/ body store fridge doors?	In the post-mortem room?
Yes	125	111	103	26
No	4	18	26	103

Source: Inquiry questionnaire 2024.

The Inquiry found that nearly all of the facilities (97 per cent) had CCTV covering all entrances. NHS England undertook an assurance exercise in relation to security in November 2021.[12] It did not inform NHS trusts about the reason for the assurance exercise because the judicial proceedings for David Fuller's crimes were not completed until December 2021. We note from the Inquiry questionnaire responses that the most common response to the NHS England assurance exercise was to review and update CCTV at mortuary entrances.

The Inquiry also observed the impact of the HTA regulatory regime for NHS post-mortem facilities on the use of CCTV in NHS mortuaries. The HTA regulatory standards for security are set out in the premises, facilities and equipment (PFE) standard for licensed mortuary facilities. This standard requires all facilities to comply with the following: *"PFE1 The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue."*[13]

11 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.155.

12 Ibid., pp.2–3.

13 HTA, Post-mortem licensing standards and guidance, December 2024, HTA website.

The guidance the HTA provides to organisations to help them comply with this standard was updated in September 2022, following the David Fuller case. The guidance in relation to ensuring that premises are secure now includes the use of CCTV:

> *"d) The premises are secure (for example there is controlled access to the body storage area(s) and PM [post-mortem] room and the use of CCTV to monitor access).*
>
> *Guidance*
>
> *Security arrangements should be robust, with effective mechanisms to strictly control access. This includes body storage units in areas outside of the mortuary such as temporary storage units and storage facilities in maternity departments.*
>
> *Although CCTV is an important security measure, it should not be used in a way that compromises the dignity of the deceased. Systems should prevent the inappropriate access or use of images."*[14]

The evolution of the HTA regulatory framework for mortuaries is discussed in more detail in Chapter 11. However, to illustrate this point in terms of the impact on NHS facilities, we noted that HTA inspection reports frequently comment on the existence and positioning of CCTV:

> *"The roller shutter door at the funeral director's entrance contains a pedestrian access door which has an automatic closing device fitted. Upon inspection, the closing device did not consistently close the pedestrian door. This area is in constant use by pedestrians, there is no CCTV that monitors the area and doors are not locked between the garage and the body store."*[15]

The HTA regulatory framework does not include facilities for storage of the deceased that are not licensed by the HTA. This means that there is no regulatory framework governing general security standards for body stores and therefore there is no external requirement for NHS trusts to implement CCTV in body stores. This is a regulatory gap that is explored in more detail in Chapter 11.

Four NHS trusts did not have CCTV at all entrances to either their mortuary or body store, one of which was planning to install CCTV at the relevant entrance.

CCTV inside the mortuary or body store

A significant number of NHS trusts that responded to the questionnaire did not have CCTV installed inside the mortuary and/or the body store. Only 26 of 129 NHS trusts with a facility to store the deceased responded that they had CCTV inside the post-mortem room.

Prior to the arrest of David Fuller, Maidstone and Tunbridge Wells NHS Trust had considered but rejected the installation of CCTV inside the post-mortem room. The reasoning for this decision was that the Trust considered the security and dignity of the deceased were at risk of being compromised. Given that this was the very security

14 Ibid.

15 HTA inspection report, HTA website.

measure that David Fuller had identified as being a barrier to his offending, the Inquiry was interested to explore this issue further with trusts.

During interviews, seven trusts told the Inquiry that they had considered installing CCTV inside the post-mortem room but did not proceed because staff were concerned about the dignity of the deceased. One of these trusts told us: *"The only area we don't have a camera is the postmortem room … Obviously, there's a lot of ethical issues in that."*[16]

Another trust told us that it had not installed CCTV to date inside the post-mortem room for reasons of dignity and respect for the deceased. However, following recent in-depth debate, it had reversed this decision and would be installing it in the near future:

> *"And I had a really good, detailed debate with the staff around why we hadn't enacted CCTV coverage in the actual PM [post-mortem] department. And to be quite honest, we took that as a conversation into our board last week. And we've agreed that we're going to proceed to put the cameras in, too, and the monitoring into that area. But the staff were, if anything, they were very paternalistic around the patients' dignity and respect, and they were seeing it very much as, it was possibly just too much intrusion for the deceased. And we had a very lengthy debate. They've also had good discussions at our sub board governance structures, which I'll come onto where they've aired those feelings and come to the conclusion that the right thing to do is add – is bring the cameras and the security monitoring in."*[17]

From the facts found in Phase 1, the Inquiry considers that the deceased are most at risk of abuse during their transfer and storage. Installing CCTV facing the doors of fridges where the deceased are stored and regularly auditing the CCTV prevent the type of abuse perpetrated by David Fuller and permit its identification. They reduce the chance of abuse taking place in the first instance by acting as a deterrent, but they also allow for the early detection of any inappropriate access or behaviour that might threaten the care of the deceased.

The Inquiry recognises that trusts are concerned about exposing the deceased to cameras, which may compromise the dignity of the deceased, particularly with regard to video of post-mortem examination tables where the deceased may be placed. However, the Inquiry considers that CCTV observation of all fridge doors is a critical step in maintaining the security of the deceased and in preventing the crimes of David Fuller being repeated. This is a particular issue when double-ended fridges are in use, with doors opening into both the post-mortem room and the reception area, as was the case at Maidstone and Tunbridge Wells NHS Trust. Safeguards should be put in place to protect against a security breach arising from the exposure of the deceased through CCTV footage. The Inquiry asks that trusts consider a way of ensuring the security of the post-mortem examination room or area by using CCTV, with mitigations in place to avoid filming the post-mortem examination table.

16 Witness transcript of A309, Chief Nurse, July 2024.
17 Witness transcript of A288, Chief Executive, July 2024.

1.4.3 Changes made by NHS trusts since December 2021

From the questionnaire and deep-dive interviews, the Inquiry identified that there had been significant changes made to the security of NHS mortuaries since December 2021, when knowledge of David Fuller's crimes entered the public domain. We identified that there were a number of influences that resulted in these changes being made. In the first instance, the 2021 NHS England assurance exercise (referred to in section 1.1) required trusts to evaluate their security procedures and make any necessary changes. Second, we were told during senior manager interviews that the publicity around the conviction of David Fuller had created an impetus for change, causing trusts to ask themselves whether such crimes could happen in their facilities. We were also told during the interviews that the publication of the Inquiry's Phase 1 Report and the subsequent Phase 2 work of the Inquiry had also been a stimulus for change:

> *"But in our response to our first set of questionnaires from the first part of the Inquiry, we've strengthened and put additional CCTV in at … for example, where going through that process, it became clear to us, there was some CCTV, but there were some gaps in where that should have been."*[18]

> *"[S]ome of what they [staff] were telling me that they'd done to improve the situation and to follow Fuller recommendations were very evident. So, you know, in all the surrounding areas, in the mortuary, apart from in the postmortem viewing areas, there is CCTV."*[19]

The final lever for change had been the recent increase in stringency of the HTA inspection process following the David Fuller case and publication of the Inquiry's Phase 1 Report.[20]

In the questionnaire we sent to all NHS trusts, we asked what changes had been made following the NHS England assurance exercise. From the questionnaire responses we received, we found that, out of the 129 NHS trusts that had storage facilities for the deceased, only one trust had taken no action following the NHS England assurance exercise. Details of the changes made are set out in Table 6.

18 Witness transcript of A347, Chief Executive, July 2024.

19 Witness transcript of A288, Chief Executive, July 2024.

20 Written statement of Dr Colin Sullivan, Chief Executive, HTA, October 2024.

Table 6: Changes implemented following NHS England's assurance exercise in November 2021

Change implemented[21]	Number of responses	Percentage of responses
Review of CCTV – increased where possible or increased monitoring	91	71%
Replacement/upgrade of equipment	72	56%
Review of access to mortuary/body store/related areas	68	53%
Review of security in mortuary/body store/related areas	55	42%
Increase in audits (of CCTV, staff, security, etc)	52	40%
Restriction of access to mortuary/ body store/related areas	35	27%
Review of Disclosure and Barring Service checks – change in level of check or need for a check where possible	26	20%
Discussions with board/internal team	6	5%
Increase in supervision	4	3%
No lone working	3	2%

Source: Inquiry questionnaire 2024.

The Inquiry found, however, that despite the improvements that had been made to security systems since November 2021, serious security breaches had continued to occur in NHS facilities. The HTA requires licensed establishments to report breaches of standards, including breaches of security standards, as HTA Reportable Incidents (HTARIs). From the document review of 24 NHS trusts, we identified that 12 trusts had reported HTARIs involving security breaches. These included an incident at Diana, Princess of Wales Hospital in Grimsby, following which a man was jailed for sexual penetration of a corpse and trespassing after he had broken into the hospital mortuary.[22]

From our Phase 2 enquiries we identified that, although nearly all NHS trusts had undertaken specific actions to improve the security of mortuaries and body stores, the extent to which these actions had improved mortuary security was not clear. This was because the actions taken were in response to very specific issues, rather than in consideration of the totality of the security systems in place. We note from the questionnaire that 42 per cent of NHS trusts responded that they had undertaken a review of security. However, we found from the document review that there was only one trust where this review included a full risk analysis of the potential threats to the deceased when they were stored in mortuaries and body stores.

21 Question was multiple choice; respondents could choose more than one answer per response.

22 'Damon Tingay jailed for Grimsby Hospital mortuary sex acts', BBC News website, 28 June 2024.

1.4.4 NHS trusts' capability to understand the effectiveness of their security systems

The Inquiry found that NHS trusts demonstrated limited understanding of how effectively their current security systems protected the security and dignity of the deceased. We also identified a lack of curiosity when security systems in the mortuary were breached. We found evidence of a reluctance to look beyond the immediate circumstances of the security breach.

This is very well illustrated by a serious security breach that we were told about: a student nurse was let into the mortuary in the early hours of the morning to have a look around. This is clearly conduct that should have resulted in the trust attempting to understand why a student nurse would be interested in looking around a mortuary at that time of the morning and considering whether this was in breach of policy. Yet the Inquiry did not get a sense of senior managers being curious about this conduct, beyond acknowledging that it should not have happened.

Of the 24 NHS trusts that provided documentary evidence to the Inquiry, 12 confirmed that HTARIs or serious incidents recorded over the past five years included security incidents. The Inquiry did not receive evidence of reports of security-related incidents from facilities that were not licensed by the HTA (i.e. body stores). It was not possible to identify a reason for the absence of reports regarding security breaches in unlicensed facilities.

However, it is likely that the requirement to report security breaches in HTA-licensed premises created a driver for reporting. This means that there may well be security breaches occurring in body stores that are not being identified or not being reported. This anomaly in reporting supports the Inquiry's finding that NHS trusts have limited insight into whether or not a security system adequately protects the deceased, whether they are in a licensed facility or an unlicensed facility.

This limited capability for insight was illustrated in a number of different ways. We identified occasions when serious security breaches had occurred but had not been investigated systemically. This prevented the organisation from understanding what systems issues existed and how they could be addressed.

In one example, two similar incidents took place in one trust within three months of each other. On two separate occasions, porters took photographs of the deceased in the mortuary while undertaking their portering duties. The first of these events took place in June 2023 and involved a porter videoing and/or photographing their colleagues as they undertook their duties transferring a deceased person into a body fridge. The incident was identified through the CCTV monitoring procedures that were in place in the trust and was investigated and reported at the time. However, a very similar incident happened at the same trust in September 2023, when, once again, routine monitoring of the mortuary CCTV identified that a porter had been using their phone to record themselves in the mortuary. Neither incident involved a deceased person being photographed in a manner that identified them. In both cases, disciplinary processes were instigated and robust disciplinary sanctions imposed.

While there were monitoring processes that enabled these porters to be identified and the misconduct to be addressed, the Inquiry could find no evidence that these incidents were reviewed from a systemic perspective. A systemic review would have enabled lessons to be learned, rather than viewing each event as a one-off. Illustrating the approach taken, the trust's Chief Executive commented during their interview:

> *"I think the two portering incidents where they were using their mobile phones to film inside the mortuary, they were picked up by CCTV, and I think, thanks to the enhanced oversight as a consequence of Fuller … I think they were picked up as a result of heightened oversight, but I wouldn't see them as a trend. I think it was two porters who did stupid, inappropriate things and were fired for it … but I wouldn't see them as consistent with, for example, a run of clinical incidents that suggested patient harm was occurring in a ward. I would see that as a different class of incident."*[23]

This response indicates that little consideration was given to the root cause of these incidents; only the actions of the individuals involved were considered. Following interviews, the Inquiry wrote to the relevant trust to share its concerns about this approach. A systemic understanding of how these events happened might have identified further improvements in the mortuary security arrangements that could reduce the chance of such conduct taking place. An example of a systemic barrier to prevent such conduct taking place would be a policy prohibiting the carrying or use of mobile phones, or any other recording device, in the mortuary or body store (or in specific areas of the facility), apart from when they are required for legitimate reasons (for example, by on-call pathologists, or cameras used for evidence collection).

Another example of NHS trusts' limited insight into the effectiveness of mortuary and body store security systems involved a trust that told us with confidence about the changes to mortuary security that had been made following the David Fuller case. These changes included the introduction of CCTV and swipe card access. Yet the 2023 HTA inspection report for this trust identified serious security issues within the operation of the mortuary and the body stores. These included the following issues:

- CCTV was positioned in such a way that there was a risk that the cameras did not cover the entrance to the body store.
- There was no CCTV covering the gate or doors to the contingency units.
- The HTA inspection team found that the funeral directors' door, which allowed direct access to the body store from the outside, had been left open when there were no mortuary staff present in the facility.
- The satellite body store was situated in full view of a service road and hospital offices, meaning that the transfer of the deceased, albeit on a covered trolley, was visible when porters brought the deceased to the body store and when mortuary staff transferred the deceased to the main body store. The inspection team considered that this arrangement posed a risk to the dignity of the deceased.[24]

23 Witness transcript of A336, Chief Executive, September 2024.

24 HTA inspection report, HTA website.

For another trust involved in the deep dive, we read the HTA report that was published in 2022. This report identified significant security concerns in the mortuary. A door alongside the funeral directors' entrance was secured by a key but the DI was not aware of who had the keys to the door. In addition, there was no formal system in place to review records of swipe card access. There was also an internal door between the viewing room and the mortuary corridor that could not be secured and posed a risk of unauthorised access.[25]

When asked about this HTA report during an interview, the Chief Executive did not appear to appreciate the security issues that were raised during the inspection:

> *"I think at that time they focussed on the fridges, the expansion of the fridges at … And where we were at with the building work over in the … site. So in terms of the licence, how we were complying, my understanding was we're compliant with many things, but they needed assurance that the building work that needed to take place for the expansion of the fridges really needed to move forward."*[26]

Given that the Inquiry identified a limited appreciation of security risks within NHS trust mortuary services from a systemic perspective, we advise that each trust should seek external support to fully assess the effectiveness of their current security systems for both mortuaries and body stores.

1.4.5 Cultural reluctance to accept that necrophilia can take place in hospital settings

In Phase 1 of the Inquiry's work, we identified a reluctance on the part of the healthcare system to consider that sexual abuse of the deceased on hospital premises could take place. This was despite Jimmy Savile's interest in and access to the dead being exposed in 2014.[27] We identified the same reluctance in Phase 2 of our work. The Inquiry found that the approach to the management of the security of mortuary and body store premises in some NHS trusts illustrated this reluctance to consider that individuals might wish to access the deceased for the purpose of abuse.

In addition to the security breaches already discussed, the Inquiry identified instances of serious security breaches that had taken place in recent years where senior managers did not recognise or consider the threat to the security and dignity of the deceased.

One trust reported to the Inquiry that its Mortuary Manager had been found to be accessing and sleeping on hospital premises outside working hours, and storing items there, including illegal drugs and related equipment.[28] The evidence the Inquiry received about this event indicates that the Mortuary Manager's conduct was considered only from the perspective that they should not have been using trust premises inappropriately, rather than from the perspective of the potential risk this behaviour presented to the deceased within the mortuary.

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25 HTA inspection report, HTA website.

26 Witness transcript of A314, Chief Executive, July 2024.

27 Susan Proctor, Ray Galloway, Rebecca Chaloner, Claire Jones and David Thompson, *The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust*, June 2014.

28 Evidence provided to the Inquiry by NHS trust, March 2024.

The Inquiry found that, since David Fuller's conviction in December 2021, NHS trusts had improved features of their security systems to protect the security and dignity of the deceased in both mortuaries and body stores. However, we identified that the majority of trusts had not undertaken a systemic review of security and were not using security breaches that had occurred as opportunities to identify systemic features of security that could be improved.

What we have found

- All but two trusts in England that responded to the questionnaire are using individualised electronic systems to restrict access to mortuaries and body stores. The two trusts that are not using individualised electronic systems do not hold Human Tissue Authority licences for post-mortems.
- Thirty-eight trusts are still using shared electronic access cards to access facilities out of hours when mortuaries and body stores are not staffed by mortuary staff, in addition to using individualised electronic systems.
- Of the NHS trusts in England that responded to the questionnaire, 96 per cent have undertaken audits of access to the mortuary or body store.
- Of 129 trusts that have facilities to store the deceased, 125 have CCTV installed at the entrances to mortuaries and body stores.
- NHS trusts are not identifying the systemic weaknesses in their mortuary and body store security systems. Security breaches are occurring and trusts are not identifying the thematic issues that are common to those breaches.
- There is no regulatory framework governing general security standards for body stores and therefore there is no external requirement for NHS trusts to implement access control or CCTV in body stores.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 1
All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of:

- the systems in place to identify any unauthorised access to the facility;
- the strength and effectiveness of barriers to prevent unauthorised access to the facilities;
- the systems in place to identify any access to deceased people for unauthorised purposes; and
- how CCTV is used, including its monitoring and any audits undertaken.

Recommendation 2
All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.

Recommendation 3
All NHS trusts should routinely audit the access data of all facilities used to store deceased people.

Recommendation 4
The practice of using shared electronic swipe cards for specific staff groups should cease immediately.

Recommendation 5
All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised.
An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.

Recommendation 6
All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.

Recommendation 7
The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.

Recommendation 8
All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.

Recommendation 9
All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.

1.5 Management and governance arrangements

In the Phase 1 Inquiry Report, we identified that, during the period from 2005 to December 2020, the management arrangements for the mortuary at Maidstone and Tunbridge Wells NHS Trust were inadequate and contributed to an environment in which David Fuller could offend for such a protracted period of time. In Phase 2, we wanted to understand the management arrangements for mortuaries and body stores in NHS trusts in terms of the level of managerial support provided to mortuaries and body stores.

One of the issues we identified in Phase 1 was that the Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust had a broad management portfolio that included other services; these services were demanding of the Mortuary Manager's time and the Mortuary Manager was located in a different hospital. This arrangement meant that there was virtually no on-site supervision of the mortuary. The Inquiry examined the level of management support for mortuaries and the professional background of Mortuary Managers.

We found that 118 of the 129 trusts that had facilities to store the deceased had a Mortuary Manager, as set out in Table 7. Out of the 118 trusts that had a Mortuary Manager, 85 per cent of these Mortuary Managers held an anatomical pathology technologist (APT) qualification. In the 15 trusts where the Mortuary Manager did not hold an APT qualification, six held a biomedical scientist qualification. When asked about the professional background of the Mortuary Manager in those cases where they did not hold an APT qualification, eight responded *"Other"* and one trust did not provide an answer.

Table 7: Number of NHS trust Mortuary Managers who hold an anatomical pathology technologist qualification

Does the Mortuary Manager hold an anatomical pathology technologist qualification?		
Response	**Number of responses**	**Percentage of responses**
Yes	100	85%
No	15	13%
Not applicable	1	0.85%
Post currently vacant, awaiting recruitment	1	0.85%
We have a mortuary service but there is not a dedicated manager post – management support is provided by pathology management	1	0.85%

Source: Inquiry questionnaire 2024.

In Phase 1, we found that having a Mortuary Manager without experience and expertise in mortuary services meant that the day-to-day operational practices of the mortuary were not effectively scrutinised, and this allowed practices that were both outdated and compromised the dignity of the deceased to continue unquestioned. It is difficult to see how a non-specialist manager could provide the mortuary with the level of professional leadership required for this specialist area.

In the Phase 1 Report, the Inquiry made the following recommendation for Maidstone and Tunbridge Wells NHS Trust:

> *"The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention."*[29]

This recommendation recognises that a mortuary service is complex, carries statutory regulation for some of its activities, and requires a commensurate level of management support. Through the questionnaire responses, the Inquiry found that 64 per cent of Mortuary Managers had only the mortuary service in their portfolio, as set out in Table 8. We also found that 35 per cent of Mortuary Managers had more than just the mortuary in their management portfolio.

Table 8: Management portfolios of Mortuary Managers in NHS trusts

Does the Mortuary Manager only have the mortuary in their management portfolio?		
Response	**Number of responses**	**Percentage of responses**
Yes	76	64%
No	41	35%
No dedicated Mortuary Manager post – management support provided by pathology	1	1%

Source: Inquiry questionnaire 2024.

Following our initial questionnaire for NHS trusts, we sent a further questionnaire to Mortuary Managers at the trusts included in the deep dive. The Mortuary Managers' questionnaire was sent to 24 Mortuary Managers in 23 of these trusts. One of the trusts had only body stores managed by on-site matrons. We received a 100 per cent response rate, with one trust providing two responses as it had two different mortuaries managed by two different individuals, accounting for 24 responses in total. Table 9 sets out the number of facilities Mortuary Managers were usually responsible for; the most common response was two facilities.

29 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.265.

Table 9: Number of mortuaries and/or body stores the Mortuary Manager is responsible for	
Please list the mortuaries and/or body stores that you are responsible for and the name of your trust.	
Number of mortuaries and/or body stores	**Number of responses**
1	8
2	10
3	2
4	1
5	2
6	1

Source: Inquiry questionnaire 2025.

Nineteen of these Mortuary Managers had been in post for longer than 12 months, and five in post for less than 12 months.

The Inquiry also asked these selected Mortuary Managers about the scope of their portfolio and if any changes had been made in the last 12 months, to cover the period following the publication of the Phase 1 Report of this Inquiry. Fifteen of the Mortuary Managers who responded to the questionnaire told us that they had only the mortuary and mortuary-related matters in their portfolio, while nine were also responsible for other services, including medical examiners, pathology services and bereavement services.

Sixteen Mortuary Managers stated that there had been no change within their role in the past 12 months; this included four of the five Mortuary Managers who had been in post for less than 12 months. One Mortuary Manager who had been in post for less than 12 months indicated that, prior to their mortuary management role, they had been responsible for only the pathology stores and their role had changed to include the mortuary. Only two respondents indicated that more resource had become available to them in their role as Mortuary Manager.

Based on the evidence collected on the experience of Mortuary Managers in the NHS, the Inquiry identified that there was still variation between trusts in terms of the scope of the role. The Inquiry spoke to one Mortuary Manager who was lead for a number of services:

> *"I do have a lot on. I have good staff underneath me. The senior APTs are really good. I have a good bereavement manager and a good lead medical examiner officer underneath me. I do manage it."*[30]

30 Witness transcript of A543, Mortuary Services Manager, March 2025.

Table 10: Available support identified by NHS Mortuary Managers	
Please describe the support in place to help you in your role as Mortuary Manager.	
Type of support[31]	**Number of responses**
Line management/general team support	21
Human Tissue Authority support	5
Designated Individual support	13
Executive/director/CEO/board-level support	12
Lack of support	1

Source: Inquiry questionnaire 2025.

The Inquiry asked the Mortuary Managers who received the questionnaire to describe the support in place for them in their role. Their responses are set out in Table 10. Twenty-one Mortuary Managers indicated that they felt they had the support of their line manager alongside their wider team, such as other colleagues and related teams. Around half of the Mortuary Managers felt that they had the support of their DI, with a similar number identifying that they had the support of executives, directors, the Chief Executive and the board. Only one Mortuary Manager expressed that they felt there was a lack of support for them in their role.

Interviews with Mortuary Managers also reflected frequent contact with and availability of the DI. The Inquiry interviewed four NHS Mortuary Managers at sites with HTA licences for post-mortem activity, and all four confirmed that they were able to contact the DI as needed.

The questionnaire also requested information on the reporting requirements of the Mortuary Manager. In 20 cases, the Mortuary Manager stated that they were required to present or report to the DI or to an HTA-related committee meeting at their trust.

All of the Mortuary Managers responded that they reported to their line manager – in most cases the head or lead of their department or above – or to their line management or governance chain. Six of the Mortuary Managers indicated that they reported to the Chief Executive, Chief Medical Officer or Chief Nurse.

In most cases, Mortuary Managers indicated that they had regular meetings with these identified individuals; the frequency of the meetings depended on the attendees, with timeframes varying from weekly to once every two months. One Mortuary Manager indicated that they had meetings once every three months unless there was an issue; in all other cases, Mortuary Managers indicated that they had at least monthly meetings with another individual or group to report on mortuary matters.

The Inquiry received evidence on support and reporting arrangements for Mortuary Managers in NHS trusts. While this suggests good working relationships between

31 Responses provided through free text; more than one form of support expressed per response.

Mortuary Managers and their teams, DIs and others, there was also variation in the involvement of senior executives in mortuary reporting, and the level at which Mortuary Managers were required to report in NHS trusts.

In interviews, we heard from Mortuary Managers directly how this Inquiry had impacted the interest in their services; examples included visits by members of senior management who had not previously been as visible to Mortuary Managers:

> *"I think that's heightened since the Fuller report, as well, hasn't it, since – the Trust takes a bigger – more interest in the mortuary."*[32]
>
> *"Yes, it is surprising how much the mortuary is in the limelight at the moment, as you will know from everywhere else in the country. With HTA and Fuller there is actually there is a lot of attention well since I have started here. Same with … there is a lot of attention now on mortuaries that are we are getting a lot of support."*[33]

1.5.1 Role of the Human Tissue Authority Designated Individual in NHS trusts

Part of the Inquiry's Phase 2 work involved looking at the role of the HTA DI in NHS trusts licensed for post-mortem activity.

Mortuaries that are licensed by the HTA are required to have a DI in place. The DI identified on the HTA licence is the person under whose supervision the licensed activity is authorised. The DI must be a named individual, rather than a corporate body. The legal responsibility for ensuring that the HTA requirements are met sits with the DI rather than with the organisation that runs the mortuary.[34]

Organisations licensed in the post-mortem sector must have a Licence Holder as well as a DI. Organisations may also appoint Persons Designated to assist and be accountable to the DI for specific departments or activities.[35]

In the Inquiry's Phase 1 Report, we found that the position of DI at Maidstone and Tunbridge Wells NHS Trust did not enhance support for the day-to-day management of the mortuary as the DI did not see themselves as part of *"management"*. The Inquiry also found that the DIs from Maidstone and Tunbridge Wells NHS Trust who were interviewed during the Phase 1 investigation did not feel able to influence service delivery in the mortuary in accordance with the standards and procedures required. It was also clear that there was limited awareness in the Trust of the legal obligations of the role of DI.

Our initial questionnaire, which was completed by 117 NHS trusts that were licensed by the HTA to undertake post-mortems, asked for information on the professional background of the DI, how long they had been in post, and the training undertaken by the DI while in post.

32 Witness transcript of A539, Mortuary Manager, February 2025.
33 Witness transcript of A542, Mortuary Manager, February 2025.
34 HTA, Legislation: Powers, Consent and Licensing, HTA website.
35 Ibid.

We interviewed DIs at 23 of the 24 trusts selected for the deep dive; one trust did not have a DI as it was not licensed by the HTA. We asked the DI of each trust to reflect on their role, their experience of the HTA and HTA inspections, and their position within the governance and management arrangements of the trust. The document review of the deep-dive trusts was also used to provide additional information.

Who is the Designated Individual in an NHS trust?

From the Inquiry questionnaire, we can understand further the context of DIs in NHS trusts in England. The following analysis is based on responses to a questionnaire filled out by NHS trusts. Table 11 shows how long DIs have been in post.

Table 11: How long has the Designated Individual been in post?

How long has the Designated Individual been in post?		
Length of time	**Number of responses**	**Percentage of responses**
Less than 12 months	14	11%
More than 12 months	107	83%
Not applicable	7	5%
Other	1	0.78%

Source: Inquiry questionnaire 2024.

In the majority of trusts (83 per cent), the DI had been in post for more than 12 months. One trust indicated that the DI at one of their sites had been in the position for more than 12 months and the DI at the other site had been in the position for less than 12 months. It is worth noting that some trusts had multiple DIs across multiple sites.

Table 12: Professional background of Designated Individuals

What is their professional background?		
Background	**Number of responses**	**Percentage of responses**
Consultant pathologist	44	34%
Biomedical scientist	32	25%
Anatomical pathology technician	14	11%
Not applicable	10	8%

Source: Inquiry questionnaire 2024.

We asked trusts about the professional background of their DI. Some trusts had multiple DIs. This question was answered with varying levels of detail, and, as the question asked about the background of the individual, the answers did not necessarily reflect their current job title or responsibilities. The most common responses (those above three per cent) are listed in Table 12. The 27 least common responses are not included above but were nonetheless considered by the Inquiry during our review.

The results of the questionnaire responses were borne out in interviews with the 23 DIs in the trusts included in the deep dive (all of which are also represented in the questionnaire responses). We found variations in the time in post and professional background of DIs in NHS trusts that were licensed by the HTA to undertake post-mortems.

The Designated Individual and governance arrangements

In Phase 1 of the Inquiry, we found that the DIs at Maidstone and Tunbridge Wells NHS Trust did not feel that they had adequate influence to make changes in the mortuary to improve professional standards and ensure adherence to HTA standards. This was reflected in the lack of discussion of the mortuary and HTA standards by the Trust Board or Board committee, and the lack of involvement of DIs in the governance of the Trust.

Interviews with the 23 trusts participating in the deep dive that had an HTA licence revealed similar limitations in governance and reporting. In this section, we explore the role of DIs in trust governance, as their involvement in relevant governance forums can reflect the extent to which DIs are able to raise issues and risks and influence decision-making within trusts. Table 13 shows whether DIs have presented to trust boards.

Table 13: Does the Designated Individual present to the trust board?

Has the Designated Individual been asked to present to trust board in relation to their role in the past 12 months?		
Response	**Number of responses**	**Percentage of responses**
No	96	74%
Yes	14	11%
Not applicable	9	7%
To be confirmed	1	0.78%
Another individual has presented to the board	5	4%
Planned for the future	1	0.78%
Other	3	2%

Source: Inquiry questionnaire 2024.

Only 14 (11 per cent) of the trusts reported that their DI had presented to their trust board in the past 12 months; a further five trusts (four per cent) indicated that another individual had presented to the board on behalf of the DI.

In interviews, 23 DIs from NHS trusts told us that DIs did not regularly present to their trust board or provide papers for discussion by the trust board. Eighteen of the DIs interviewed had never presented to their trust board, and six had either attended meetings, provided papers for discussion but had not attended in person, or planned to attend at a future date.

The majority of DIs (82 per cent) did not meet with their Chief Executive or met with them only as required, as shown in Table 14. There is no way of confirming the frequency of the *"as required"* meetings in these 69 NHS trusts; however, it can be concluded that there was no set meeting between the DI and Chief Executive, and that this may have indicated the level of importance given to the role within the trusts and how DIs were integrated into trust leadership and governance.

Table 14: How often does the Designated Individual meet with the Chief Executive?

How often does the Designated Individual meet with the CEO to discuss their responsibilities as DI?		
Frequency	**Number of responses**	**Percentage of responses**
Monthly	3	2%
Quarterly	7	5%
Annually	3	2%
As required but at no fixed interval	69	53%
Never	36	28%
Not applicable	11	9%

Source: Inquiry questionnaire 2024.

The level of engagement between DIs and the most senior managers in trusts is relevant to the level of understanding among executives of the role of the DI, including their personal legal responsibility, and can also be linked to an overall understanding of the HTA as a regulator and the associated legislation and standards.

Interviews with Chief Executives and senior trust management revealed variations in awareness of who the DI was and of who held ultimate legal responsibility for delivery against HTA standards. In interviews, at least one participant in each trust stated that the person with ultimate legal responsibility was either the Chief Executive or the Licence Holder, or the trust as a corporate entity.

In DI interviews, we often found that DIs were confident they could escalate issues if needed to the Chief Executive or other executives, despite the Inquiry finding confusion about areas of responsibility and the role of the DI throughout our work. The Inquiry notes that this reflects a disparity between the experience of the DI and the level of awareness of the executives about this role.

In the questionnaire, all trusts with mortuaries or body stores were also asked whether the DI attended any governance forums specifically in relation to their role as DI. Twenty per cent of trusts told us that the DI did not attend any governance forums specifically in relation to their role as DI, as shown in Table 15.

Table 15: Does the Designated Individual attend governance forums?		
Does the Designated Individual attend any governance forums specifically in relation to their role as DI?		
Response	**Number of responses**	**Percentage of responses**
Yes	88	68%
No	26	20%
Not applicable	8	6%
To be confirmed	1	0.78%
Attends Human Tissue Authority committee	1	0.78%
Meets with Chief Nurse every six weeks	1	0.78%
Attends cellular pathology governance forum	1	0.78%
Attends Business Unit Board (and other trust boards as required) when Human Tissue Authority reports are presented	1	0.78%
Mortuary Manager (a Person Designated) attends meetings and reports to the Designated Individual	1	0.78%

Source: Inquiry questionnaire 2024.

All of the DIs interviewed told us that they attended governance forums in relation to their role as DI. However, there was a mixed level of understanding of onward escalation processes and if and how reports provided to governance forums were taken to the board or to board subcommittees.

Both the questionnaire responses and interviews illustrated that issues found in Phase 1 of this Inquiry appear to be present in other NHS trusts in England. The lack of influence of the DI is reflected in their absence from governance structures, while the lack of understanding of the role is reflected in senior managers often not being sure of who is occupying the role at any specific time. This issue is explored in further detail in section 1.6.

Experience of being a Designated Individual

In the Inquiry's interviews with DIs from 23 NHS trusts, we asked them to reflect on our findings from Phase 1 and to compare these with their experience. The questions focused on the Phase 1 finding that the role of the DI could be challenging, with significant personal legal responsibility but often little opportunity to effect change.

The level of seniority of the individual occupying the role of DI was commented on throughout all of the interviews the Inquiry conducted with DIs. Those in more senior positions told us that they believed it was their 'day-to-day' position in the trust that allowed them to be effective as a DI, rather than the post itself. In these instances, the DIs had access to governance forums, routes of escalation and discussions about funding, which made it easier for them to effect change in the mortuary:

> *"I am able to make those changes and have that responsibility and be able to make them as Head of Service rather than just as the manager."*[36]
>
> *"[O]f course, because I have the CD [Clinical Director] as well. So, I am within the management structure, although I'm not the budget holder. But if I ring up my general manager and I tell them that this is required for this, it will be done."*[37]

The seniority of the individual and their legal responsibility were also considered by the DIs we interviewed. One DI told us that they did not believe it was appropriate to give that responsibility to anyone below executive level due to the amount of influence in the organisation required to undertake that responsibility effectively:

> *"Whereas, as an executive, that's the degree of accountability I share with other executives for a number of different services and so, it comes with the role. So, I don't think it's appropriate to have a mortuary manager or a pathology services manager to hold the legal accountability.*
>
> *…*
>
> *[I]f someone is going to be personally accountable, I do think it should be somebody at executive level because I don't think it's appropriate to ask anybody lower down the hierarchy to do that."*[38]

DIs also told us about challenges in accessing funding to make changes in the mortuary, but they said that HTA guidance and inspection reports could often be key to accessing funding and decision-making to enact these changes. They also reported that the NHS England assurance exercise in 2021, the publication of the Phase 1 Report of this Inquiry, and interest generated by their trusts' involvement in the deep dive of Phase 2 of the Inquiry had led to greater interest in mortuary services and HTA requirements in their organisations:

> *"[B]ut with the Fuller, things became hectic. You know, there was top level executive look down and if you couldn't get something done yourself, then you just had to go slightly higher up the chain and it would get done. And that is, that's new, that's Fuller and our HTA inspection."*[39]
>
> *"[W]e can also escalate it to an external body if we find out that we weren't necessarily getting the traction that we needed."*[40]

36 Witness transcript of A360, Designated Individual, August 2024.
37 Witness transcript of A377, Designated Individual, August 2024.
38 Witness transcript of A385, Medical Director and Designated Individual, July 2024.
39 Witness transcript of A351, Designated Individual, July 2024.
40 Witness transcript of A303, Designated Individual, July 2024.

This evidence shows that there needs to be formal reporting and consideration of the mortuary in the upper levels of trust governance in order to highlight the importance of mortuary services in an NHS trust. The role of the DI could be enhanced in this context.

At interview, DIs also shared the way they had come to the role of DI. Sixteen of the DIs we spoke to either took on the role when the previous DI left the organisation or went on long-term leave, or the position as DI was included as an 'add-on' to their role. Three DIs had been DI since the requirement to have one came into force. All of the DIs interviewed held other roles within the organisation. At the seminar held by the Inquiry, NHS DIs told us about the difficulty in finding someone to willingly take on the role:

> *"And actually one of the main reasons that I continued, and I still do perform that role and I am still in that role, is because I happen to be the clinical director and I haven't yet found anybody who has expressed an interest to be doing that role."*[41]

This echoes the findings of Phase 1 of the Inquiry, in which the Inquiry heard about the struggle to fill the role of DI.

What we have found

- The majority (85 per cent) of mortuaries are managed by individuals holding an anatomical pathology technologist qualification.
- Mortuary Managers in NHS trusts continue to have roles and responsibilities beyond the running of the mortuary alone. The level at which they report on mortuary matters varies across trusts, as does the extent of visibility of senior executives.
- Designated Individuals across NHS trusts face similar challenges to those found in Phase 1 of this Inquiry: a lack of time, support and adequate power to effect change are all present in their roles.
- There is still confusion and a lack of clarity surrounding the role and personal legal responsibility of Designated Individuals in NHS trusts.
- Designated Individuals are not clearly included in governance forums or escalation routes. Despite being confident that they can raise issues if needed, there are no clear lines of accountability beyond the Designated Individual in NHS trusts.

41 Inquiry seminar for Designated Individuals, November 2024.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 10
NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.

Recommendation 11
NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.

Recommendation 12
NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.

Recommendation 13
A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.

Recommendation 14
NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.

1.6 Executive accountability for mortuary services

When the Inquiry was investigating Maidstone and Tunbridge Wells NHS Trust during Phase 1, we found that lines of accountability to the Trust Board were unclear. These unclear lines of accountability were illustrated by confusion among Trust executives regarding who held accountability for the mortuary service. This confusion was one aspect of the limited oversight of the performance of the mortuary service. We found that the confusion regarding executive accountability and limited oversight contributed to the environment in which David Fuller was able to perpetrate his crimes for such a protracted period. Given this finding, the Inquiry was interested to understand the level of oversight provided to mortuaries and body stores across NHS trusts.

From the Inquiry's Phase 2 investigations, we found evidence of widespread confusion in NHS hospitals regarding accountability for mortuary services. This was illustrated by the contradictory findings between the NHS Phase 2 questionnaire and the interviews with senior trust executives. The Inquiry questionnaire responses indicated that, in 57 per cent of NHS trusts with facilities that stored the deceased, the responsible executive director was the Medical Director. The next most common executive director accountable for the mortuary was the Chief Operating Officer or equivalent (19 per cent). The questionnaire responses are set out in Table 16.

Table 16: Executive director accountability for mortuary services		
Which executive director has accountability for the mortuary/body store service?		
Accountable executive	**Number of responses**	**Percentage of responses**
Medical Director	73	57%
Chief Operating Officer	24	19%
Chief Nurse	18	14%
Chief Executive	4	3%
Director of Governance	2	1.6%
Director of Strategy	1	0.78%
Chief Medical Officer	1	0.78%
Director of Integrated Care	1	0.78%
Divisional Director	1	0.78%
Director of Operations	1	0.78%

Source: Inquiry questionnaire 2024.

The questionnaire responses are contradicted by the evidence heard in interviews with trust executives. We found that, out of the 24 NHS trusts that we included in the deep dive, in 14 trusts the accountable executive was the most senior manager for operations, most commonly called the Chief Operating Officer. In only seven of the deep-dive trusts was the Medical Director identified as the accountable executive for the mortuary. In one trust accountability for the mortuary was shared between the Chief Operating Officer and the Medical Director. One trust identified the Director of Emergency Care as the accountable executive, and one identified the Chief Nurse. This is set out in Table 17.

Table 17: Executive accountable for mortuary services as identified in executive interviews		
Role	**Number of responses**	**Percentage of responses**
Chief Operating Officer or equivalent	14	58%
Medical Director	7	29%
Accountability shared between Chief Operating Officer and Medical Director	1	4%
Director of Emergency Care	1	4%
Chief Nurse	1	4%
Total	**24**	

Source: Inquiry executive interviews 2024.

We considered whether the difference in results between the self-reported questionnaire and the interviews could have been due to the selection of the 24 NHS trusts for the deep dive. To address this issue, we reviewed their questionnaire responses and compared them with the answers given in senior executive interviews for the same NHS trust. We found a discrepancy between the responses given in the questionnaire and the interview responses from the trusts.

Ten NHS trusts gave the same response to the question about the accountable executive in the questionnaire as they did in the interviews. There were also four trusts that told the Inquiry during the interviews that they had made changes in the accountability structure since the questionnaire had been submitted. However, if we set aside these four trusts, the Inquiry found that there was a discrepancy between questionnaire responses and interview responses for ten NHS trusts. We are unable to say whether this discrepancy would be the same for the trusts that were not included in the deep dive. However, we note that the discrepancy that occurred in the deep-dive trusts involved the trust self-reporting that the Medical Director was the accountable executive, while trust executives identified the most senior operations manager as the accountable executive. This error was an over-reporting of the Medical Director as the accountable executive. As the most commonly self-reported executive in the questionnaire was the Medical Director, the Inquiry considers that this error could well be occurring across the NHS.

The discrepancy between the self-reported questionnaire and the evidence given in interviews indicates confusion regarding trusts' understanding of who is the accountable executive for the mortuary. This may be explained by the person completing the questionnaire not fully understanding the lines of accountability. However, the Inquiry also heard examples where executives within the same trust were confused about accountability for mortuary services. In one instance, the Chief Nurse identified the Chief Medical Officer as the accountable officer and the Chief Medical Officer identified the Chief Operating Officer. The questionnaire response for this trust had previously identified the Medical Director.

We were unable to ascertain whether this was specific to mortuary services or a more generalised confusion about accountability structures within NHS hospitals. We did identify a variability in understanding of trusts' accountability structures, as illustrated below:

> *"Before I arrived, this would have sat … I think, potentially have reported to the Medical Director. I couldn't be quite, totally certain about that because accountabilities were very confused."* [42]

42 Witness transcript of A338, Chief Executive, September 2024.

1.6.1 Governance framework for mortuary and body store services

NHS trusts organise their services into service delivery groups; they consider this the most appropriate structure to manage and oversee delivery.

Each service delivery group feeds into the trust management structure and ultimately to the trust board. The Inquiry found that mortuary and body stores were managed within Pathology departments in all of the trusts that participated in the deep dive. Pathology departments sat within care groups that provided clinical support and diagnostic services, and these divisional-level care groups had a wide variety of titles. In all trusts there was a clear line of structural accountability for the governance of the care group to the trust board.

In six NHS trusts selected for the deep dive, there were Private Finance Initiative (PFI) contracts in place. PFIs occur when an independent company funds and hence owns the building in which NHS services are delivered and leases the building to the NHS trust. The PFI holding company usually contracts with the building company to provide building maintenance and technical facilities. Sometimes other services, such as catering, portering, security and domestic services, are also contracted out. These outsourcing arrangements do not diminish the ultimate responsibility of the NHS trust for the management and governance of services to patients, but they can complicate them. The terms of the various contracts and compliance with them can complicate accountability and management arrangements, particularly when changes in service specifications are required.

In Phase 1, the Inquiry found that the PFI arrangements at Maidstone and Tunbridge Wells NHS Trust complicated management and security arrangements for maintenance staff, which made it more difficult to have an overall picture of what was happening in relation to DBS checking and access to the mortuary. The Inquiry was interested to understand if management arrangements in trusts with PFI contracts were affecting the practices and procedures in place to protect the deceased in NHS hospitals.

From the evidence we collected through the document review and interviews, we found that the impact of PFIs varied in the six trusts. For three of the trusts, running a hospital under a PFI arrangement was not seen as detrimental to decision-making on issues related to the mortuary. In one interview, we were told that the PFI involved only an additional reporting and decision-making process that had to be completed:

> *"It's just that the combination of how we do things and who does it is slightly different on each site. Because the security team – I'll give you an example. Security and portering is run by a combination of us and a total facilities management company at [Hospital A]. And here is run through the PFI contract and is delivered by [independent contract firm]. So, I mean, at the end of the day, the standards around access are the same it's just that the Director of Estates has to have two conversations, slightly different depending on who runs what. And that's just an arrangement we've inherited over the years because [Hospital B] was built as a PFI. But I think the line up to one Director of Estates creates the consistency that you need because you've got one set of eyes overseeing all things buildings and operational."*[43]

43 Witness transcript of A390, Chief Operating Officer, September 2024.

However, the remaining three trusts told the Inquiry about aspects of being a PFI hospital that caused problems in relation to mortuary and body store facilities. The main issue that was raised was the delay in getting agreement for essential building fabric alterations required to ensure compliance with either HTA standards or NHS England requirements:

> *"[B]ecause that's [fridges] the only one that we've identified is still not fully compliant … We do have an issue here because we're a PFI. It's not just as simple as us saying yes to try and work with our partners. And that's been very frustrating to me, because I thought that it would have been built by now. And it was only a few months ago, and I said, 'Well, has that been built?' And I went – 'No.' I was very surprised. I had a conversation with the Finance Director. I was about to blame him. And it wasn't him. It was stuck in the estates process. So, it's just the complicating factors of doing any work in a PFI environment. It's quite frustrating. It takes longer than you would imagine it should take."*[44]

One trust identified the PFI arrangements as the reason it was not able to implement electronic swipe card access:

> *"Some of them are key code, and some of them are physical key. I think you may be aware that in the report that came to the executive team in November 2021, there was a recommendation around swipe card access. But our buildings are often PFI owned or not within our ownership and so we weren't able to take that forward."*[45]

In this particular trust, the majority of the estate was owned under different PFIs, which created even more difficulty:

> *"It would be another hour to go into the complexity of our estates … if we work to the principle that we own 7% of our estate, the other 93% is in the main PFI. It is various different PFI individuals as well. So, it's not one PFI provider that we're working with … yeah, we own very little of our estate and it's not even as if we could have one conversation, we have to have several in getting to a consensus position across the board."*[46]

The Inquiry heard that PFIs could complicate the management arrangements that accompany decision-making in mortuary-related matters:

> *"So, for example, access to the autopsy theatre, and they will be swipe card shortly. One of our mortuaries is a PFI and it just takes longer to get everything done."*[47]

We found an example where we consider the security and dignity of the deceased to have been compromised where an essential measure – individualised electronic access – was not implemented because of the inflexibility of the PFI arrangements in place:

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44 Witness transcript of A304, Executive Medical Director, July 2024.
45 Witness transcript of A387, Chief Medical Director, July 2024.
46 Witness transcript of A388, Chief Operating Officer, July 2024.
47 Witness transcript of A374, Medical Director, July 2024.

> *"[T]hat has proved to be a step that we couldn't have the – we weren't able to affect that change. So at the time that in the, when the safety alert came through and we were asked to take action around the CCTV and the swipe cards and give that assurance that that was in place. Whilst we were able to get the CCTV comprehensively installed across all of the five units, none of the PFI providers were able to assist us with the swipe card access. And so, we remain with a key and lock position, but weren't able to agree with them that that was something that would be in place."*[48]

In those trusts that identified PFI as an arrangement that detracted from management decision-making ability in relation to mortuary security, this impediment was not always fully appreciated by the executive team. In a trust that was not able to install new body fridges, the Chief Executive demonstrated no awareness at all about the impact the PFI arrangements were having on the trust's ability to adhere to HTA standards.

In relation to PFI arrangements, the Inquiry found that it was not the PFI relationship itself that impacted on the trust's ability to implement measures that would protect the security and dignity of the deceased; rather, the quality of the management arrangements and relationships at the most senior level of the trust with the PFI provider determined how easily any potential difficulties were negotiated.

1.6.2 Reporting arrangements to the trust board

In Phase 1, we found that there was minimal reporting to the Maidstone and Tunbridge Wells NHS Trust Board or Board committees regarding important issues of performance against HTA standards and security in the mortuary. For this reason, the Inquiry was interested to understand how NHS trust boards received assurance about the performance of the mortuary and body stores.

In the Inquiry questionnaire, we asked whether trust boards had received an HTA report, internal report or peer review about the mortuary since 2014. The Inquiry specifically asked to hear about reports received in this time period as the investigation into matters relating to Jimmy Savile at Leeds Teaching Hospitals NHS Trust published its report in 2014, and the report raised the issue of risk of abuse in hospital mortuaries. The Inquiry considered that the publication of this report should have prompted trust boards to think about the possibility of abuse occurring in their own mortuaries and body stores. We found that 79 per cent of trusts indicated that the trust board had received a report about the mortuary since 2014. Table 18 summarises the responses.

48 Witness transcript of A388, Chief Operating Officer, July 2024.

Table 18: Number of NHS trusts that have received a report about the mortuary since 2014		
Has the trust board ever received a report such as an HTA report, an internal report or a peer review report about the mortuary since 2014?		
Response	**Number of responses**	**Percentage of responses**
Yes	102	79%
No	19	15%
Not applicable	2	2%
Other	6	5%

Source: Inquiry questionnaire 2024.

The trusts were then asked when their trust board had received this report: 45 per cent of the trusts that had received a report (or had selected *"Other"*) indicated that this had been more than 12 months ago. Table 19 summarises the responses.

Table 19: When the trust board last received a report about the mortuary		
If so when did the trust board receive this report?		
Response	**Number of responses**	**Percentage of responses**
Within the past six months	33	31%
Within the past 12 months	22	20%
More than 12 months ago	49	45%
Not applicable	5	5%

Source: Inquiry questionnaire 2024.

1.6.3 Trust boards and the Inquiry's Phase 1 Report

All trusts with a mortuary and/or body store were asked in the Inquiry questionnaire if the trust board had discussed the Phase 1 Report of the Independent Inquiry into the issues raised by the David Fuller case. We asked this question because the Inquiry's Phase 1 Report, while being specific to what had happened in Maidstone and Tunbridge Wells NHS Trust, could have prompted trust boards to consider whether the recommendations applied to their own trust. The questionnaire responses indicated that only 37 per cent of trust boards had discussed the Phase 1 Report and that 51 per cent had not discussed it. Twelve per cent of respondents did not know whether the Report had been discussed by the trust board. Table 20 summarises the responses.

Table 20: Was the Phase 1 Report discussed by the trust board?		
Has the Phase 1 Report of the Independent Inquiry into the issues raised by the David Fuller case been discussed at trust board?		
Response	**Number of responses**	**Percentage of responses**
Has been discussed	48	37%
Has not been discussed	66	51%
Don't know	15	12%

Source: Inquiry questionnaire 2024.

We reviewed trust board assurance for mortuary and body store services through the document review for the 24 NHS trusts selected for the deep dive. We asked the trusts included in the deep dive to provide the Inquiry with details of trust board papers showing where the mortuary had been discussed over the past two years. The results were as follows:

- Twelve NHS trusts did not provide any evidence to the Inquiry of trust board discussions taking place regarding any matters related to the mortuary or body store over the past two years.
- Twelve NHS trusts supplied evidence that matters related to the mortuary were discussed by the trust board.

Where discussions about these services were held, the majority related to performance against HTA regulations: for example, an HTA report. There was very limited evidence of trust board discussions of mortuaries and body stores that were unrelated to the HTA.

The evidence provided through the document review contradicted the evidence given to us in senior executive interviews. During the senior executive interviews, all NHS trusts described to us how mortuary matters progressed through the governance framework. As part of these descriptions, all 24 trusts told us that the trust board received assurance regarding matters relating to the mortuary.

From the evidence we received through the Inquiry questionnaire, document review and senior executive interviews, the Inquiry found that the governance and assurance of mortuary services were variable across NHS trusts. Furthermore, the Inquiry also found that senior executives did not fully appreciate whether or not their trust board had oversight of mortuary services.

In terms of how frequently the trust board received reports about the mortuary, we found that the majority of trusts (18) reported by exception. A minority (three) had a regular reporting system, which varied from an annual report to, in one trust, a quarterly report, with three more planning to implement routine reporting in the future. Exception reporting does not provide sufficient opportunity for the trust board to have oversight of the regulated activities in mortuaries and body stores. This oversight is required to provide assurance that the security and dignity of the deceased are protected.

This lack of oversight was identified during executive interviews. We identified an instance where a very poor 2023 HTA report, identifying serious shortfalls against HTA standards, had come as a surprise to the executive team:

> *"Was it a surprise? I mean, it wasn't – I didn't think I knew this was coming. If I'm honest, I think I wasn't aware of the risks we were holding in that space is the truth of it. And when we found out from the report that there were issues, we thought, blimey we need to get on top of this. So, in a sense, quite timely. And we had done the bit of work around security, access swiping as a result of the Fuller. But actually, some of the stuff around the consent process and those open actions from last time, unfortunately, and this will be my bad, I wasn't sighted on those from previously when I'd taken over."*[49]

This was the case despite David Fuller's crimes in a hospital mortuary receiving significant national attention, and despite the assurance exercise conducted by NHS England.

We found that governance, accountability and trust board reporting were most frequently mentioned during interviews as the areas that required improvement:

> *"One of the things that I think we will strengthen is a more systematic and regular reporting from our site leadership teams into our board committees. So, we will want – I think at the moment – and it's understandable this, and I don't think it's caused us any issues, by the way – but at the moment, it's done on a risk exception basis, you know, which is how we handle loads of stuff, frankly, but I think we've been having a bit of pause for thought around, actually, would we be better – and you've always got to think about proportionality. Our board meetings are long enough, frankly – our board meetings are long enough. But is there a better opportunity to be a bit more systematic about, you know, we think it would be good to have a bit of an annual report coming out of our mortuaries."*[50]

> *"And in fact, in light of some of the Fuller findings, we're just going to beef up that governance a bit more. He's going to run a sort of twice a year group that pulls things together alongside the other Designated Individuals for other matters inside the Trust. So, it's kind of complex in a sort of matrix system that we would understand. But the day to day running is very clearly with the individual hospitals through to their Chief Execs, and then through to me, ultimately."*[51]

> *"So when, shortly after I arrived here there was some concerns about the mortuary, which prompted me to raise questions about response to returns required and stuff last Autumn. We initiated a series of visits and tried to get a grip of what the organisation had said it was going to do around mortuary compliance and security, et cetera. Again, from that, were a series of new action plans, visits from me or the directors, the chairman went to visit the mortuaries, you know, et cetera, as well. Produced an action plan that's been through various committee processes here. And a subsequent HTA visit a few … a couple of months ago, which indicated much better compliance at that point. So I think it's fair to say that the organisation hadn't been fully aware I don't think,*

49 Witness transcript of A371, Medical Director, July 2024.
50 Witness transcript of A347, Chief Executive, July 2024.
51 Witness transcript of A335, Group Chief Executive, September 2024.

of the Inquiry and its implications, and this was part of a range of issues where general oversight and governance had been deteriorating for some time. So a lot of things that should have been being checked weren't being checked."[52]

1.6.4 Senior executives' understanding of the Human Tissue Authority framework

From the interviews we conducted, the Inquiry found that there was a widespread misunderstanding of the legal framework of the HTA across the most senior executive level of NHS trusts. From the 23 Chief Executive interviews we undertook with those with HTA-licensed premises, 22 Chief Executives identified the HTA Licence Holder or themselves as the individual ultimately legally responsible for ensuring that HTA-licensed mortuaries adhere to the required HTA standards. This is incorrect. The HTA DI is the person who has the legal responsibility for ensuring that the mortuary is fully compliant with HTA standards. Only one Chief Executive correctly identified that the DI was the legally accountable person for adherence to HTA requirements.

A failure to adhere to the requirements of the Human Tissue Act 2004 has the potential to incur criminal liability for the DI. An example of such criminal liability is found in section 5 of the Act, which creates an offence of collecting human tissue samples, as specified in section 1 of the Act, without appropriate consent:

"A person guilty of an offence under this section shall be liable—

(a) on summary conviction to a fine not exceeding the statutory maximum;

(b) on conviction on indictment—

(i) to imprisonment for a term not exceeding 3 years, or

(ii) to a fine, or

(iii) to both."[53]

No Chief Executive of an NHS trust that held an HTA licence demonstrated an understanding that the position of DI was one that had the potential to attract criminal liability, or of the grounds on which such liability might occur. All of the Chief Executives whom we interviewed were able to confirm either the role or the name of the DI. However, in one trust, three executives interviewed could not correctly identify the DI, either by role or by name.[54] This was the case even though the Inquiry issued invitations to interview at least two months in advance of the interview and advised individuals of the areas that would be covered. The Inquiry was so concerned by this that it wrote to the trust on the instructions of the Chair of the Inquiry, sharing the information the Inquiry had identified.

52 Witness transcript of A338, Chief Executive, September 2024.

53 Human Tissue Act 2004, section 5, ss.7.

54 Witness transcripts of A331, Medical Director; A345, Chief Operating Officer; A397, Chief Nurse, July–August 2024.

What we have found

- There is widespread confusion across NHS trusts regarding who is the accountable executive for mortuary and body store services. In their questionnaire responses, 57 per cent of trusts identified the Medical Director and 19 per cent the Chief Operating Officer or equivalent as the accountable executive. These responses were contradicted by the executive interviews.
- Private Finance Initiatives complicate decision-making arrangements for mortuary services. However, the strength of wider management and governance arrangements determines the extent to which Private Finance Initiatives impact on trusts' ability to implement security measures.
- There is wide variability in terms of reporting to trust boards, with only 50 per cent of trust boards receiving a report about the mortuary in the past 12 months, according to the questionnaire responses. The document review has identified that 50 per cent of trust boards have not received a report on the mortuary in the past two years. This is the area that Chief Executives most frequently identify as the one that should be improved.
- There is limited understanding in NHS trusts about the legal framework of the Human Tissue Authority.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 15
All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include:

- staffing matters;
- security incidents;
- all serious incidents;
- Human Tissue Authority reports (where applicable); and
- all security audits, including audits of access and any access breaches.

Recommendation 16
Trust boards should assure themselves that the recommendations in this Report have been implemented.

Recommendation 17
Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people.

Recommendation 18
Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.

1.7 Safeguarding the security and dignity of deceased people in NHS hospitals

1.7.1 What do we mean by safeguarding?

The Inquiry was required to consider the practices and procedures that are in place to protect the security and dignity of deceased people in different settings. In both the NHS and local authorities, the practices and procedures to protect the security and dignity of the living are contained within a system called safeguarding. Safeguarding is the term used by agencies to describe the processes and procedures that support a person's *"right to live in safety, free from abuse and neglect"*.[55] It involves proactive measures to prevent harm and protect those at risk of abuse or neglect, particularly vulnerable adults and children.

The Care Act 2014 places a general duty on all local authorities to promote the wellbeing of individuals; this includes the duty to make appropriate enquiries if the local authority suspects that an adult is experiencing or is at risk of abuse.[56] [57]

NHS England provides the following definition of safeguarding: *"Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect."*[58]

In its Safeguarding Accountability and Assurance Framework (SAAF), NHS England sets out the responsibilities of NHS organisations in relation to safeguarding and cites a wide range of legislation which it considers places a duty on organisations to adhere to their safeguarding responsibilities:

> *"Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice."*[59]

NHS England has a system of governance and oversight of safeguarding procedures and processes. At an individual NHS trust level, this requires up-to-date policies and procedures for safeguarding and regular reporting systems to the trust board of each NHS organisation. The extent to which NHS providers of care comply with the obligations set out in the SAAF are overseen by the Care Quality Commission.[60]

55 DHSC, Care and support statutory guidance, updated 18 February 2025, gov.uk website.
56 Care Act 2014, section 1, ss.1–2.
57 Care Act 2014, section 42, ss.1–3.
58 NHS England, About NHS England Safeguarding, NHS England website.
59 NHS England, Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework, updated 9 July 2024, NHS England website.
60 Ibid.

1.7.2 Does safeguarding legislation extend to deceased people?

Safeguarding legislation, as set out in the Care Act 2014 and other safeguarding legislation such as the Children Act 2004, does not extend to deceased people.[61]

The Inquiry's Terms of Reference required us to consider the processes and procedures in place to protect the security and dignity of deceased people. Although we recognise that the current safeguarding legislation, in the Care Act 2014 and other related legislation, does not extend to deceased people, we considered how far the safeguarding system, as set out by NHS England, was being used to protect deceased people.[62]

1.7.3 Is there a basis for NHS safeguarding policies to encompass deceased people?

In terms of the Care Act 2014, the Inquiry acknowledges that the legal position in relation to safeguarding is clear: safeguarding legislation does not extend to deceased people. However, when we reviewed NHS England's list of statutes on which its assurance framework was based, it was clear that the Sexual Offences Act 2003 was included.[63] The Inquiry noted that the 2003 Act does include provisions criminalising the abuse of deceased people through sexual penetration:

> *"**70 Sexual penetration of a corpse***
>
> *(1) A person commits an offence if—*
>
> *(a) he intentionally performs an act of penetration with a part of his body or anything else,*
>
> *(b) what is penetrated is a part of the body of a dead person,*
>
> *(c) he knows that, or is reckless as to whether, that is what is penetrated, and*
>
> *(d) the penetration is sexual."*[64]

It is clear to the Inquiry that NHS trusts already have a framework in place through which they could include deceased people in their safeguarding policies: NHS England's SAAF. The aspect of this framework that is relevant to deceased people extends only as far as the limits of the Sexual Offences Act 2003: namely, protection from sexual abuse in the form of sexual penetration. However, putting in place systems such as CCTV, and using and auditing them to protect service users from such offences under the 2003 Act, would also capture a wider range of potential abuse that could be perpetrated against deceased people.

The Inquiry asked NHS trusts during the key witness interviews to describe the safeguarding policies and systems of oversight and governance in place to protect the living. We also asked trusts to tell us to what extent they were using these safeguarding systems to protect the deceased.

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61 Legal advice from Inquiry Counsel, May 2024.

62 Legal advice from Inquiry Counsel, May 2024.

63 NHS England, Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework, updated 9 July 2024, NHS England website.

64 Sexual Offences Act 2003, section 70.

1.7.4 Safeguarding practices and processes in place in NHS trusts

All 24 trusts in our deep-dive sample described robust structures and processes in place to identify the safeguarding needs of their patients and families and their staff. The Chief Nurse held the executive responsibility for safeguarding in all of these trusts. In addition to systems to identify the safeguarding needs of patients and other individuals, all 24 trusts described a system of oversight that was robust and had a clear line of reporting, through the governance framework, to the trust board. Reports were presented to all trust boards regularly, with trusts describing either a quarterly report or a more frequent reporting cycle. All trusts stated that the Chief Nurse presented an annual written safeguarding report to the trust board. We concluded from this that there appeared to be well-established systems in place to protect vulnerable adults and children in all trusts and that these systems were subject to oversight.

1.7.5 Do trusts extend safeguarding practices and procedures to deceased people?

Senior executives from all of the trusts we spoke with believed that the safeguarding needs of deceased people should be considered within the current safeguarding framework. For example, we were told:

> *"Although I think in the legal framework of safeguarding, there are – it needs to be further defined. But for us in our organisation, safeguarding is applicable to all patients, all families, all staff and deceased."*[65]

Although all trusts considered that deceased people should be included in the safeguarding process, this view was not reflected in their safeguarding policies. A minority (four) of Chief Executives recognised this disparity:

> *"But I think our Chief Nursing Officer would say that – and she has said, I've heard her talk about this before, that you know, our responsibility for patients, you know, alive or deceased, ends when they leave the premises. So, by definition, that will therefore include anybody that's in a deceased holding unit or in our mortuary. But I don't think we've made it explicit in a safeguarding policy per se."*[66]

Of the 24 trusts involved in our interviews, only three told us that their safeguarding policies included deceased people. One trust told us that these policies had been changed following an internal review of safeguarding: *"I asked for a safeguarding independent review when I first came into post because I felt there was more things we could do."*[67]

We were told that mortuary staff were included in safeguarding training, but it was not clear if this training addressed the specific needs of deceased people or was limited to the protection of the living.

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65 Witness transcript of A317, Group Chief Nurse, July 2024.
66 Witness transcript of A335, Group Chief Executive, September 2024.
67 Witness transcript of A368, Chief Nursing Officer, July 2024.

The disparity between what senior trust leaders think should happen and what happens in practice could be explained by the lack of inclusion of deceased people in the Care Act 2014, combined with a lack of awareness of the basis on which NHS England's SAAF is based. The Inquiry also considers that the lack of focus on deceased people until the crimes of David Fuller were exposed contributed to their lack of inclusion in current safeguarding policies.

There was significant confusion among those we interviewed regarding whether their organisation's policies contained references to deceased people. Eight Chief Executives were unsure whether their organisation's safeguarding policies and procedures extended to deceased people. Furthermore, five Chief Executives told us that their safeguarding policies did extend to deceased people, but their Chief Nurses told us that they did not. We found that two Chief Nurses did not know whether their organisation's safeguarding policies extended to deceased people.

The fact that there was evident confusion among NHS senior leaders regarding whether their organisations' safeguarding policies extended to the deceased indicated the level of uncertainty regarding whether the current framework assists trusts in protecting the security and dignity of the deceased.

The Inquiry was particularly interested in the role of the Chief Nurse as the accountable executive for safeguarding within NHS trusts. We noted in our Phase 1 Report that, as part of their role, the Chief Nurses at Maidstone and Tunbridge Wells NHS Trust did not adequately consider the protection of deceased people during their stay in the mortuary. Rather, the Chief Nurses focused on the needs of deceased people in relation to the experience of relatives. We found that the majority of Chief Nurses we interviewed in Phase 2 of the Inquiry did not consider how to protect the security and dignity of deceased people using the NHS safeguarding framework, even though they had accountability for the implementation and oversight of this framework. The Inquiry acknowledges that NHS England's SAAF does not mention deceased people. It does, however, reference the Sexual Offences Act 2003, which includes section 70 offences against deceased people.[68]

We did hear from 11 Chief Nurses that the protection of the deceased as a vulnerable group was considered in the implementation of their policies, even though the deceased were not formally included in NHS England's SAAF or in trust policies. For two trusts, the Chief Nurses told us that the needs of the deceased were included in their annual safeguarding report.

68 NHS England, Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework, updated 9 July 2024, NHS England website.

What we have found

- NHS England's Safeguarding Accountability and Assurance Framework has the potential to include deceased people. However, the current NHS England safeguarding framework, as applied by the majority of trusts, does not extend to deceased people and the majority of trusts do not include deceased people in their safeguarding policies.
- There is confusion among senior NHS leaders regarding whether current safeguarding policies are used to protect the security of deceased people.
- The role of the Chief Nurse in safeguarding the security and dignity of deceased people is not clear if deceased people are not included in trust safeguarding policies.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 19
NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.

Recommendation 20
The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.

Recommendation 21
NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.

1.8 Human Tissue Authority Evidential Compliance Assessments and pilot inspections of Welsh body stores

The HTA told the Inquiry that it had been strengthening its approach to assessing compliance with key standards relating to security, governance and quality in the post-mortem sector. This included carrying out Evidential Compliance Assessments (ECAs) in the first half of 2023/24, during which establishments licensed to conduct post-mortems were required to submit evidence from their organisation on mortuary security and access, including access control, known risks, and policies and procedures.[69]

69 Information provided to the Inquiry by the HTA, October 2024.

The HTA found that only 29 out of 129 NHS trusts were compliant with the necessary standards. Sixty-five NHS trusts were compliant only after receiving advice and guidance from the HTA and 35 were not compliant.[70]

The HTA explained that the following action would be taken with the 35 organisations deemed 'not compliant' following the ECA:

- If the establishment already had an open Corrective and Preventative Action (CAPA) process in place – for example, for shortfalls identified at an inspection – follow-up to the ECA was via ongoing engagement and oversight by the regulation manager managing the open CAPA Plan.
- If the establishment had already been included on the HTA's inspection schedule for 2024/25, this was retained and was the route for following up the ECA.
- If the establishment was neither under existing oversight through an open CAPA Plan nor otherwise scheduled for inspection in 2024/25, the establishment was fast-tracked for a focused inspection against the standards relevant to the ECA and any identified potential shortfalls.[71]

The Inquiry is concerned that so many organisations are not compliant with the HTA standards that are key to the work of the Inquiry. This is particularly concerning given the case of David Fuller, the steps NHS England has taken to seek assurance from all trusts following his arrest, and participation by NHS trusts in this Inquiry.

The HTA also undertook a series of pilot advisory inspections of six unlicensed body stores run by Welsh health boards. These inspections aimed to provide advice and guidance on potential areas of concern. The HTA found that all of the six sites visited for advisory purposes would have been subject to major shortfall findings if assessed against HTA standards.[72]

For one health board, advice from the HTA following the advisory inspections included: *"replace external door key locks with swipe card access to mitigate risk of unauthorised access should manual locks not be deployed"*.[73] The HTA also found that one body store had doors which opened into an area frequented by the health board's staff; the HTA advised that this area be screened.[74] At another health board responsible for three of the six body stores, the HTA found that CCTV had blind spots and that mortuary staff were unable to access CCTV in order to conduct audits.[75] All of the six body stores received security-related advice from the HTA.

70 Information provided to the Inquiry by the HTA, March 2025.
71 Information provided to the Inquiry by the HTA, October 2024.
72 Written statement of the HTA, October 2024.
73 HTA inspection report appendix, HTA website.
74 Ibid.
75 HTA inspection report appendix, HTA website.

1.9 Conclusions

The Inquiry has considered security, management and governance, and safeguarding arrangements in NHS trusts with mortuaries and body stores. This module has also included the role and experiences of the DI and Mortuary Managers in those trusts. The findings and recommendations for these themes are included throughout this chapter and reflect a large variation in such arrangements between NHS trusts in England. These findings are also reflected in information shared with the Inquiry by the HTA.

As we have illustrated in this chapter, the Inquiry has found examples where mortuary services are still poor. A further example is an NHS trust that shared details with the Inquiry of an HTARI raised in 2024 relating to the treatment of deceased people which is now the subject of a police investigation. This was of concern to the Inquiry and the Inquiry wrote to the trust in March 2025, requesting confirmation of actions the trust has taken in light of the allegations.

Although it is understood that investigations have been conducted by the hospital, these are serious allegations and, if correct, show an NHS mortuary failing to protect the security and dignity of deceased people.

The trust has confirmed that it has revised its policies and procedures in light of the allegations and has addressed the alleged unacceptable practices within the mortuary.

These allegations remain under investigation and the Inquiry is unable to provide further detail in this Report in order to avoid causing any risk of prejudice.

Based on the evidence provided to the Inquiry, there is a need for the recommendations in this Report to be implemented as soon as possible to ensure the security and dignity of deceased people in the care of NHS hospitals.

Chapter 2: Independent hospitals

2.1 Introduction

The independent healthcare sector plays a significant role in the delivery of healthcare in England. Some individuals choose to fund their own healthcare, either by paying an independent healthcare provider directly or through healthcare insurance. In addition, the NHS also contracts with independent healthcare providers to increase capacity for elective surgery and some specialist services, to improve the delivery of healthcare to the population. In 2023/24, the NHS spent seven per cent of its £182 billion budget on healthcare services supplied by bodies from the independent sector.[1]

Independent hospitals are regulated by the Care Quality Commission. They are not licensed by the Human Tissue Authority to undertake post-mortem examinations.

There are five main independent providers of elective healthcare in England. These are:

- Spire Healthcare;
- Circle Health Group;
- Ramsay Health Care UK;
- HCA Healthcare UK; and
- Nuffield Health.

Most independent healthcare providers have limited facilities to deliver emergency clinical care and therefore select the cases they undertake carefully to reduce the likelihood of a medical emergency occurring. As a result of this restricted case selection, the relative number of deaths in independent facilities is low compared with NHS acute hospitals. Where medical emergencies do occur, the normal procedure is to call an emergency ambulance to transfer the individual to a local NHS provider with the necessary services to deal with a medical emergency. However, deaths do occur in independent hospitals, and it is for this reason that the processes and practices in place to protect the security and dignity of the deceased in the independent healthcare sector were included in the Inquiry's Terms of Reference for Phase 2.

1 Department of Health and Social Care, *Annual Report and Accounts 2023–24*, HC 476, December 2024.

2.2 How we did our work

We began the Inquiry's work on independent hospitals by engaging with representatives from the Independent Healthcare Providers Network (IHPN), the organisation which represents the independent sector in healthcare, to establish the basic facts about the sector. IHPN contacted its members to let them know about the Inquiry and to encourage them to participate in it.

Following this, we approached the five main independent providers of healthcare in England (see section 2.1) to invite them to submit a statement to the Inquiry setting out the policies and procedures they had in place to protect the security and dignity of deceased patients. The information they provided was reviewed independently by two members of the Inquiry team and, in some cases, further clarifications were sought from the healthcare providers.

We also approached three independent providers of mental healthcare – Priory, Cygnet Health Care Ltd and St Andrew's Healthcare (a charity) – inviting them to provide a statement setting out the measures they have in place to protect the security and dignity of deceased patients.

2.3 Our findings

2.3.1 Incidence of patients dying in independent hospitals

To consider the incidence of patients dying in the independent sector compared with the NHS, we examined two ratios: deaths to episodes and deaths to spells. An episode is a continuous period that a patient spent under the care of one consultant in one healthcare provider, whereas a spell is a continuous period of time a patient spent in hospital. Spells may contain a single episode or multiple episodes at the same health provider.

In NHS hospitals in England in 2023, the ratio of deaths to episodes was 1:27 and the ratio of deaths to spells was also 1:27. This compares with independent hospitals in England in 2023, where the ratio of deaths to episodes was 1:3,151 and the ratio of deaths to spells was 1:3,141.[2]

There are several reasons why fewer deaths occur in independent hospitals, one being that independent hospitals treat fewer patients than NHS hospitals, and so this is to be expected. Most independent hospitals do not provide emergency care, as they do not have Accident and Emergency departments. The type of activity that occurs in independent hospitals is largely elective or planned and more risk stratified to reduce highly complex cases or cases with significant risk of morbidity or mortality.[3]

2 Information provided to the Inquiry by the Department of Health and Social Care Analytical Team.
3 Ibid.

2.3.2 Policies and practices in place – independent providers of elective healthcare

None of the five main independent providers of healthcare in England have their own mortuaries or body stores. The information they provided to the Inquiry sets out the procedures they have in place if an inpatient dies while in their care.

The Inquiry found that there was common practice across all five independent healthcare providers in that deceased patients were kept for relatively short periods of time in their own rooms, before being transferred to a funeral director or, in some cases, an NHS hospital mortuary. Any patients who died and were referred to the coroner were transferred to whichever mortuary provided services to the coroner. There was variation in access to deceased patients across providers, with one provider reporting that staff had unrestricted access to patients' rooms. Another reported that staff had access to the ward areas, and it was also possible for them to access deceased patients' rooms. They went on to say that they were improving signage to be displayed on doors to heighten awareness that no one should enter the room without seeking permission from the nurse in charge. Three providers told the Inquiry that the nurse in charge was responsible for controlling access to deceased patients' rooms. All five independent healthcare providers told the Inquiry that funeral directors collecting deceased patients did so under the supervision of the nurse in charge. Given the present lack of regulation in relation to the care of the deceased, the Inquiry does not criticise independent providers for the current variation in access to deceased patients. However, the Inquiry encourages all independent providers to control access to deceased individuals while they await collection by a funeral director, ambulance or the police, as appropriate.

2.3.3 Policies and practices in place – independent providers of mental healthcare

None of the three independent providers of mental healthcare that the Inquiry contacted had their own mortuaries or body stores. Deceased patients were kept in their rooms until they were collected by a funeral director. Unlike practice in the independent elective healthcare sector, all three independent providers of mental healthcare told the Inquiry that rooms containing deceased patients were locked. One told us that, if it was not possible to lock the area where a patient had died, it was guarded by two members of staff.[4] This difference in practice from the providers of elective healthcare may be explained by the requirement from the police to secure the area in the event of a death caused by self-harm.

Practices controlling access to the room containing a deceased patient, in cases where the police or coroner were content for hospital staff to enter or where the death did not need to be referred to the coroner, differed between providers.

One told the Inquiry that the site manager or assistant manager controlled who had access to the secure area or room, and that the key to the room was usually kept in the possession of the nurse in charge or delegated person. This provider told us that it had

4 Written statement of A436, provider of independent mental health services, October 2024.

no policy covering the numbers of staff who must be present with a deceased patient, only that there must be supervision by one other staff member.[5]

Another said that the senior person in charge ensured that no unauthorised person gained access to the room or area where a deceased person was. Once police had allowed entry, the senior person would only allow family to enter, or two designated staff members in preparation for the family's visit.[6]

The third provider told the Inquiry that it was the responsibility of the nurse in charge to ensure that a patient's dignity was maintained following their death, which included managing access to the room where the patient was located and ensuring that only staff who had a reason to access that location entered.[7]

All three independent providers of mental healthcare told the Inquiry that funeral directors were escorted on site. However, two providers went on to say that there was no requirement to supervise funeral directors once they were in a deceased patient's room.

2.3.4 Adverse incidents

All the independent healthcare providers told the Inquiry that they had not had any adverse incidents that they were aware of regarding the security and dignity of deceased patients.

What we have found

- The Inquiry has found that deceased patients are kept in their rooms in independent hospitals for a relatively short period – up to 12 hours maximum in the elective healthcare sector – before being transferred elsewhere. This, together with the low incidence of patients dying in independent hospitals, suggests that the opportunity for a recurrence of the crimes that David Fuller committed at Maidstone and Tunbridge Wells NHS Trust in independent settings is low. However, there is a reliance on the nurse in charge to supervise access to the deceased in the five main providers of elective healthcare in the independent sector.
- The situation is different in the case of independent providers of mental health services, in that rooms containing deceased patients are generally locked. However, where access to such rooms is permitted, there is a similar reliance on the senior person or nurse in charge to control access.

5 Ibid.
6 Written statement of A437, provider of independent mental health services, September 2024.
7 Written statement of A438, provider of independent mental health services, August 2024.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 22
Independent sector healthcare providers should ensure that there are Standard Operating Procedures and policies in place to protect the security and dignity of any patients that die under their care. Wherever possible, deceased patients' rooms should be kept locked. Providers should also ensure that staff are aware of the need to protect the security and dignity of deceased patients and are able to assess and mitigate risks to this.

Recommendation 23
Independent sector healthcare providers should ensure that only people who have a legitimate reason to access a room that contains a deceased patient do so, even if they are staff members, and that they are always accompanied.

Chapter 3: Medical education and training

3.1 Introduction

This chapter describes the Inquiry's work exploring the arrangements for the care of deceased people in organisations providing medical education and training in England. This covers both undergraduate education and training through medical schools, as well as postgraduate training currently overseen by NHS England. For this module, the Inquiry focused on medical schools that provide cadaveric dissection as part of their education and training offering, and on postgraduate surgical training locations that use human donors.

Organisations in England and Wales that conduct anatomical examination and those that store anatomical specimens must be licensed by the Human Tissue Authority (HTA) under a licence for the anatomy sector.

The HTA requires settings licensed for anatomical examination to have a Licence Holder and Designated Individual (DI); these are similar to the roles required for HTA post-mortem licences. One difference between the licensing arrangements for the post-mortem and anatomy sectors is that HTA anatomy sector licences do not require the reporting of HTA Reportable Incidents (HTARIs),[1] [2] but the DI is encouraged to contact the HTA if they have any concerns about an adverse event.

Prior to the Human Tissue Act 2004 and the creation of the HTA, the use of human material in the anatomy sector was covered by the Anatomy Act 1984, which enabled people to donate their bodies for anatomical examination.[3] The 1984 Act repealed the original Anatomy Act of 1832, which gave surgeons and students legal access to bodies for study, as well as providing for the donation of bodies for medical study by next of kin.[4] Under the Human Tissue Act 2004, informed consent ahead of death is required for body donation.[5] The Human Tissue Act 2004 abolished the position of Her Majesty's Inspector of Anatomy in England and transferred the functions from that post, including the issuing of licences, to the HTA.[6]

1 HTA, Anatomy Licensing Standards and Guidance, HTA website.

2 Note that all establishments licensed by the HTA are required to have an internal system for reporting adverse events and, where necessary, instigating an investigation or root cause analysis. For the anatomy sector, there is no requirement to report adverse incidents to the HTA.

3 UK Parliament, Body snatching, last updated 1 May 2014, UK Parliament website.

4 Ibid.

5 Ibid.

6 Vishy Mahadevan, 'The Human Tissue Act 2004: implications for anatomical work at the College', *Bulletin of the Royal College of Surgeons*, 88:8 (2006).

The standards for medical education and training, and the regulation of all stages of training and professional development for doctors, are provided by the General Medical Council (GMC). The GMC provides approval and quality assurance for settings providing this education and training.[7]

The anatomical work that takes place within these settings is not limited to those studying medicine or undertaking further medical training. Other students, healthcare practitioners and researchers also use donated human specimens in their study or work with the settings explored in this chapter.

In order to reflect the language used in the sector, we refer to deceased people used for educational and training purposes as 'donors' throughout this chapter. The donors used for medical education and training settings can be preserved by being either embalmed or 'fresh-frozen' (donors are frozen and then thawed before use). We refer to both throughout the text.

3.2 How we did our work

3.2.1 Medical schools

At the start of the Inquiry's investigation into the sector, a short questionnaire was sent to 37 medical schools in England. This is reproduced in Appendix 6. These medical schools were identified through the Inquiry's engagement with bodies representing medical schools, as well as with the HTA, and through the Inquiry's own research. The questionnaire allowed us to identify those schools that offer cadaveric dissection as part of their courses, and whether the schools are licensed by the HTA or have links with any other facilities or organisations for these purposes.

From the questionnaire responses, six medical schools that offer cadaveric dissection were selected for further investigation. The criteria used to select these medical schools were:

- the geographical distribution and a mix of larger urban areas and smaller cities and towns and rural locations;
- the size and scale of the facility itself; and
- facility-specific factors, such as links with other organisations.

The Inquiry interviewed the DI at each of these six medical schools. Questions covered the governance arrangements for the anatomy settings where donors were stored and used, as well as governance relating to HTA reports and action plans, the experience of the DI, and policies and procedures in place to ensure the security and dignity of the donors. The Inquiry also requested documentation, including Standard Operating Procedures, training documents, HTA reports and information on any incidents reported to the HTA, noting the relevant HTA requirements as discussed in section 3.1.

7 GMC, Standards of UK medical education, GMC website.

3.2.2 Postgraduate surgical training locations that use human donors

The Inquiry also sent a short questionnaire to each of the NHS England postgraduate regional deans, covering the seven NHS England regions. This questionnaire is reproduced in Appendix 6. All of these organisations responded to the Inquiry questionnaire. All but one of the regions confirmed that the regional team offered postgraduate medical training using cadavers, and provided the names of the sites used for this training.

The information about sites that provide training using donors was drawn from the responses to this questionnaire and from interviews with two NHS England postgraduate regional deans.

3.2.3 Other organisations

In addition to these education and training organisations, the Inquiry requested witness statements from the Royal College of Surgeons of England (RCS),[8] the Royal College of Physicians (RCP)[9] and the Academy of Medical Royal Colleges (AOMRC).[10] We requested statements from these organisations to support the findings of this module. The Inquiry also requested statements from the London Anatomy Office (LAO)[11] and the National Repository Centre, based in Nottingham.[12] We explore how these specific organisations interact with the sector in section 3.3.3.

The findings in this chapter are drawn from all the evidence collected, including evidence collected on site visits to specific organisations. The site visits are discussed in full in Chapter 10.

3.3 Our findings

3.3.1 Medical schools

Of the 37 medical schools that received the questionnaire, 35 completed it and returned their response to the Inquiry. Two medical schools that received the questionnaire wrote to the Inquiry confirming that they did not offer cadaveric dissection.

Of the 35 organisations that responded to the questionnaire, 23 confirmed that they offered cadaveric dissection as part of their teaching or training programmes. An additional three medical schools confirmed that students were given only dissected material from donors to learn from (as opposed to whole cadavers). All the 26

8 The Royal College of Surgeons of England is a professional membership organisation concerned with ensuring excellence in surgical care.

9 The Royal College of Physicians is a professional membership organisation concerned with improving the practice of medicine.

10 The Academy of Medical Royal Colleges is a membership organisation for the UK and Ireland's medical royal colleges and faculties.

11 The London Anatomy Office coordinates the donation of bodies to its member organisations' medical schools.

12 The National Repository Centre is based at City Hospital in Nottingham and supports members of the public who wish to donate their bodies to medical education, training and research.

organisations that indicated that they offered some form of anatomical examination also confirmed that they held an HTA licence for such examination. Some of these were satellite sites of another Licence Holder. The anatomy sector licence was often held alongside a research licence; 15 medical schools indicated that they had both. Five medical schools had relationships with other sites for their programmes; the licensing arrangements for these varied depending on their use. All but one medical school currently offering cadaveric dissection indicated that they intended to continue using this as part of their anatomy teaching over the next five years.

Nine medical schools that responded to the questionnaire responded *"No"* to offering cadaveric dissection. Of these nine, five confirmed that they did not have an HTA licence for anatomical examination or that they had an HTA licence for research only; none of the nine offered anatomical teaching using cadaveric material at any other sites.

Security

An effective security system is designed to prevent unauthorised and inappropriate access and includes an audit process to support the identification of unauthorised and inappropriate access should other security controls fail. For example, restrictions on access are strengthened where there is a regular process of review to identify irregularities.

In Phase 1, the Inquiry found that mortuary security controls were inadequate at Maidstone and Tunbridge Wells NHS Trust. We found, among other issues, that security controls were updated in a piecemeal manner, that there were protracted delays to the installation of security enhancements such as CCTV, and that there was a failure to regularly review staff access to the mortuary.

As part of this module, the Inquiry used the documents received from medical schools, as well as interviews with DIs, to explore the security arrangements for donors used in medical schools. It should be noted that the HTA standards for organisations licensed for anatomical examination differ from those for the post-mortem sector[13] and do not refer to the use of CCTV.[14]

All of the six medical schools that took part in our interviews confirmed that there were security and access restrictions in place for the storage, laboratory and teaching areas where donors were stored and used, including alarm systems in case of intruders out of hours. Each school also confirmed that individualised swipe cards were in use to access the main facility, and that authorisation was reviewed to ensure that the only people who could access areas where donors were present were those who needed to for their role or study. They stated that access to such areas was covered by a variety of security measures, including: swipe cards in four medical schools; a keypad code in one; and physical keys in two (one of which was in addition to swipe card access).

All of the six medical schools involved in interviews and from which we requested documents confirmed that they had CCTV located at access points to areas where donors were stored or used, at a minimum. The evidence provided reflects discussions

13 HTA, Post-mortem licensing standards and guidance, December 2024, HTA website.

14 HTA, Anatomy Licensing Standards and Guidance, HTA website.

we heard across the Inquiry modules about balancing privacy and security when deciding on the placement of cameras. Three medical schools confirmed that CCTV cameras did not cover all areas in the facility where donors could be present:

> *"CCTV, not within the mortuary itself, but all access points leading up to it. It balances out between, I suppose, dignity – and we don't want – … but about balancing up between recording of individuals, sort of the whole time, all the time, which didn't feel was necessary."*[15]

The extent to which CCTV and access were audited varied across the six schools, with only one school providing us with a security and access audit policy that recorded weekly access and cross-referenced it with CCTV footage.[16] We heard in interviews that two medical schools were intending to implement similar audit processes.[17] Three schools confirmed that out-of-hours or unusual access attempts would be recorded and flagged by their security system.

The Inquiry considers that auditing access to areas where donors are being stored and used for study purposes is essential for organisations to ensure the security and dignity of the deceased. An auditing process would allow medical schools to identify illegitimate access to these restricted areas by cross-referencing swipe card data with CCTV, as well as identifying any unusual patterns or frequency of access.

Physical security and access arrangements were the areas in which the six medical schools we interviewed diverged most. All six medical schools provided policies covering: lone working in the areas where donors were stored; phone and device use in areas where donors were used; and the receipt, release and storage of donors. All six of the medical schools that participated in our interviews also confirmed that any maintenance or domestic staff who needed to access the facility did so during working hours and were accompanied.

Governance and management

Medical schools are subject to regulation both by the GMC for the education and training they provide[18] and by the HTA for the relevant licences they hold.[19] They are also subject to regulation by the Health and Safety Executive (HSE) as places of work.[20]

For the six medical schools that took part in our interviews, the Inquiry also requested information on the reporting structures in place for the anatomy settings where donors are stored and used, as well as on governance with regard to HTA reports and action plans.

All of the schools provided information through interviews and statements to the Inquiry on their governance and management arrangements. They all confirmed the involvement of their executive and leadership team in the governance of the anatomy

15 Witness transcript of A513, Designated Individual, October 2024.
16 Document provided by A81, January 2025.
17 Witness transcripts of A506 and A504, Designated Individuals, October 2024.
18 GMC, Standards of UK medical education, GMC website.
19 HTA, Anatomy Licensing Standards and Guidance, HTA website.
20 HSE, How we work, HSE website.

facilities, with scheduled meetings at least twice a year that included discussion of HTA licensing and the reporting of any issues. All of the medical schools provided evidence that described the reporting and meeting arrangements in place for managing the anatomy facilities and that set out the involvement of their HTA Licence Holder.

With regard to the reporting of adverse events and incidents, medical schools have different requirements for reporting to the HTA compared with other HTA-licensed premises, as described in section 3.1. The medical schools all provided information on how incidents relating to HTA standards would be reported and escalated. Two medical schools provided evidence of HTARIs or adverse events, and in our interviews two medical schools told us about security-related incidents. Evidence was provided that both of these security-related incidents had been followed up and that processes were in place to avoid such events compromising the security and dignity of the deceased. However, the Inquiry considers that the difference between the reporting requirements for other HTA-licensed premises and those for the anatomy sector (which do not require the reporting of HTARIs) makes it difficult for numbers of adverse events to be formally recorded across the sector by the HTA.

Role and experience of the Designated Individual

In the interviews, the Inquiry asked DIs to reflect on their role and experience of being the HTA DI for their school's anatomy licence. The evidence provided suggests that the role of the DI is both well supported and well understood within medical schools, with all six DIs providing evidence of training or information-sharing with other staff members on HTA requirements and the role of the DI, either in documents submitted or in interviews. All six schools also provided evidence that information on the HTA and on the role of the DI was provided to students.

The interviews with DIs also reflected a high level of understanding of the role of the DI and HTA requirements among other members of senior management in the medical school, with all six DIs confirming the involvement of their Licence Holder in the management and governance of the HTA licence for the facility. All six DIs were able to give clear examples of senior management participating in governance forums and commented on the understanding that senior management had of the licence and its conditions and the role of the DI as an individual with a statutory role:

> *"Head of School is very aware that there is a prison sentence and how kind of significant this role is and how serious it is. In addition, the anatomy team, the technical team are as well."*[21]

This level of understanding among senior management in the medical schools appeared to translate into empowering the DIs to make changes where required in their organisations. The DIs interviewed by the Inquiry all confirmed that they felt they had the ability to make changes to bring their organisation in line with HTA requirements, with two specifically noting the responsiveness of colleagues in these instances.[22]

21 Witness transcript of A497, Designated Individual, October 2024.

22 Witness transcripts of A498 and A506, Designated Individuals, October 2024.

At the seminar for DIs held by the Inquiry in autumn 2024, which is explored further in Chapter 11, we asked DIs to reflect on changes they would like to see to the role of the DI. We heard from medical school DIs that they would like to see better links established between organisations in the anatomy sector. They compared the current situation with the previous regulatory regime:

> *"There is not a very clear kind of collaboration, like the HTA does not share best practices as much as we used to under the Anatomy Act and I think that would be something that would be useful."*[23]

In interviews, DIs reflected that the HTA could provide more guidance and advice when DIs contacted them with queries, as well as providing greater clarity in describing the role of the DI.[24]

3.3.2 Postgraduate surgical training locations that use human donors

The Inquiry sent a short questionnaire to each of the NHS England postgraduate regional deans, covering the seven NHS England regions. All of these organisations responded to the Inquiry questionnaire. All but one confirmed that the regional team offered postgraduate surgical training using cadavers and provided the names of the sites used for this training.

The Inquiry also interviewed two postgraduate regional deans. In these interviews, the Inquiry focused on the governance and accountability arrangements between NHS England and the providers of postgraduate surgical training. Training can take place in NHS hospitals or local authority mortuaries, and the settings are licensed by the HTA and subject to local governance arrangements to ensure the quality of their processes and policies.[25] Both postgraduate deans told the Inquiry that there were differences between NHS England regions in the provision and management of the postgraduate training offered.[26] [27]

The Inquiry asked one postgraduate dean about the role of the postgraduate deanery in ensuring that postgraduate surgical training settings have policies and procedures in place to manage the security and dignity of donors:

> *"I think it's fair to say it's limited at the moment … We would normally expect that a provider organisation or a local authority mortuary were adhering to the appropriate … HTA guidance and procedures around security and access to bodies."*[28]

23 Inquiry seminar for Designated Individuals, November 2024.
24 Witness transcript of A506, Designated Individual, October 2024.
25 Witness transcript of A519, Postgraduate Dean, November 2024.
26 Ibid.
27 Witness transcript of A100, Postgraduate Dean, April 2024.
28 Witness transcript of A519, Postgraduate Dean, November 2024.

During the same interview, the Inquiry was told about a potential access and security issue that had arisen at a provider organisation. This incident was followed up through the relevant governance processes, and the different considerations of the deanery and the provider organisation illustrated that there was a distinction between the 'fitness to practise' considerations of the deanery and the security policies and procedures set by the provider organisation.[29]

An interview with another postgraduate dean included discussion of the contracting arrangements with provider organisations, and whether these involved specifications regarding the security and dignity of donors used for training in these settings.[30] Following this interview, the Inquiry was provided with a contract between NHS England and an NHS trust providing training; the provider organisation had included in the contract that training was provided on the principles of inclusion and diversity, and that this included *"donors are treated with dignity and respect"*.[31]

In terms of providers' accountability for the training they provide, one postgraduate dean described the routes for escalation and resolution should there be concerns about the provider organisation or a need to be involved from a governance perspective:

> *"So, if there was a specific issue with governance or delivery of education at a provider mortuary level, the NHSE [NHS England] quality framework would allow me to hold them to account through an action plan … The GMC also have the tools through a process called their enhanced monitoring process, to hold the provider organisation's board to account. And the GMC have an ultimate ability to suspend training if they felt that provider organisation are not working to help solve the problems. It's much less clear on how we would engage and interact with, say, a local authority mortuary, because although they might be undertaking training opportunities for postgraduate doctors and training, the commissioning link is nowhere near as mature and developed as that with the provider organisation."*[32]

The Inquiry visited two postgraduate surgical training facilities during the locality visits. Both of these sites use fresh-frozen cadavers as part of their training. In one site, we found a process of transition around governance arrangements; the university and the NHS trust had found the governance arrangements to be lacking clarity, particularly with regard to HTA regulation of the postgraduate site and accountability for compliance. In the other site, we found clear governance processes in place, including a Memorandum of Understanding between the NHS trust and the university that specified where responsibility for the HTA licence lay and included a commitment for the DI to involve staff in training and governance processes where required.[33]

The relationships between NHS England, NHS organisations, universities and postgraduate training providers is described further in Chapter 10, about the locality visits.

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29 Ibid.
30 Witness transcript of A100, Postgraduate Dean, April 2024.
31 Document provided to the Inquiry, May 2024.
32 Witness transcript of A519, Postgraduate Dean, November 2024.
33 Document provided to the Inquiry, March 2024.

3.3.3 Other organisations

The Inquiry requested statements from the RCP, RCS and AOMRC. The RCP and RCS provided information on their HTA licence arrangements and on whether they hold any deceased people for any purposes. The RCP does not have a licence and has no storage facility for cadavers.[34] The RCS confirmed that it holds an HTA licence for anatomy, but does not store or use whole bodies for the educational courses it delivers. The RCS cadaveric courses are delivered by third-party centres that are separate entities and responsible for their own licensing and processes. The RCS told the Inquiry that it *"consider[s] licensing, storage, care, dignity and consent as important criteria for assessment on a centre's suitability"*.[35]

The AOMRC and RCS were asked if they knew of any settings beyond those identified by the Inquiry where deceased people could be held. They both confirmed that they were not aware of any further settings where storage of the deceased could be taking place, other than museums similar to those present at the RCS.[36] [37] The Inquiry considers that such museums containing human material are not within the Terms of Reference of Phase 2 of the Inquiry.

The Inquiry also requested statements from the LAO and the National Repository Centre, based in Nottingham. The Inquiry asked for the statements to cover the HTA licensing arrangements of the organisation, the processes and procedures for body donation, assurance from receiving organisations, and how these ensure the security and dignity of the deceased. Those organisations, which support the donation of bodies to medical education and training, are not used by all of the medical schools or training facilities from which we received evidence for this module. Some medical schools in England receive donors bequeathed directly to their school rather than through these organisations, or through a combination of donation routes.

The LAO coordinates the donation of bodies to its member organisations' medical schools and is funded by and accountable to the London and South East Committee of Anatomists (LSECA).[38] This coordination activity takes place with institutions that provide appropriate storage facilities for donors, including funeral directors, hospitals, hospices and member organisations.[39] The LAO does not hold an HTA licence as it does not store, handle or remove human tissue from donors.[40]

34 Information provided to the Inquiry by the RCP, October 2024.
35 Written statement of the RCS, November 2024.
36 Information provided to the Inquiry by the AOMRC, November 2024.
37 Written statement of the RCS, November 2024.
38 LSECA is a not-for-profit organisation that brings together anatomists within the medical schools served by the LAO.
39 Written statement of the LAO, November 2024.
40 Ibid.

In its statement to the Inquiry, the LAO described the processes and procedures in place to support its member organisations in maintaining the security and dignity of donors:

> *"The LAO may review the HTA inspection report to check for compliance by the Member Institution, to have an oversight of the findings and for quality assurance where improvements in shared processes can be made. The LAO may need to offer support to the Member Institutions to ensure that they are adhering to the best practices and continuing to maintain public trust in medical education and training.*
>
> *…*
>
> *The LSECA have worked with the University of London to implement a Code of Practice (COP), which all Member Institutions are required to read, sign and comply with. The aim of this document is to ensure there is a formal agreement detailing expectations and providing consistency in relation to body donation. The Code of Practice also sets out the parameters which should be followed by the Member Institutions, to consider the security, respect and dignity of donors. It is the responsibility of the Designated Individual at each Member Institution to ensure compliance with the Code, and any complaints or incidents must be reported to the Chair of LSECA for further investigation."*[41]

In its statement to the Inquiry, the National Repository Centre confirmed that it is licensed by the HTA and it currently receives over 100 body donations per year, providing cadaveric tissue for medical education and surgical training centres locally and nationally.[42] All of the centres to which the National Repository Centre provides donors are licensed by the HTA. The National Repository Centre also periodically undertakes 'Duty of Care Visits' to the centres to *"ensure we are satisfied the licensed centres are adhering to the standards with respect to the dignity, security and storage of the cadaveric specimens that we have provided"*.[43]

The National Repository Centre also described its security and access arrangements to the Inquiry; these include locked fridges, swipe card access and CCTV, with both of the latter audited. The Centre was inspected by the HTA in 2023[44] and no shortfalls were reported.[45]

41 Ibid.
42 Written statement of the National Repository Centre, November 2024.
43 Ibid.
44 HTA inspection report, HTA website.
45 Written statement of the National Repository Centre, November 2024.

3.4 Conclusions

Based on the evidence provided by organisations to this Inquiry, the medical education and training sector appears to be at lower risk of compromising the security and dignity of deceased people than other sectors examined by the Inquiry. At the Inquiry's seminar on regulation, Dr Colin Sullivan, Chief Executive of the HTA, noted the comparison between the post-mortem sector, which has an average of 7.8 shortfalls per inspection report, and the anatomy sector, which has an average of 1.5.[46]

The HTA inspection reports provided, as part of their document submission, by the six medical schools that were interviewed by the Inquiry support this summary. None of the medical schools has had any major shortfalls, and only two have had any shortfalls in their most recent inspection. Both schools with shortfalls provided Corrective and Preventative Action (CAPA) Plans, evidencing action to remedy the shortfalls identified in their inspection reports.

At the Inquiry seminar for DIs, one medical school DI suggested that this lower risk could be due to the smaller numbers of deceased people being stored by the organisation, as well as the long history of regulation in the anatomy sector:

> *"I think a lot of it is obviously down to numbers. Obviously we are a much smaller unit, our donors are from a much smaller catchment. We don't have obviously the deceased patients that you have coming in, so I think that applies as well. Obviously our regulation from obviously the Anatomy Act is very similar to the HTA in the way that … all of our standards and guidance have been quite controlled over the years and we have much more limited activities."*[47]

We have received feedback on how the work of the Inquiry has caused organisations to reflect on the security and dignity of the donors in the care of medical education and training settings:

> *"I think it's just good that the Inquiry is happening because it makes us all think about how we can support and improve our standards for the deceased and their quality and dignity."*[48]

The Inquiry is aware of ongoing debates in the media and within medical schools themselves relating to the use of cadaveric dissection in anatomy teaching. It is not our intention to comment on the practice in this Report, only to explore the current arrangements with regard to the security and dignity of the deceased who are present in these settings.

46 Inquiry seminar on regulation, November 2024.

47 Inquiry seminar for Designated Individuals, November 2024.

48 Witness transcript of A504, Designated Individual, October 2024.

What we have found

- The Inquiry has heard that preserving the dignity of donors in medical education and training settings is extremely important in all the organisations explored in depth in this chapter. All six medical schools we have interviewed consider the dignity of deceased people in their organisation and include references to dignity and respect in the Codes of Conduct provided to anyone entering the facilities where donors are used.
- All the schools also convey their gratitude for the donors they use in their teaching, training and research programmes. This is reflected in the acts of remembrance, such as annual services of thanksgiving held by the medical schools in memory of those who bequeath their bodies to the organisation.
- From the evidence from the postgraduate surgical training sector, both from postgraduate deans and during site visits, the Inquiry has found that, where there is interaction between universities, NHS settings and postgraduate training settings, the governance arrangements sometimes lack clarity.
- We have seen evidence of organisations supporting body donation in England seeking to ensure the dignity and security of donors in participating organisations – for example, by developing Codes of Practice and undertaking visits.[49] The Inquiry has also received evidence that the London and South East Committee of Anatomists has held meetings with its members on the Phase 1 Report of this Inquiry and on the recommendations made in that Report.
- As we explore further in Chapter 10, about the locality visits, we have found significant links between medical education settings and the funeral sector. All the establishments we contacted for further information or visited have confirmed that funeral directors are regularly used to transport the deceased to or between facilities. Two medical school Designated Individuals specifically noted that they would welcome the regulation of funeral directors.[50] The Inquiry's work on the funeral sector is covered in Chapter 8.
- The medical education and training sector appears to be at lower risk of compromising the security and dignity of the deceased than other sectors examined by the Inquiry.

49 Written statements of the LAO and the National Repository Centre, November 2024.
50 Witness transcripts of A513 and A506, Designated Individuals, October 2024.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 24
All organisations providing anatomical education and training using donors should make sure that policies and procedures are in place to ensure the security and dignity of donors. These should include:

- security and access policies and the auditing of security and access measures such as swipe card access, CCTV and access to the locations where donors are kept;
- governance arrangements to ensure effective oversight of and accountability for the security and dignity of donors;
- a review of contracts or agreements with external organisations for the transfer of donors to or between facilities; and
- policies and processes on incident reporting, both within the organisation and to the Human Tissue Authority, that are clear and accessible to all students and staff.

Recommendation 25
Postgraduate training providers using donors should ensure clarity in their governance and information-sharing, in particular where the providers are linked to both university and NHS settings. This clarity should include formal agreements, where relevant, including management, governance and Human Tissue Authority licensing arrangements for the organisations involved.

Recommendation 26
The Human Tissue Authority should change its guidance to require that relevant adverse incidents in the anatomy sector are formally reported as Human Tissue Authority Reportable Incidents (HTARIs).

Chapter 4: Hospices

4.1 Introduction

Hospice care aims to improve the quality of life and sense of wellbeing for adults, children and young people who have a terminal illness or a long-term condition that cannot be cured. It is free for patients, their carers and relatives. Hospices provide inpatient care, 'hospice at home' care, befriending and visiting services. Hospices caring for children and young people also support their families in their day-to-day life, as well as in bereavement, offering both counselling and practical help.

Most hospices are independent charities, funded from a combination of charitable income and NHS income. Some hospice services are part of NHS trusts and are therefore subject to the governance arrangements in place at the trust. Hospice providers vary considerably in size – there are two national hospice providers, as well as multiple local hospices – and a single hospice provider may run more than one site. In England, there are around 170 hospices that provide End of Life Care (EoLC) for adults and around 40 that provide hospice care for children and young people, while some hospices provide care to both.[1]

Hospices have a wide range of trained staff and volunteers, including bereavement support counsellors, therapists, doctors, healthcare assistants, nurses and social workers. Visitors to hospices include the family and friends of those receiving care, funeral directors, and external contractors who may need to attend the site for maintenance.

Most hospices provide some level of care after death. Where a death has occurred on hospice premises, family and relatives are usually able to spend some time with the deceased person at their bedside. For some hospices, arrangements are made shortly after death to transfer the deceased person into the care of the chosen funeral director. Care after death in this circumstance is therefore very short-term. Other hospices may have a dedicated facility within their premises where they can provide care after death over a longer period.

This chapter sets out the results of the Inquiry's investigation into the processes in place to safeguard the security and dignity of deceased people in hospices.

1 Department of Health and Social Care, Biggest investment into hospices in a generation, 19 December 2024, gov.uk website.

4.2 How we did our work

The Inquiry issued a questionnaire to all hospices in England, based on a list provided by Hospice UK.[2] The questionnaire was intended to determine whether deceased people were cared for on the hospice premises, and if so, where and how, and to understand the measures in place to safeguard their security and dignity. This questionnaire used a combination of standard multiple-choice questions and free text responses. A copy of the questionnaire is in Appendix 6. A total of 187 responses to the questionnaire were received, comprising responses from:

- 144 adult hospices;[3]
- 24 children and young people's hospices;
- 11 combined adult, children and young people's hospices ('combined hospices'); and
- eight hospices that provide hospice at home and/or palliative care services.

Of the 128 hospices that confirmed in their response to the questionnaire that they cared for deceased people on their premises, the Inquiry selected a sample of 26 hospices for interview, supporting an analysis of 28 individual hospice sites. This provided an opportunity to elaborate on the responses to the questionnaire, with the aim of understanding the processes and practices in place for safeguarding the security and dignity of deceased people. The sample was selected to ensure a geographical spread, as well as a mix of different types and sizes of hospice, and a mix in the kinds of areas, in terms of size and nature, where deceased people were kept. The sample comprised 16 adult hospices,[4] nine children and young people's hospices, and three combined hospices.

The Inquiry then undertook a thematic analysis of the evidence collected via the questionnaire and interviews. The Inquiry also considered what role the Care Quality Commission (CQC) and other organisations have with regard to the security and dignity of deceased people in hospices.

4.3 Summary information from questionnaire and interview responses

This section contains a high-level summary of the information received via the questionnaire and interviews to establish how many hospices keep deceased people on their premises, where they are kept and for how long.

2 This included all hospices in England registered with Hospice UK, the national charity for hospices and EoLC.

3 Three adult hospices provided a single questionnaire response covering multiple sites. These have been counted as a single hospice for the purpose of this analysis, as it was not possible to break their responses down further.

4 For the purposes of the interview analysis: (i) two adult hospices selected for interview had two sites each, and have been counted as four individual hospices due to different arrangements in place at each of their sites; and (ii) one hospice caring for both adults and children and young people only provided hospice at home services for children and young people. This hospice has therefore been categorised as an adult hospice.

In this chapter, the terminology used is based on what the hospice providers used when responding to the Inquiry. The term 'mortuary' was often used by respondents to describe the area where they cared for deceased people, but it did not mean a mortuary licensed by the Human Tissue Authority (HTA). The term 'cold room' was also used. Both 'mortuary' and 'cold room' in this context generally meant a room with cooling methods to help preserve the condition of deceased people.

None of the children and young people's hospices had mortuaries, and instead cared for deceased people either in their inpatient bedrooms, or in a dedicated cold room which was often part of a wider bereavement suite.

4.3.1 Adult hospices

A total of 144 adult hospices responded to the questionnaire. Table 21 lists the areas where questionnaire respondents stated that they cared for deceased people on their premises.

Table 21: Types of area where deceased people are kept in adult hospices

Type of area	Number of hospices
Cold room	42
Mortuary	34
Bedroom/private room	17[5]
Chapel/room of rest	2

Source: Inquiry questionnaire 2024.

A total of 95 adult hospices indicated that they cared for deceased people on their premises. Key findings from their questionnaire responses include:

- Around half (47) said that this happened for, on average, less than 24 hours, indicating that these hospices facilitate short-term care after death only.
- Just under half (42) said that they cared for deceased people for between one and seven days, on average, while four said that this was more than seven days.
- A total of 42 had a cold room and 34 had what they described as a mortuary. Six of these mortuaries had capacity for more than ten deceased people, with the largest being for 18 deceased people. In four of these mortuaries deceased people were kept for, on average, three to seven days, and in two of these mortuaries the average was over seven days.

5 This number is likely to be higher, as hospices that keep deceased people in their inpatient bedroom for a short time after death may have answered *"No"* to the question: *"Are deceased people kept on your premises?"*

Of the 16 adult hospices selected for interview:

- Ten had what they described as a mortuary. The capacity of these hospices ranged from 15 to 32 inpatient beds, and mortuary capacity from eight to 18 spaces. The length of time that deceased adults were in the mortuary ranged from one to seven days for most hospices. One hospice noted that deceased people might be kept in the mortuary for up to two weeks, by exception.
- Four had a cold room. The capacity of these hospices ranged from ten to 18 inpatient beds, and cold room capacity from one to three spaces. The length of time deceased adults were kept in the cold room ranged from one to three days.
- Two hospices arranged for funeral directors to collect deceased adults directly from their inpatient bedrooms shortly after they had died. The inpatient capacity of these hospices ranged from 16 to 32 beds.

Of the 14 adult hospices interviewed that had a cold room or mortuary, these facilities were usually in active use. As an example, one hospice cared for an average of three to five deceased people per week in its mortuary.

Five of the adult hospices interviewed were considering whether to decommission their mortuary, and the two adult hospices using inpatient bedrooms to care for deceased people had both previously had a mortuary but had decommissioned these by the time of interview. This is discussed later in this chapter (see section 4.7).

4.3.2 Children and young people's hospices

In total, 24 children and young people's hospices responded to the questionnaire, 22 of which indicated that they cared for deceased children and young people on their premises. In 20 hospices, deceased children and young people were cared for in a cold room; in two hospices, they were cared for in their inpatient bedroom with cooling equipment. None of these hospices had a mortuary.

In 16 of these hospices, deceased children and young people were cared for on the premises for an average of three to seven days. In two hospices, the average was between one and two days, and in four hospices this was over seven days.

Of the nine children and young people's hospices selected for interview, inpatient capacity ranged from three to 14 inpatient beds. Of these:

- Seven hospices had a dedicated cold room, often forming part of a 'bereavement suite'. These facilities were offered to enable relatives to spend time with the deceased child or young person to support the grieving process, usually with the option of using onsite accommodation.
- Deceased children and young people could be accommodated within the cold room for an average of five to seven days, with six of the seven hospices only accommodating one deceased child at a time.
- Two hospices cared for deceased children and young people in their inpatient bedroom, using specialised cooling equipment. The average length of time was around three days.

Hospices for children and young people are generally smaller in size, and episodes of care after death are more infrequent. As such, the Inquiry heard that facilities to care for deceased children and young people in some hospices were infrequently in use. One hospice described how it would consider use of its cold room as *"an exceptional circumstance"*.[6]

4.3.3 Combined adult, children and young people's hospices

Eleven combined adult, children and young people's hospices responded to the questionnaire. All indicated that they cared for deceased people on their premises. Arrangements for deceased people in these hospices were:

- Four hospices moved all deceased individuals, whether they were an adult, child or young person, to a cold room.
- Two hospices kept deceased adults in the inpatient bedroom where they had died, until collected by funeral directors, and moved deceased children or young people to a cold room.
- Two hospices moved deceased adults to mortuaries, and deceased children or young people to a cold room.
- Two hospices – where they only had adult inpatients, caring for children and young people as day patients or via hospice at home services – moved deceased adults to mortuaries.
- One hospice only had deceased children or young people on the premises, and moved them to a cold room.

For the ten combined hospices caring for deceased adults on the premises, the average amount of time deceased people were kept on the premises was less than 24 hours in six hospices. In three hospices, the average was between three and seven days, and in one hospice, it was between one and two days.

For the nine combined hospices caring for deceased children and young people on the premises, the average amount of time deceased people were kept on the premises was between one and two days in one hospice. In four hospices, the average was between three and seven days, and it was more than seven days in three hospices. One hospice did not indicate a specific policy.

Of the three combined hospices selected for interview, inpatient capacity ranged from four to six beds. For two of these hospices, deceased adults were collected by funeral directors directly from bedrooms on the inpatient unit. The third used a cold room to care for deceased adults. All three had a cold room for caring for a deceased child or young person as part of a bereavement suite. None of these hospices had a set policy or upper limit on how long they could care for a deceased child. The Director of Care at one hospice described in their interview how the cold room to support the care of a deceased child was rarely in use: *"It has only been used twice in the three years that I've been here. The more recent time was July of this year, so it is not used very often at all."*[7]

6 Witness transcript of A470, Director of Care, December 2024.
7 Witness transcript of A468, Director of Care, December 2024.

4.4 Our findings

The Inquiry identified the following themes from the evidence we collected from the questionnaire responses and interviews:

- security arrangements in hospices;
- governance, incident reporting and concerns;
- changes since publication of the Inquiry's Phase 1 Report;
- CQC; and
- other oversight.

4.5 Security arrangements in hospices

This section sets out the evidence the Inquiry gathered on the systems and controls in place to protect the security and dignity of deceased people in hospices. These systems and controls serve two functions: first, to prevent unauthorised access to deceased people; and second, to identify any inappropriate or unauthorised access or conduct that may have taken place, in order that it can be understood, stopped and dealt with promptly.

An effective security system is designed to prevent unauthorised and inappropriate access, and should include an audit process to support the identification of unauthorised and inappropriate access should other security controls fail. For example, restrictions on access are strengthened when there is a regular process of review to identify irregularities. In Phase 1, the Inquiry found that mortuary security controls were inadequate at Maidstone and Tunbridge Wells NHS Trust, with security controls updated in a piecemeal manner, protracted delays to security enhancements such as CCTV, and a failure to review staff access to the mortuary on a regular basis, among other findings.

The evidence considered includes: how access is restricted to areas where deceased people are cared for in hospices; the presence and effectiveness of CCTV; and whether unaccompanied access is permitted. We have considered this separately for each group of hospices, to identify both common factors and differences in approach.

4.5.1 Adult hospices

Access control

From the questionnaire, we found that most hospices with a mortuary or cold room had a range of access control measures in place, restricting access to areas where deceased people were kept. Table 22 lists the different measures. In addition, four hospices placed a symbol on the inpatient bedroom door to indicate that the occupant had died.

Table 22: Different control measures used to manage access to deceased people in adult hospices	
Access control measure	**Number of hospices**
Swipe card/magnetic lock	43
Key	37
Digital lock/keypad	18
Intercom	1
Staff control/monitor access	3
Fob/dongle	4

Source: Inquiry questionnaire 2024.

In terms of physical controls, 13 of the 16 adult hospices interviewed used electronic swipe cards or fobs to control access, four of which had only recently installed this technology. A further two hospices planned to install either swipe card or fob access soon and were currently using a key. This covered all hospices with a mortuary or cold room. The remaining hospice used a key only.

All the adult hospices interviewed secured their main entrances, and 14 out of 16 additionally secured the area where deceased people were cared for, as shown in Table 23. Seven of these used multiple physical security controls in combination – for example, swipe card access in addition to using a secured key.

Table 23: Level of access control (by number of measures used to manage access to deceased people) in adult hospices				
	Number of hospices by type of area			
Level of access control	**Mortuary**	**Cold room**	**Bedroom**	**Total**
Entry to hospice secured	10	4	2	16
Entry to area where deceased people are cared for …				
… is not physically secured by access controls	0	0	2	2
… is physically secured by one access control	4	3	0	7
… is physically secured by two access controls	4	1	0	5
… is physically secured by three or more access controls	2	0	0	2
Total	**10**	**4**	**2**	**16**

Source: Inquiry interviews 2024.

The Head of Clinical Services at a hospice where a key was required to access the mortuary, alongside other access control measures, explained that its approach was modelled on that for managing access to controlled drugs:

> *"So it complies with controlled drug regulatory requirements. So there's just one set of keys. It's the nurse in charge that holds that set of keys per duty … it's then handed over to the next nurse in charge. And we just have two shifts; a day shift and a night shift, so there will always be a nurse in charge on each shift, and that's a senior nurse."*[8]

The use of multiple access controls in tandem was more common in hospices with a mortuary. The Head of Clinical Governance at one hospice described in detail how it employed different controls to help keep deceased people safe and secure:

> *"So we have electronic key fob access. So, and those fobs are programmed with staff who should have access to the mortuary … In addition to the fob, there's a keypad, and that keypad is changed every 6 months. And that code is obviously then only shared with those staff who need it. There's CCTV on the outside of the mortuary that sort of faces as you go in and then once you're into the mortuary the fridge area is locked, so that's a key lock, and that key's in a key safe, and that's got a separate key code to it. So we can have sort of like housekeeping staff going into the mortuary who might have the fob and [digital] access, but they won't necessarily, once they get in there, have the key to the fridges to access."*[9]

In contrast, neither of the hospices where deceased people were cared for in an inpatient bedroom had a physical access control on the room itself. Reasons given for this included having a policy of not locking inpatient bedrooms, and the difficulty of maintaining controls to individual bedrooms:

> *"So, swipe card controls for the wards … are used primarily out of hours because the wards are relatively open during the day, you know, from an activity level. And we've got swipe controls on key areas, not on individual rooms, because obviously that would be too difficult to maintain."*[10]

The Chief Nurse of one hospice acknowledged that leaving bedrooms unlocked meant unauthorised entry by external visitors to the hospice was possible but they believed unlikely:

> *"[I]nadvertently another visitor could walk into a room, but it is unlikely because they tend to stay in their own rooms. But I think that's probably for me the only significant risk. There are other people in the building other than just staff, but it's rare that they're moving around the building out of hours."*[11]

8 Witness transcript of A459, Head of Clinical Services, December 2024.
9 Witness transcript of A461, Head of Clinical Governance, December 2024.
10 Witness transcript of A464, Chief Nurse, December 2024.
11 Ibid.

The Director of Care Services of another hospice similarly described how the inpatient bedrooms had good levels of visibility: *"We don't have locks on doors or bedroom doors … we can see every door from our staff base."*[12]

A risk of unauthorised entry by staff into inpatient bedrooms was more openly acknowledged, with three hospices interviewed using a sign or symbol on the door as a signal to alert staff when a deceased person was being cared for. This included two hospices that placed the sign on the bedroom in advance of a deceased person being transferred to their mortuary. The Director of Care Services at one of these hospices explained:

> *"[W]e put a sign on the door … So, it's like an internal message that we know that there's somebody who's died that's in that room, but there isn't any formal security in place for those rooms."*[13]

The Chief Nurse of one hospice had reinforced this as a policy in response to a cleaner inadvertently accessing a room when a deceased person was being cared for:

> *"I think it was done previously as more of a sign of dignity and just be quiet around this space. But actually, they did a bit more rigour around that because they'd had a housekeeper go in and then she was distressed, you know, because she didn't want to be in there … so as much to protect the team and as to protect the body, to be honest, you know, it was like, you don't need to be in that room at this point in time. Just don't go in."*[14]

The Director of Nursing of another hospice had similarly reinforced its use of a symbol to protect against unaccompanied or unauthorised entry by staff, but with a less direct focus on supporting staff wellbeing:

> *"So we use the [symbol] which we put on the door which alerts people for nobody to go in that room unless they're going with a clinical member of staff. So, again, whilst there's no mandate to do that, we're just sort of trying to think ahead a little bit around making sure that we're trying to think of every little bit of wiggle room where there could be opportunity."*[15]

CCTV

The questionnaire asked if hospices had CCTV coverage of the area where deceased people were kept. In the questionnaire responses, 23 adult hospices said that they had CCTV in the areas where deceased people were kept; 18 adult hospices said that they had CCTV in other areas of the hospice; and 52 adult hospices said that they did not have CCTV in any area of the hospice.

Of the 16 adult hospices selected for interview, 12 had CCTV installed, as shown in Table 24. Four of the hospices interviewed had no CCTV. Three of these hospices were planning to install it, to directly cover the area where deceased people were cared for,

12 Witness transcript of A460, Director of Care Services, December 2024.
13 Ibid.
14 Witness transcript of A464, Chief Nurse, December 2024.
15 Witness transcript of A465, Director of Nursing, December 2024.

specifically a mortuary at two hospices, and a cold room at one hospice. One hospice had no CCTV and felt that cost was a limiting factor to installing it.

Table 24: Use of CCTV in adult hospices

	Number of hospices by type of area			
CCTV installation	**Mortuary**	**Cold room**	**Bedroom**	**Total**
Covers area where deceased people are kept	4	1	0	5
Covers internal corridors and external entrance/exit points only	2	0	0	2
Covers external entrance/exit points only	2	2	1	5
No CCTV in any area of the hospice	2	1	1	4
Total	**10**	**4**	**2**	**16**

Source: Inquiry interviews 2024.

The Inquiry was told by the Director of Finance and Corporate Services at one hospice that preserving dignity was a key consideration on where and how to use CCTV:

> *"We have decided to increase our CCTV provision … so that [it] would have direct view of the [fridges], and obviously, staff will be aware of that. I think it's important – obviously, we're trying to get the balance of dignity and respect and control all those sorts of things as part of this."*[16]

The Head of Clinical Services at another hospice described how additional governance and staff consultation fed into decision-making about installing CCTV in both its mortuary and its cold room:

> *"The mention of CCTV initially, it was like, really kind of mixed as to, is that appropriate? Is it not? Is it appropriate more at … where people are in fridges, but not where people are in the kind of open cold room? And we had some really good debates about it and started to think about, you know, what we need to do to make sure this never happens and actually, is there a kind of compromise here? And actually, if it was your loved one in there, would you prefer this or this, and have those sort of debates. And I think we've changed the culture a little bit in getting people to actually think about … like if CCTV goes in, there will be very close governance around who can access that CCTV and putting those assurances in place. It's not like it's going to be like a show running for somebody to watch and actually managing that worry."*[17]

16 Witness transcript of A454, Director of Finance and Corporate Services, December 2024.
17 Witness transcript of A459, Head of Clinical Services, December 2024.

Unaccompanied access

Staff and contractors

In the questionnaire responses, 58 adult hospices said that staff and contractors were accompanied when they accessed areas where deceased people were kept, while 35 adult hospices said that staff and contractors had unaccompanied access to these areas.

Of the 16 adult hospices interviewed, all restricted which staff could access areas where deceased people were cared for. For hospices with a mortuary or cold room, access was generally allowed for named staff across both clinical and non-clinical roles, noting that five hospices employed either porters or stewards to support the transfer of deceased people. For hospices caring for deceased people in inpatient bedrooms, permitted access was generally restricted to clinical staff only. Two adult hospices told the Inquiry that they reviewed access rights upon staff appointment or exit from the organisation.

The hospices interviewed also indicated that staff who did not have permitted access were always expected to be accompanied. In addition, seven of these hospices required staff with permitted access to always work in pairs when entering areas where deceased people were cared for. In contrast, eight of these hospices did permit some lone working by staff with permitted access. Examples of access given included:

- activities by cleaners and maintenance workers;
- checking fridges; and
- undertaking body checks.

The Director of Finance and Corporate Services of one hospice explained that capacity and practicality were factors influencing a policy of allowing lone working:

> *"[I]t's impractical for people not to be by themselves sometimes because of the nature of their role. Some of the examples are someone like a cleaner. We can't sort of shadow a cleaner all the time. Or we might have – a doctor might need to go down and check something about the deceased, and we would let them go down by themselves. Or you might have an estates team member who needs to do a bit of maintenance. So where it is relevant for their role, people will be by themselves. But that's not for the taking down or exiting, it's more if any activities need to be carried out, just as part of the running and the maintenance of the mortuary."*[18]
>
> *"[I]f we've got core extended maintenance, you know, if it's something, I don't know, it's going to take a couple of hours, we wouldn't sit with them as a matter of rule while they do that work."*[19]

The Inquiry wrote to this hospice to express concern about this practice, while noting that the hospice did intend to install CCTV within the mortuary. The hospice confirmed that it was reviewing its policy.[20]

18 Witness transcript of A454, Director of Finance and Corporate Services, December 2024.
19 Ibid.
20 Email to Inquiry, March 2025.

The Inquiry heard that, of the eight hospices interviewed that permitted lone working, two had embedded additional assurance or controls around this policy. One had a dedicated lone working policy, to govern access by porters for out-of-hours checks, supported by additional assurance. Another planned to introduce a log of lone working instances to build a better understanding of reasons for requiring unsupervised access.

In terms of external visitors, all but one of the hospices interviewed described policies in place to either ensure that contractors were supervised if undertaking work in areas where deceased people were cared for, or that these areas were only accessed when not in use. This includes one hospice which had configured its design to enable fridge maintenance to be undertaken without contractors being able to directly access the area where deceased people were kept.

Funeral directors

All adult hospices supervised funeral directors during collection of a deceased person and undertook identity checks of both the funeral director and the deceased person. Three of the hospices interviewed indicated a policy of requiring funeral directors to attend in pairs. The Director of Care Services of one hospice with such a policy said that this had been a point of tension with local funeral directors that they worked with:

> *"There are occasions where funeral directors can be difficult, when they're a small independent, where there might be just two of them in the business, and they can't get two of them to come and collect the deceased … But it is for us about the manual handling and the equipment needed to transfer the deceased with dignity and safety."*[21]

Further detail on how hospices work with funeral directors is set out in section 4.6.3.

Family visitors

Many of the hospices interviewed described how, due to the nature of the care provided, families were well known to the hospice and good relationships were in place. Hospices told us that they deployed a range of measures to support and monitor family access, including:

- sign-in, sign-out systems;
- issuing families with their own access-controlled swipe pass; and
- requiring a clinical staff member to 'buzz' them in, or escort them to the area.

All hospices supported family members to spend time with the deceased person immediately after death, and this would generally not be supervised. The exception to this would be where specific safeguarding concerns had been raised, or there was a family dispute concerning the deceased person. As an example, the Inquiry heard that one hospice had experienced a dispute between family members over religious requirements, meaning that it needed to liaise with the coroner to seek guidance on its approach.

21 Witness transcript of A458, Director of Care Services, December 2024.

Once the deceased person had been moved from the inpatient bedroom, arrangements for viewing were more varied. Four of the ten adult hospices with a mortuary that were interviewed told the Inquiry that they had a viewing area where family could spend time with the deceased person. Three of these hospices always supervised visits, while one escorted the family to the area and left them alone. For the remaining six adult hospices with a mortuary that were interviewed, and for all the hospices interviewed that had a cold room, it was considered rare to support family visits once the deceased person had been moved from the inpatient unit. Instead, families were encouraged to undertake viewings once their deceased relative had been transferred to the care of their chosen funeral director. Three hospices referenced how the pausing of family viewings during the COVID-19 pandemic had influenced this practice.

4.5.2 Children and young people's hospices

Access control

The questionnaire responses indicated a range of access control measures in place for the areas where deceased children and young people were cared for. Note that none of the children and young people's hospices had mortuaries, and instead cared for deceased children and young people either in inpatient bedrooms or in a dedicated cold room, which was often part of a wider bereavement suite. Table 25 lists the different measures.

Table 25: Different control measures used to manage access to deceased people in children and young people's hospices

Access control measure	Number of hospices
Swipe card/magnetic lock	10
Key	5
Digital lock/keypad	2
Doorbell	1
Staff control/monitor access	4
Fob	1

Source: Inquiry questionnaire 2024.

Nine children and young people's hospices were selected for interview. These hospices also reported a similar range of controls used to restrict access either to the premises, or to the area where deceased children and young people were cared for.

All the hospices interviewed secured their main entrance points and ward areas. Within the hospice, seven out of nine hospices also reported that cold rooms and inpatient bedrooms were secured, either by key, magnetic lock or swipe card entry. Two of these hospices used electronic swipe cards or fobs to control access to cold rooms or inpatient bedrooms. One further hospice planned to install fob access to the bedrooms, which were currently secured with keypad access. The remaining four

hospices relied on physical keys to secure their cold rooms. Three of these used swipe card access within the wider hospice, and one was planning to extend this to the cold room. Only one hospice using a key did not use electronic access controls within the wider hospice.

Two hospices that secured their cold rooms or bedrooms used more than one type of physical access control to these areas, as shown in Table 26.

Table 26: Level of access control (by number of measures used to manage access to deceased people) in children and young people's hospices

	Number of hospices by type of area		
Level of access control	**Cold room or bereavement suite**	**Bedroom**	**Total**
Entry to hospice/ward secured	7	2	9
Entry to area where deceased people are cared for …			
… is not physically secured by access controls	1	1	2
… is physically secured by one access control	5	0	5
… is physically secured by two or more access controls	1	1	2
Total	**7**	**2**	**9**

Source: Inquiry interviews 2024.

Only two hospices did not physically secure the rooms where deceased children or young people were cared for. In both hospices, the rooms were sited within a wider clinical area that was secured using swipe card or fob access. One of these hospices was considering installing fob access to the room in which deceased children or young people were cared for, for the specific purpose of care after death:

> *"[O]bviously one of the recommendations [in the Inquiry's Phase 1 report] was about … fob access to certain rooms. So, we've had an internal meeting with our head of health and safety and the facilities lead, and one of the things we are considering doing is providing fob access to designated bedrooms where we could deliver the care of the body. So, as much as we would have fob access to the rest of the building, they could be fob access, we could instigate during an episode of care of the body. And then we could run those access reports off that fob."*[22]

22 Witness transcript of A509, Head of Performance and Delivery, December 2024.

Several hospices described using a sign on the door of the room to alert staff to the fact that a deceased child or young person was being cared for. The Director of Nursing and Care of one hospice described how this policy had been strengthened in response to the Inquiry's Phase 1 Report:

> *"[W]e used to put sort of a sign warning [the] staff that … we've got a deceased child in the hospice. So they're sensitive to that when they come in through the building. But also, that picture would have been used to warn other staff, but wouldn't have necessarily said that staff couldn't access, but they can't now. And that's a very deliberate change we've made off the back of your recommendations and me being in role."*[23]

CCTV

Of the 22 children and young people's hospices that indicated that they cared for deceased people on their premises, only one indicated that it had CCTV in the area where deceased children and young people were kept.

In terms of the nine hospices selected for interview, five confirmed that they had CCTV within the wider hospice, and another hospice was planning to install it. None of these hospices used CCTV in the areas where deceased children or young people were kept, mirroring findings from the adult sample for hospices without a mortuary. Table 27 shows that most of these hospices used CCTV externally.

Table 27: Use of CCTV in children and young people's hospices

	Number of hospices by type of area		
CCTV installation	**Cold room or bereavement suite**	**Bedroom**	**Total**
Covers internal corridors and external entrance/exit points	1	0	1
Covers external entrance/exit points only	3	1	4
No CCTV in any area of the hospice	3	1	4
Total	**7**	**2**	**9**

Source: Inquiry interviews 2024.

Only one of the hospices interviewed used CCTV to survey internal corridors and could use this to audit any unauthorised access to rooms where deceased children and young people were cared for. The Head of Quality and Assurance of a hospice with a cold room justified the decision not to use CCTV in this area, but acknowledged that families might have a different perspective:

23 Witness transcript of A477, Director of Nursing and Care, December 2024.

> *"[W]e felt that the child was protected by the staff we've got in place, but the addition of CCTV directly in that area may feel quite intrusive for families. So it was that kind of balance. If families understood why, you know, I'm sure they would get it. But equally, that's quite a distressing conversation in terms of explaining why you would have the need for it. So, I don't know whether families would feel like that or whether we're just feeling like that for them."*[24]

Three of the hospices interviewed that used cold rooms did not have any CCTV and did not plan to install it. The Inquiry notes that they therefore had limited ability to audit any unauthorised access.

Unaccompanied access

Staff and contractors

Half of the hospices that responded to the questionnaire said that staff or contractors could access the area where deceased children and young people were kept without being accompanied, and half said that staff and contractors were always accompanied.

This was also reflected in the interviews, where all hospices confirmed that they restricted staff access to areas where deceased children and young people were cared for. These restrictions generally applied to clinical staff, with none of the hospices employing porters or stewards. Seven of the nine children and young people's hospices interviewed specified that they restricted access to clinical staff only. While it was common practice for staff with permitted access to work in pairs when providing care to deceased children and young people, over half of these hospices did allow staff with permitted access to undertake some lone working. Reasons given included:

- to undertake temperature checks;
- to allow flexibility to respond to family requests; and
- to relieve staffing pressure.

Two of the hospices interviewed gave the example of families asking for staff to spend time with their child after death, meaning that the staff member would be alone with the deceased child. One Director of Nursing and Care described how their hospice had recently amended its policy in response to the Inquiry's Phase 1 Report, requiring a stronger focus on safeguarding and documentation of such instances, while also seeking to accommodate family wishes:

> *"We've also, as part of this new process … we've said that if personal care is being delivered, that there needs to be two staff present … I think initially, my intention was, off the back of your recommendations, was that no one is in there alone with a child. The difficulty we've had from that and the feedback from staff is that that feels uncomfortable to them in the position that often families will say, "I want you to sit and read with my child" … So we haven't incorporated that into the policy, but what I have said is that people need to safeguard themselves as much as they need to safeguard the child."*[25]

24 Witness transcript of A475, Head of Quality and Assurance, December 2024.
25 Witness transcript of A477, Director of Nursing and Care, December 2024.

In terms of external visitors, all the hospices interviewed either did not permit access by external contractors (i.e. workers who were not directly employed by the hospice) when there was a deceased child or young person in the room, or only allowed access when supervised.

Funeral directors

All hospices similarly supervised funeral directors throughout the time they came to collect a deceased child or young person, and undertook identity checks of both the funeral director and the deceased person at the point of collection. Further detail on how hospices work with funeral directors is set out in section 4.6.3.

Family visitors

Bereavement care is an important focus of hospices catering for children and young people, and it is important that family can spend time with their deceased child, should they wish to do so. The length of time families spent in the hospice with their deceased child or young person typically ranged from five to seven days. Cold rooms in this context are a key part of the care journey. All but two of the hospices interviewed also described how family would have the option of using onsite accommodation, to be near their child after death, as the Director of Care at one hospice described:

> *"Some families don't choose to stay, just because the biggest thing for our families is they don't want the children to go to the mortuary … they like to know that they're in bed where they left them, and so they might well go home, but they know they're in our care, or … they basically stay and live with us for those three days and can come in and out of the room as they like. The child is still staffed with two members of my team 24/7."*[26]

Most of the hospices interviewed also described how close family would be well known to the hospice. Generally, the time that close family spend with their deceased child is not supervised but access controls are used, such as signing in and out. Other approaches included:

- Four hospices said that families were not issued with their own key or access permissions, and that staff oversaw access to the room.
- One hospice issued families with their own swipe card (with limited access).
- One hospice had two family flats above the cold room, and the configuration allowed the occupants of both flats to access the cold room. The hospice said it would be rare for both flats to be in use, but it would isolate cold room access if this situation were to arise.

None of the hospices interviewed indicated that they would allow other visitors, beyond the immediate family or guardian, to spend time with the deceased child or young person unsupervised. Instead, visits from wider family members or friends would be arranged in advance for when the immediate family or guardian were already present.

26 Witness transcript of A479, Director of Care, December 2024.

In terms of security when the immediate family or guardian were not present, three hospices specified that the bereavement suite in which the cold room was sited was locked when families were not using it. The Inquiry heard that two hospices had received feedback from families in relation to the security of their deceased child:

- One hospice had a practice of leaving the key unsecured on a hook directly outside the cold room when locked. One family had requested a change to this practice while their child was being cared for. The Inquiry sent a letter of concern to this hospice about this practice, and the hospice confirmed that it was reviewing its policy.[27]
- One hospice had a practice of only locking the bereavement suite at a family's request, but otherwise leaving it unlocked. One family had queried this practice. This hospice kept the key with a duty manager and had additionally decided to install swipe card locks to the bedrooms. The Deputy Director of Care described how this decision had involved actively challenging their mindset:

  > *"So part of having the [swipe card] locks inputted was about providing choice for families, but almost it's, 'this is going to happen', and changing our thought process, and everybody, from a team perspective, has gone, 'gosh, we actually need to really think about this and manage that, really, and be open with families about why we're doing that, to protect families.' Because we can still offer what we offer, but in a more governance-type response I suppose."*[28]

Most of the children and young people's hospices interviewed also accepted transfers in for deaths occurring in the community or at hospital, and in cases like these the families would be less well known to the hospice. The Inquiry heard from one hospice that its transfer policy did not cover verification of family members in these circumstances, although three other hospices all flagged that any safeguarding concerns relevant to the family would still be planned for in advance. The Registered Manager for one of these hospices outlined how its online referral process would flag any safeguarding concerns and prompt liaison with other professionals to support a decision on whether to accept the transfer:

> *"So we've got an online referral form that is managed by our senior care team. So we'd need two people to approve that and fast track it, which basically means that we'd pick it up a lot sooner. One of the initial safeguards around that is that there is a section on it that says that it's looked at kind of family members, and if there is any immediate kind of safeguarding concerns that we need to be made aware of … if there's anything that comes up on that, that yes, there has been some safeguarding concerns within the family, we can then obviously reach out and liaise with other professionals and kind of see what that would look like. We do run a [Sudden and Unexpected Deaths in Infancy and Childhood] service. So we've got close links with [local police] in terms of how we can kind of manage that and how we can safeguard that. So obviously, if we have a family that has got some questions around kind of safeguarding, we would be liaising with the police to see if we can accept. Obviously,*

27 Email to Inquiry, December 2024.

28 Witness transcript of A472, Deputy Director of Care, December 2024.

if we can't accept, then it would be a different avenue and it would be kind of going through the funeral director and the mortuary and we may not be able to accept. So obviously, we've got that kind of safeguard that we can potentially kind of avoid anything like that happening from the get go."[29]

4.5.3 Combined hospices caring for adults, children and young people

Access control

The questionnaire responses indicated a smaller range of access control measures in place for the areas where deceased people were kept in combined hospices, compared with the individual adult hospices and children and young people's hospices. Table 28 lists the different measures.

Table 28: Different control measures used to manage access to deceased people in combined hospices

Access control measure	Number of combined hospices
Swipe card/magnetic lock	10
Key	5
Digital lock/keypad	2
Staff control/monitor access	3

Source: Inquiry questionnaire 2024.

In terms of the three combined hospices selected for interview, two hospices used swipe card entry to control access across their whole site. One hospice used different arrangements for the two patient groups cared for, requiring swipe card access to the area where deceased adults were cared for, and keypad access to the area where deceased children and young people were cared for. One hospice additionally used a key to lock adult bedrooms when a deceased person was being cared for, as well as an illuminated sign to alert staff. The Director of Care of one hospice described how its controls worked together as part of a wider approach:

"All staff who access the [cold room] when it's occupied must have a DBS, and everybody who enters actually signs in. We have a template that we use, that we document and sign. When somebody is in the [cold room], there are checks every two hours, so whoever goes into the room must document and sign, and that must state the reason for the access, the care or the checks provided."[30]

29 Witness transcript of A476, Registered Manager, December 2024.
30 Witness transcript of A468, Director of Care, December 2024.

CCTV

The questionnaire responses indicated that none of the combined hospices had CCTV in the area where deceased people were kept.

In terms of the hospices selected for interview, two of the three hospices confirmed that CCTV was installed within the wider hospice. Neither used this to directly survey facilities for deceased people, electing instead to survey external entrance and exit points, and internal corridors. This mirrors findings from both the adult, and children and young people's hospice interview samples. The Director of Clinical Services at one hospice explained that this was to avoid compromising the deceased person's dignity:

> *"We don't have CCTV within the rooms – that's a very deliberate choice … We only have one body at a time in each of the rooms. And because our focus of care is about death and dying and supporting people in bereavement care, and dignity of people up to and after their death is paramount within hospice care. We care for people on the bed after their death … So to have CCTV in the room itself feels very undignified and lacking of consent. So we felt that the other measures were adequate to secure the safety of the bodies without CCTV within the rooms."*[31]

The third hospice reported that costs were a prohibiting factor for installing CCTV.

Unaccompanied access

Staff and contractors

Five combined hospices that responded to the questionnaire said that staff or contractors could access the area where deceased people were kept without being accompanied, and six said that they were always accompanied.

In terms of the three combined hospices selected for interview, each restricted staff access to the cold rooms or the bedrooms where deceased people were being cared for. For two of them, this was restricted to clinical staff only, with one Director of Clinical Services describing how clinical staff would only let housekeeping staff into a room once empty:

> *"Maintenance and housekeeping don't have swipe access to the rooms, so they have to be let in. So, we would obviously always have them cleaned after the room's been used, but the housekeeper would be let in by the clinical staff so that we can just double check the room is vacant. They would be left to do their cleaning, and they would use the external card that's on the wall to let themselves out."*[32]

The Director of Governance and Quality of another hospice explained how they reviewed access permissions when a new staff member joined, but also as part of the care plan for each child. This hospice did support some limited lone working (for example, when a room was unoccupied). Two hospices also required staff to always work in pairs when caring for deceased people. None of these hospices employed porters.

31 Witness transcript of A473, Director of Clinical Services, December 2024.
32 Ibid.

In terms of visitors to the hospice, external contractors were generally either supervised or only permitted access when a room was empty. The Director of Clinical Services of one hospice explained how they also recorded details of any visit:

> *"Yes. So we have a standard operational procedure and a risk assessment, and both of those say that anyone entering the room should enter in pairs and that we should document on [the electronic patient record system] who the pairs were, and the reason for entering the organisation."*[33]

Funeral directors

All hospices supervised funeral directors during collection of a deceased person, and undertook identity checks of both the funeral director and the deceased person at the point of collection. One hospice required funeral directors to work in pairs. Further detail on how hospices work with funeral directors is set out in section 4.6.3.

Family visitors

For adults, all three of the combined hospices interviewed supported family visits at the bedside immediately after death. The hospice using a cold room described how family would be escorted to the room. For children and young people, visits from close family would generally not be supervised unless safeguarding issues had been identified. One hospice described an example of a safeguarding risk around a family member, which had led to close liaison with the police and coroner pre-death to determine the approach.

Two hospices had recently improved their assurance around family visits, including making sure that all visitors signed in and out, as well as taking steps to update the electronic patient record of the deceased person with details of any visits to provide an audit trail.

4.6 Governance, incident reporting and concerns

This section sets out the evidence the Inquiry gathered at interview on issues of governance and other systems and controls around the security and dignity of deceased people in hospices. This includes: management and governance arrangements, including employment checks and auditing access arrangements; approaches to incident reporting, including a summary of any relevant historical incidents relating to the care of deceased people; approaches to networking in the locality, including funeral directors; approaches to episodes of care; the role of staff wellbeing and organisational culture; and, lastly, coroners' cases.

4.6.1 Management and governance arrangements

Hospices are generally charitable organisations, governed by a board of trustees who delegate the operational management to an executive team. The details varied, but all of the hospices interviewed described in general terms a three-tier governance model

33 Ibid.

where one or more operational groups reported to a subcommittee of the board of trustees, who reported to the board itself.

Of the 28 hospices in the interview sample, 25 specified that oversight of issues relating to care after death and management of the facilities where deceased people were cared for fell under the remit of a quality committee (or similar), which had responsibility for clinical governance, quality of care, incident reporting, patient safety, and health and safety. One Director of Care Services gave an account of how their hospice governance had mobilised to support a review of the Inquiry's Phase 1 Report:

> *"When the Phase One recommendations came out, we actually held a separate subset of that meeting and did particular focus work like a task and finish group … then that work then went back into the [governance group]. The [governance group] itself actually feeds up into our overarching [clinical governance group], which then feeds up into our committees, which is where our trustees and our exec board oversee everything and scrutinise everything."*[34]

All hospices also described having written policies and procedures relevant to care after death. These policies were generally developed and reviewed initially by the hospice executive team or relevant operational group, then ratified via the relevant committee and the board. One hospice stated that its care after death policy was based on guidance provided by Hospice UK. Other related policies or approaches mentioned included:

- EoLC policy;
- mortuary or cold room policy or Standard Operating Procedure (including security and access);
- routine care after death audit processes (audit against relevant clinical guidance, for example);
- transfer after death policy;
- safer recruitment policy;
- child death policy; and
- transport policy (covering the hospice facilitating transfer of deceased people from the hospital or to the funeral director).

Approaches to safeguarding were also mentioned by 13 of the hospices interviewed, including having a named lead or liaising regularly with local safeguarding teams. Five hospices also mentioned the relevance of internal speaking up or whistleblowing processes.

Employment checks

Across all the hospices interviewed, there was a strong focus on Disclosure and Barring Service (DBS) checks for all staff, and one hospice required all contractors to have an enhanced DBS check as well. The Deputy Director of Care of one hospice also flagged the importance of building this into a wider approach:

34 Witness transcript of A460, Director of Care Services, December 2024.

"And, yeah, and I think that whole trust thing, or, you know, we have a safer recruiting policy, you know, DBSs are all enhanced, but that's only as good as the day that they're done, and you can never be 100%, can you? And I think, not that you want to make everybody guilty, but it's having that awareness and actually protecting as much as you can. So as an organisation, we've taken that quite seriously."[35]

Audit of access

Most of the hospices interviewed had a defined approach to auditing access to deceased people (e.g. by reviewing CCTV footage or auditing swipe card access), as shown in Table 29. Over half of the adult hospices interviewed did this on a routine basis. For children and young people's hospices, one-third audited compliance with policy on a routine basis, and another third on a by exception basis, reviewing only when an incident or event had occurred. All combined hospices audited access on either a routine or by exception basis.

Table 29: Approaches to auditing access to deceased people in hospices

Audit approach	Adult hospice	Children and young people's hospice	Combined hospice	Total
Routine audits in place	10	3	1	14
By exception audits only	5	3	2	10
No defined approach	1	3	0	4
Total	**16**	**9**	**3**	**28**

Source: Inquiry interviews 2024.

The Director of Clinical Services of a combined hospice described how a routine approach to auditing access formed part of its overall quality approach:

"We do have a policy for care of patients after their death … the rooms are swipe controlled, and they are only accessible to the clinical team. When occupied, it's displayed that they're occupied, staff visit in pairs, the body is checked, the individual is checked 6-hourly, routinely, and that is documented on the electronic patient record. And we audit monthly. We … randomly identify usually 20 to 25% of the deaths that we've had that month and look at a number of factors including who accessed – if they've accessed, is there a template on [the electronic patient record system] that reflects why they accessed, how long have they stayed with us, what was the temperature control?"[36]

The Head of Clinical Governance of an adult hospice that also undertakes routine access auditing described how this approach had been employed to investigate in a potential case of attempted access:

35 Witness transcript of A472, Deputy Director of Care, December 2024.
36 Witness transcript of A473, Director of Clinical Services, December 2024.

> *"[W]e had a report come through where a fob had been activated on the mortuary doors by a relative … So what we were able to do is go back to the CCTV and look at that and correlate the two, but, you know, ultimately it was just somebody steadying themselves with their hand on a wall. It was nothing, but it just kind of showed for us that we do pick up on that sort of process when they're not there."*[37]

All three of the hospices interviewed that were planning to install CCTV also planned to regularly review footage. The Director of Finance and Resources of one adult hospice commented on how the recent upgrade of its CCTV system was presenting new possibilities in terms of access audit and monitoring:

> *"And actually it's – in terms of analytics as well as I think, being able to deliver an effective review process, it's an absolute game changer. So just simple things like we can see how many people enter and leave the building, what times of day they're doing it. So, you can do a lot of anonymised analytics rather than having to look through images, et cetera, which has certain data protection limitations."*[38]

The Director of Finance and Corporate Services of another adult hospice, meanwhile, flagged the potential limitations of the approach if used in isolation from other controls:

> *"I suppose it's important to say as well, it's 24/7 access as well, because we're a 24/7 ward … [for] a team like the stewards who isn't unusual for them to go in a lot, it would be less likely to pick up things in terms of frequency because it's part of the nature of their role."*[39]

Five hospices did not currently have either electronic access controls or CCTV installed, so had more limited means of audit. Non-electronic means of auditing access that were mentioned by adult hospices included:

- unannounced quality inspections by a member of the hospice's senior leadership team; and
- sign-in, sign-out systems.

One hospice used a keypad to control access to its mortuary with no way of auditing how often the room was being accessed and used, although the code was changed on a quarterly basis. This hospice was currently considering decommissioning its mortuary, which is discussed later in this chapter (see section 4.7).

4.6.2 Incident reporting

All of the hospices interviewed described their approach to incident reporting and confirmed that this would extend to any incidents occurring as part of care after death, or within the area where deceased people were being cared for. Of the 28 hospices in the interview sample, 17 described using an electronic incident reporting system. Two hospices also used their incident reporting system to manage changes to policy, including setting routine review schedules.

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37 Witness transcript of A461, Head of Clinical Governance, December 2024.

38 Witness transcript of A457, Director of Finance and Resources, December 2024.

39 Witness transcript of A454, Director of Finance and Corporate Services, December 2024.

Three hospices mentioned that they applied the NHS Patient Safety Incident Response Framework within their hospice. The Inquiry heard that one hospice had adapted this for hospice use, while another was currently working with other local hospices to align the incident coding categories used.

In all hospices, the Inquiry was told that the board and relevant committee would receive a routine report on incidents, with frequency ranging from monthly to quarterly or annually. This would include any incidents relevant to the care of deceased people. At executive and hospice management level, this was often supported by a weekly incident review meeting. Two hospices also specifically mentioned that a senior manager was always on call in the case of emergency incidents. The Director of Finance and Corporate Services of one hospice described the role of organisational culture in relation to encouraging good reporting:

> *"But I do think first and foremost our culture is our most important control, and our openness and the bit with the willingness to learn from incidents. So in all our governance committees, we always review each and every incident every quarter with learnings from it, and we have a very strong, no blame culture."*[40]

Incidents relating to working with funeral directors

None of the hospices providing care solely for children and young people that the Inquiry interviewed mentioned any historical or current concerns about the funeral directors they worked with. With reference to the 21 hospices caring only for adults, or for adults, children and young people, the Inquiry heard of the following issues with local funeral directors:

- Two adult hospices reported incidents relating to whether the incorrect body had been collected for burial. In one case, this proved to be unfounded, and in the other, a miscommunication between the family and the funeral director was resolved. The latter hospice had reviewed its processes to prevent a reoccurrence.
- One adult hospice and two combined hospices reported incidents relating to the manual handling of a deceased person by a funeral director. All incidents were followed up with the funeral directors concerned. Upon review of the incident, one hospice reported that it had invested in manual handling equipment.
- Two adult hospices mentioned past concerns, rather than formal incidents, relating to the unprofessional behaviour of funeral director staff, such as being dressed inappropriately. These were resolved directly with the funeral director firms concerned.

In addition, the Inquiry heard from one hospice that some religious leaders were able to visit a deceased person in the hospice unsupervised (on the family's request), and the hospice considered this a potential safeguarding risk. Another hospice mentioned one family opting to transport their deceased relative themselves and noted a lack of guidance for this circumstance.

40 Ibid.

Incidents relating to hospice care

Four of the hospices interviewed had recorded incidents relating to the care of deceased people by hospice staff:

- In one case, a deceased adult had been accidentally left unattended in a viewing room overnight. A full investigation was done, and processes adapted as a result.
- Two hospices for children and young people advised that families had requested changes regarding the security of their deceased child, as highlighted earlier in this chapter. The Deputy Director of Care of one of these hospices described how this incident had contributed to a review of security arrangements, but with an ongoing focus on the family's needs:

  > *"I think it's really made us think, actually, as much as we want to make sure that families do have access to their child at all times and it doesn't become really difficult for them from a bereavement perspective, because a lot of what we get from a family perspective is, in hospitals, they get a really awful experience where a child's taken away, put in a mortuary, and this allows the family time to cuddle them, spend time, and actually work through that process. So, as much as we are doing it, we're trying to think about it really carefully, because we don't want to lose our ethos either. But safeguarding will always trump that, you know."*[41]

- One adult hospice had an incident relating to manual handling of a deceased person by staff. This led to the purchase of a motorised trolley to mitigate against the risk of further staff injury.

Three hospices (one adult, one combined and one children and young people's hospice) had incidents relating to temperature control within their mortuary or cold room, with one issue raised externally by a local funeral director. In all cases, this led to a review of policy and procedure.

4.6.3 Working with others, including funeral directors

Local networks

Several hospices described networking arrangements in place with other hospices and relevant organisations in their local area, flagging the importance of these networks for sharing learning and best practice. One hospice said that its local network included external agencies, such as the coroner, medical examiner, crematorium manager, other hospices, doctors and bereavement practitioners. The Director of Nursing of one hospice, meanwhile, described joint work with other hospices in their locality to develop a shared approach to risk assessment:

41 Witness transcript of A472, Deputy Director of Care, December 2024.

> *"I think [the] hospice world can be quite isolating and often what's happening in one you can replicate in another with a few tweaks. So we developed an [Integrated Care Board] risk assessment which each organisation then took back and used depending on their processes, because some hospices have got mortuaries, some hospices have just got a cold room and rapid transit from the hospice. So it put us all on a level playing field from a process point of view, if nothing else, and we're able to talk in a common language about our improvements through using it."*[42]

The Director of Care of one hospice similarly described their local network as an important *"other layer of education and support"* and *"a really good place in terms of best practice benchmarking and making sure that we are aligned to best practice and any national changes"*.[43]

Funeral directors

All the hospices interviewed liaised with funeral directors. Local funeral director firms and their staff tended to be well known to hospice staff. For five of the hospices interviewed, these relationships were very well established, with local funeral directors supporting staff training on care after death.

The majority of the 16 adult hospices interviewed had either formal or informal arrangements in place with local funeral directors. Seven had informal arrangements with a local funeral director for contingency storage when needed for deceased people, but did not undertake any associated checks or due diligence on these firms. A further three adult hospices had more formal service level agreements in place and did require additional due diligence – for example, by requiring membership of a trade organisation or undertaking assurance visits. In addition, two hospices described work under way to strengthen or formalise their local arrangements with funeral directors, linked to plans to decommission their mortuaries. The remaining four hospices did not indicate that any arrangements with funeral directors were in place, whether formally or informally.

In addition, one combined hospice had a policy of requiring the family to nominate a funeral director within the first 24 hours after death.

None of the children and young people's hospices interviewed described either informal or formal arrangements of the nature detailed above, but four did mention seeking advice from local funeral directors about care of deceased people. One hospice liaised with GPs or the local hospital for similar advice. The Director of Clinical Services of one hospice acknowledged that hospice staff were not necessarily experts in care after death and might require support from other partners:

> *"If we had concerns about deterioration of the condition of the body, we would ask the funeral director to come in and check the condition of the body with us and to make some recommendations, which may include the young person going into a closed coffin … or another measure, but it's to support our staff and to make sure that we're giving the best care we can in an area where we're not the experts, the*

42 Witness transcript of A465, Director of Nursing, December 2024.

43 Witness transcript of A470, Director of Care, December 2024.

funeral directors are, but allowing that blending of two care providers to ensure that the best care can be offered to families after the death of a young person."[44]

4.6.4 Extended episodes of care after death

The Inquiry heard from three of the adult hospices interviewed that public health funerals funded by the local authority were a key factor contributing to longer stays in a hospice mortuary. One of these hospices mentioned that a public health funeral in 2023 had led to a stay of around eight weeks, and that it had consequently developed an agreement with its local authority that it would only accept any similar cases for a maximum stay of two weeks. One hospice mentioned that direct cremations could also be a factor contributing to more time spent in the mortuary. One adult hospice and one combined hospice also mentioned that they had occasionally had to raise concerns over, or seek advice on, the care of deceased people due to extended episodes of care.

4.6.5 Staff wellbeing and organisational culture

Organisational culture emerged as a strong theme throughout the interviews, with care after death seen as a continuation of a patient's time with the hospice. The Director of Clinical Services of one hospice said:

"Both [cold rooms] are newly refurbished, and they matter to us, because care after death matters to us. And death and dying is what we do. So I think for hospices, it would be less likely for it to be out of sight, out of mind, because of the nature of death and dying being what we do, and care after death being as important to us as care pre-death. We kind of see it as our 11th room, if you like, the unit."[45]

There were also strong acknowledgements that thinking differently about security and risk would require adjustments to team culture, as the Deputy Director of Care of one hospice described:

"I think it's really hard, isn't it? Because our families and children are at the centre of everything we do, and I know our teams have been hugely impacted by the thought of us locking [the bereavement suite] and that will take some time for them. It's a culture change … and I think it's made us really think, you just never know."[46]

The Director of Clinical Services of another hospice also reflected on how working in pairs was considered important for staff and their wellbeing, as well as for safeguarding:

"Sometimes if you need to go in and be with that deceased patient, you go with a colleague or you go with somebody to support you from a nursing perspective."[47]

44 Witness transcript of A473, Director of Clinical Services, December 2024.
45 Ibid.
46 Witness transcript of A472, Deputy Director of Care, December 2024.
47 Witness transcript of A467, Director of Clinical Services, December 2024.

4.6.6 Coroners' cases

A total of 71 adult hospices indicated in their questionnaire response that they had had coroners' cases in the last five years.

All hospices selected for interview indicated that coroners' cases would be very infrequent, since deaths in hospices were normally expected, as the Interim Chief Nursing Officer for one hospice described:

> *"[A] post mortem would be hugely unlikely, because all of our patients generally are expected deaths, and therefore, they wouldn't qualify for a post mortem. I can genuinely tell you, in the last two and a half years, there have been no suspicious deaths whilst in my care that would require a post mortem."*[48]

Hospices providing care for adults confirmed in interview that, when coroners' cases did occur, these were normally known about in advance. Examples included where asbestos contact or other industrial factors were suspected as a factor in a patient's death and there was a potential compensation claim. Cases might also occur involving prisoners if a hospice had a secure facility nearby.

Two hospices noted in interview that coroner referrals were sometimes also made for specific clinical presentations, such as the need to remove non-invasive ventilation. Another described how, when a case was being considered by the coroner, the deceased person would remain in the hospice's mortuary until the hospice had written clearance to release them, either for further examination or to the family's chosen funeral director.

Most hospices mentioned that medical examiners had now become the key liaison point, and they would liaise directly with families, independently of the hospice, on issues like death certification and whether a coroner's referral was required. Liaison with the medical examiner would be done via the hospice's medical team.

If a post-mortem examination (PME) was required, all the hospices interviewed described how the coroner's team would arrange for the deceased person to be transferred to an HTA-licensed facility. Arrangements would be identical to those described for a funeral director but would involve using a specific funeral director contracted to either the coroner or the receiving facility. One hospice indicated that collections normally happened quickly.

For those hospices we interviewed providing services for children and young people, PMEs were more likely to be required where:

- the hospice had accepted a transfer in of a death occurring in hospital or in the community; or
- there had been a traumatic labour or birth injury.

There was evidence of different approaches in place for children and young people requiring a PME:

- One hospice had a policy of not accepting deceased children into its care if they required a PME.

48 Witness transcript of A462, Interim Chief Nursing Officer, December 2024.

- The Director of Care for one hospice said that it would not accept children back into the hospice after a PME, as this would breach its policy on length of stay after death: *"It just wouldn't be appropriate. Because I do have to consider my team as well as the family's needs."*[49]
- The Registered Manager of another hospice described how it had accepted a deceased child after a PME, acting on the family's wishes. This had led to a delay in the child arriving at the hospice: *"We had to wait for several weeks … but the family really wanted them to come to us afterwards."*[50]

One hospice mentioned an incident where the coroner refused to receive a deceased person due to the lack of an audit trail concerning their care after death. This led to the installation of swipe card access at the hospice. One other hospice had received guidelines for what to do when a PME on a child was expected.

4.7 Changes since publication of the Inquiry's Phase 1 Report

This section outlines changes already made by hospices in response to this Inquiry's Phase 1 Report.

Many of the hospices that responded to the questionnaire, and that participated in interviews, had already made changes to their policies and procedures following the Inquiry's Phase 1 Report. These included:

- escorting and observing contractors in the area where deceased people are kept;
- reviewing which staff can access the area where deceased people are kept;
- installing swipe card access to, or CCTV in, the area where deceased people are kept;
- routine audits of access to the area where deceased people are kept;
- ensuring no lone working in the area where deceased people are kept;
- reviewing processes where keys are being used, or changing locks to the area where deceased people are kept;
- incorporating care of deceased people into governance arrangements – for example, by:
  - updating or introducing new policies;
  - improving assurance information provided to the board; or
  - reviewing risk assessment procedures; and
- commissioning a review of external security, including of the mortuary.

49 Witness transcript of A479, Director of Care, December 2024.
50 Witness transcript of A471, Registered Manager, December 2024.

The Head of Clinical Services at an adult hospice described how the Phase 1 Report had informed its planning:

> *"[I]t was interesting, because when we looked at the recommendations of the Phase One report and when we did our own risk assessment, there's some areas that, despite us having no concerns and no concerns being reported to us about security and patients post death, that we were able to say actually, we could do that a little bit better. We could absolutely implement that."*[51]

Seven of the 16 adult hospices interviewed had also either decommissioned their mortuary or were considering doing so at the time of the interviews. The David Fuller case was not the sole reason behind any decision to decommission, but was flagged as a key consideration in the decision-making process. Other reasons given included:

- changes to practice as a result of the COVID-19 pandemic;
- a lack of funding for additional security measures; and
- reducing the need for manual handling.

4.8 Care Quality Commission inspections

Hospices are registered with and inspected by the CQC. This section considers the role of this regulator regarding the care of deceased people in these settings.

The questionnaire responses indicated that many CQC inspections included inspections of the area where deceased people were kept: this was confirmed by 70 adult hospices, 21 children and young people's hospices and eight combined hospices.

In terms of the hospices selected for interview, relatively few had recently been inspected by the CQC. Some hospices reported that the CQC had visited either the mortuary or the cold room as part of their last inspection, but often as part of a general tour of facilities. As the Head of Performance and Delivery of one hospice described:

> *"So, we give them an open tour access all areas part of the building as part of the inspection process, and then we will respond directly to any information they request. So generally, they request a full suite of our policies and procedures. And it might be a question that's raised on the day in terms of how we manage and how we provide care at the body, it's generally one of the things that does come up in the tours, because again, many people don't understand it's a service we provide, and how we're uniquely able to provide that … I think in reality, those conversations are more curious questions from the CQC rather than specific."*[52]

While most of the 28 hospices in the interview sample said that the CQC had not flagged anything relevant to care after death in their last inspection, six of the hospices interviewed did recall some relevant issues raised during their last CQC inspection:

51 Witness transcript of A459, Head of Clinical Services, December 2024.

52 Witness transcript of A509, Head of Performance and Delivery, December 2024.

- For two hospices (inspected in 2019 and 2016), the CQC had raised matters relating to infection prevention control within the mortuary or cold room respectively. This is reflected in the CQC inspection report for one of these hospices: *"The [cold room] … had a separate entrance that could be used privately. Funeral directors also had an additional separate entrance."*[53]
- One hospice (inspected in 2024) recalled detailing to the CQC inspection team some changes it had made upon publication of the Inquiry's Phase 1 Report, which prompted a discussion about mortuary security.
- The Chief Nurse of one adult hospice (inspected in 2021) recalled how the CQC had enquired about processes for checking the temperature of the fridges in the mortuary, prompting a change to the hospice's approach:

  > *"They reviewed the mortuary … They identified that we were checking the temperatures every day. We recognised that we had no idea who was checking that temperature every day … So, it did give us a cause for review, but that otherwise they were really satisfied with our processes, both from the knowledge and insight of the staff about how they would manage a patient right from bed to mortuary and out. I think that they were really satisfied that that was a secure process, but also a dignified one because the clinical staff were involved in every element of that."*[54]

- The Registered Manager of a hospice for children and young people recalled that security measures were considered at an inspection in 2024:

  > *"So they [the CQC] were really happy with us that we'd just gone onto swipe cards because we changed that over at the beginning of last year for that extra security. And in terms of obviously locks, so they were asking around obviously keys and who has the management of the keys and things like that … and asking around arrangements around kind of, how long people can be there. What we kind of cap at that, the reasonings behind why we'd cap it, the reasons why we may not be able to accept. And then they looked at documentation around kind of body mapping … and all those kind of things."*[55]

One hospice also mentioned that the CQC had recently attended to 'sign off' its new premises and had suggested privacy screening on the doors where funeral directors come for collection, which was actioned.

4.8.1 Care Quality Commission interviews

The Inquiry interviewed representatives from the CQC, who outlined their understanding of what CQC hospice inspections covered in relation to areas where deceased people were kept.

53 CQC inspection report, CQC website.
54 Witness transcript of A464, Chief Nurse, December 2024.
55 Witness transcript of A476, Registered Manager, December 2024.

Ms Joyce Frederick, Director of Policy and Strategy at the CQC, told the Inquiry: *"[O]ur regulations stop at the services provided to the living."*[56] Ms Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare at the CQC, told the Inquiry:

> *"[W]e will look a little bit at the care of the deceased. So, we will make sure that there is – what the arrangements are for respectful transportation. You know, the movement of a deceased person out of the hospice. Some hospices have got mortuary facilities. So, just making sure that there are facilities for cold storage."*[57]

Ms Jenkinson also shared with the Inquiry the prompts for inspection teams within the CQC's framework for hospices; these include matters relating to the security and dignity of the deceased.[58] For example:

> *"*
> - *How is the body of a deceased person looked after, and are there effective arrangements with undertakers in place?*
> - *Are there policies and procedures for monitoring and managing cold body storage fridge temperatures, including a procedure to follow if temperatures are out of range?*
> - *Preparing the body for transfer to the cold body storage area or funeral director's premises. Is there discrete parking and access for funeral director vehicles?*
> - *Ensuring the privacy and dignity of the deceased person is maintained."*[59]

4.8.2 Review of Care Quality Commission hospice inspection reports

The Inquiry reviewed reports of recent CQC hospice inspections. Several reports published during 2024 make observations concerning mortuary and cold room management:

> *"Cold room storage facilities complied with NHS England guidance for staff responsible for care after death (2011). We observed mortuary fridge temperatures were in range. Staff monitored and recorded daily fridge temperatures and knew the process to action if there was variation. The cold room had CCTV monitoring with a separate external entrance. The cold fridge was serviced annually and there was an up-to-date service level agreement in place. The fridge had capacity of 6 bays. The service had an SLA in place with the local acute NHS trust and funeral director for additional off site cold room storage if and when required."*[60]

56 Witness transcript of Ms Joyce Frederick, Director of Policy and Strategy, CQC, October 2024.
57 Witness transcript of Ms Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare, CQC, June 2024.
58 Email to the Inquiry from Ms Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare, CQC, 7 July 2024.
59 Ibid.
60 CQC inspection report, CQC website, January 2024.

> *"Secure access was required for clinical areas which included the cold room. The cold room was in a private area of the service to ensure dignity for the deceased. We reviewed the services risk assessment for the cold room which had last been completed in June 2023. Potential risks and controls were carefully considered and documented. The service provided evidence of regular temperature checks of the cold room and of the cooling blankets (used to keep deceased patients cool)."*[61]
>
> *"Staff had restricted access to the mortuary, and we saw evidence of regular temperature checks."*[62]
>
> *"The mortuary had a temperature checklist staff checked weekdays to ensure it stayed within the suitable range of 4–8 degrees for cold body storage. This meant cold room storage facilities complied with NHS England guidance for staff responsible for care after death (2011). The guidance stated cold rooms should be below 12°C."*[63]

One CQC inspection report that rated a hospice as 'Requiring improvement' highlighted management of the cold room as a contributing factor. Extracts from the report read:

> *"The service must ensure all premises and equipment, including but not limited to, the cold room, are safe, clean, and properly maintained, and that this is recorded appropriately. (Regulation 12(1)(2)(d)(e)(h))."*
>
> *"We were concerned about potential IPC [infection prevention and control] risks to staff and patients because cold room storage facilities did not comply with NHS England guidance for staff responsible for care after death (2011). The guidance stated cold rooms should be below 12°C (ideally 4–8°C). However, the service's temperature monitoring records from January to October 2023, showed the cold room temperature was consistently outside the required range when it was occupied. For example, in May 2023, on days when the room was occupied, actual temperatures ranged from 5.6°C to 20.1°C."*
>
> *"We were concerned there were no cooling blankets available for patients after death. Although these are not compulsory, cooling blankets help to maintain the appearance, condition, and dignity of the deceased. We noted purchase of cooling blankets was an action on the risk register, to help mitigate risk associated with the inadequate cold room facilities. However, we discussed this with managers at the time and were told funding was still to be approved before they could be ordered."*[64]

The CQC regulations do not cover the care of deceased people. However, the role of hospices in supporting EoLC may result in confusion about whether areas where deceased people are kept in hospices should be inspected, and what aspects of care this should include. The Inquiry therefore considers that this area would benefit from further guidance and clarification.

61 CQC inspection report, CQC website, April 2024.
62 CQC inspection report, CQC website, April 2024.
63 CQC inspection report, CQC website, April 2024.
64 CQC inspection report, CQC website, January 2024.

The CQC's remit in relation to the care of deceased people is explored in more detail in Chapter 11.

4.9 Other oversight

4.9.1 Role of Integrated Care Boards

Since 2022, Integrated Care Boards (ICBs) have had a legal responsibility to commission health services that meet their population's needs, including palliative care and EoLC services.[65] Seven hospices carrying out NHS-funded work relating to EoLC mentioned that representatives from the local ICB would attend committee meetings, or receive reports, in relation to services commissioned by the NHS. The Director of Care of one combined hospice described how its ICB had undertaken an inspection of its premises:

> *"I think, probably, the ICB inspection was probably two years ago. On a quarterly basis, I submit a report to the ICB that covers all our activity. What's gone well, what hasn't gone so well. As part of that, they get sight of our incident log, and then we meet with them."*[66]

Hospices stated, however, that the ICB was not involved in reviewing matters in relation to the security and dignity of deceased people. One hospice interviewed was in the process of implementing the NHS Patient Safety Incident Response Framework and planned to involve the local ICB in the review of its plans.

4.9.2 Role of NHS England

The Inquiry found three CQC inspection reports published during 2024 that highlighted NHS England guidance regarding the management of a cold room. Guidance for staff responsible for care after death, published by the then National End of Life Care Programme in 2011, remains available via the NHS England website and contains the following:

> *"Many hospices have cold rooms that offer the family the opportunity to view the body beyond the time possible in other environments. In this facility the room temperature needs to be kept below twelve degrees centigrade and preferably between four to eight degrees centigrade. This may not be tolerable for relatives who wish to be in the room for extended periods and there are now cold beds and blankets that can offer effective cooling systems. Viewing beyond three days after death is not advised due to the natural deterioration of the body that takes place after this time."*[67]

The Inquiry was unable to find a more recent version of this guidance.

65 NHS England, Palliative and End of Life Care, no date, NHS England website.

66 Witness transcript of A468, Director of Care, December 2024.

67 National End of Life Care Programme, *Guidance for staff responsible for care after death (last offices)*, 2010 (available via NHS England website), para. 37.

NHS England, among other organisations, is listed as a contributor to the *Care after Death* guidance published by Hospice UK.[68] Ensuring the privacy and dignity of deceased people is a strong theme in this guidance, although the Inquiry notes that security is not mentioned.

One hospice mentioned guidance provided by NHS England in the form of the *Health Building Note (HBN) 16-01: Facilities for mortuaries, including body stores and post-mortem services*,[69] stating that it was attached to an NHS provider and therefore required to comply with mandated safety and security controls for mortuaries, including keypad locks, swipe access cards and CCTV monitoring. The HBN is not mandatory, although it does state:

> *"Whilst aimed specifically at the NHS, this guidance has been designed to be of use to all parties responsible for planning and operating mortuaries and body stores."*[70]

The HBN is covered in further detail in Chapter 11.

What we have found

- In response to the publication of the Inquiry's Phase 1 Report, many hospices have made changes to their approaches for ensuring that deceased people in their care are cared for in a secure and dignified way. However, there is considerable variation in practice across the hospice sector. No hospices referred to any guidance available to them on managing security around caring for deceased people, except for a single reference to NHS England's HBN guidance as summarised in section 4.9.2.
- This variation in practice is partly due to differences in the delivery model for different types of hospice and the facilities they have in place to care for deceased people. However, the absence of mandatory standards on security and dignity for areas where deceased people are kept in hospices can lead to longstanding and concerning practices that have not been reviewed. It is important that hospices understand the risk to the security of deceased people that comes from, for example, not having CCTV, which can act as a deterrent and provide an audit trail.
- The Care Quality Commission's consideration of the care of deceased people within hospices has the potential to provide false assurance to hospices and others reading inspection reports, as we saw in Phase 1 of this Inquiry.

68 Hospice UK, *Care After Death Guidance: 5th edition*, October 2024.

69 NHS England, *Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services*, 2023.

70 Ibid.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 27
Hospices that care for deceased people on their premises should:

- introduce auditable access control of the area where deceased people are kept;
- have Standard Operating Procedures regarding the care of deceased people, including security of and access to the areas where deceased people are kept; and
- minimise unaccompanied access to areas where deceased people are cared for, wherever possible.

Recommendation 28
To avoid confusion over its remit, the Care Quality Commission should issue clear guidance to inspectors (and others) that hospice inspections should not include areas where deceased people are kept, other than to focus on the needs of bereaved relatives.

Recommendation 29
Hospices should be considered in scope for the regulatory measures recommended in Chapter 11.

Chapter 5: Ambulance services

5.1 Introduction

Ambulance services are key to the urgent and emergency care system in England. Ambulance services convey patients to a hospital or other setting and provide paramedic care in the community.[1] At the time of the Inquiry's investigations, there were ten full NHS ambulance service trusts in England, plus an ambulance service on the Isle of Wight run by the Isle of Wight NHS Trust.

As in any part of the urgent and emergency care system, deaths do occur among patients in the care of ambulance services. It is for this reason that consideration of the procedures and practices to safeguard the security and dignity of the deceased in ambulance services is included in the Inquiry's Terms of Reference.

5.2 How we did our work

We began by interviewing the Chief Operating Officer of the College of Paramedics[2] and the Chair of the Association of Ambulance Chief Executives.[3] The purpose of these interviews was to fact-find about the incidence and likelihood of patients dying while being conveyed by ambulance, and to understand their expectation of policy and practice in this area.

Following this, we asked all 11 NHS ambulance services to provide statements to the Inquiry, setting out their policies and procedures for safeguarding the security and dignity of deceased patients in their care. The 11 NHS ambulance services are:

- London Ambulance Service NHS Trust;
- Yorkshire Ambulance Service NHS Trust;
- South East Coast Ambulance Service NHS Foundation Trust;
- East of England Ambulance Service NHS Trust;
- West Midlands Ambulance Service University NHS Foundation Trust;
- North West Ambulance Service NHS Trust;
- South Central Ambulance Service NHS Foundation Trust;
- East Midlands Ambulance Service NHS Trust;

1 NHS England, Urgent and emergency care, Ambulance, no date, NHS England website.
2 A professional body for paramedics in the UK.
3 A membership organisation for the UK's statutory ambulance services.

- South Western Ambulance Service NHS Foundation Trust;
- North East Ambulance Service NHS Foundation Trust; and
- Isle of Wight Ambulance Service, part of Isle of Wight NHS Trust.

We also asked them to provide the Inquiry with sections of relevant policies.

The transcripts of interviews, statements and sections of relevant policies were independently reviewed by two members of the Inquiry team.

5.3 Our findings

5.3.1 Circumstances under which deceased patients would be conveyed by ambulance

Mr Lewis Andrews, Chief Operating Officer of the College of Paramedics, told the Inquiry that the role of the college was to develop the curriculum for paramedic training. While it is best practice for higher education establishments to use the curriculum, he told us that this was not mandated. Mr Andrews went on to say that the curriculum did not prescribe the circumstances under which an ambulance crew might convey a deceased patient:

> *"So, the College is limited in its interaction at granular level, I would say. So, I'm able to give you this [examples of when a deceased patient might be conveyed] because of my experience. Where and how has the college become involved, it would literally be touched very lightly on here and now."*[4]

Daren Mochrie, Chair of the Association of Ambulance Chief Executives between August 2020 and December 2024, told the Inquiry that instances of ambulance crews conveying deceased patients would vary across the country and would be dependent on the circumstances of the death:

> *"So, so it probably does vary up and down the country and it's usually agreed with your local coroner and your local police force and the geographical area that you are responsible for, but in the main, it is highly unusual for ambulance crews to remove the deceased from a home address unless it was active resuscitation ongoing, maybe we're going off to a hospital. And if somebody has passed away in a home address, it's either usually broken down into suspicious circumstances or non-suspicious circumstances. If it was suspicious circumstances, we would always contact the police and the police would always arrive on scene because there is a potential crime scene. And again, it would be highly unusual in those circumstances for an ambulance crew to remove deceased after any criminal evidence gathering has taken place. It would be the police that would make those arrangements. And it's the same in a major incident scenario as well where you might have multiple casualties. Ambulance services role would be to pronounce life extinct but not to remove deceased from that kind of scenario. The other scenario within a home address would be non-suspicious circumstances. So that could be, let's say, I don't know, an elderly patient who has got*

4 Witness transcript of Mr Lewis Andrews, Chief Operating Officer, College of Paramedics, February 2024.

> *cancer who has sadly passed away and then the ambulance crew have been on scene. Again, it would be unusual for us to move the body from the home address. What we would do following our procedures that have been agreed with the local coroner, is arrange for the undertaker to come out and dispose of the deceased to a funeral care home, for example."*[5]

In their statements, the ambulance services described the scenarios in which they might encounter a deceased patient.

Seven ambulance services told the Inquiry that, if they were called to attend a deceased patient in their own home and the death was expected, they would not transport the patient. They would advise the deceased patient's family or a responsible adult to contact a funeral director to collect them. Two ambulance services said that, if the patient was alone and there was no known next of kin, they would contact the police for instructions.

Where a death at home was unexpected and the police were not already present, six ambulance services told us that they would contact the police to attend the scene and provide instructions to them. Eight ambulance services said that they would only transport a deceased patient to a mortuary in the case of an unexpected death if they were instructed to do so by the police. The Inquiry was told that this did not happen often and, when it did, the reason for it was to remove the deceased person from public view.

If a patient died while being transported by ambulance and the death was expected, seven ambulance services told the Inquiry that they would continue to their intended destination, which was usually a hospice or hospital, or return the patient to their home address to be collected by a funeral director. Three ambulance services said that, if a patient died during transport and the death was not expected, they would contact the police for instructions on what to do.

In their statements, the ambulance services set out the different arrangements that were in place for paediatric deaths. Where they attended a paediatric death, ambulance services would transport the deceased child to the Accident and Emergency department of an NHS hospital. One told the Inquiry that they would seek advice from healthcare professionals who had been involved in the child's care first, if it was an expected death, to determine what should happen. The child would then either be left at home, or conveyed to an Accident and Emergency department or a hospice.

The different arrangements for paediatric deaths were also explained by Mr Mochrie:

> *"If the patient is under-18, normally ambulance crews wouldn't necessarily cease resuscitation and most often than not those under-18 patients would be transported, and active resuscitation would be in place. If it was indisputable in terms of death for that under-18 patient, then more often than not we would take them to a prearranged mortuary."*[6]

5 Witness transcript of Mr Daren Mochrie, Chair, Association of Ambulance Chief Executives, February 2024.
6 Ibid.

Not all the scenarios described by the ambulance services fall within the Inquiry's Terms of Reference. The Inquiry's focus is therefore on scenarios where a deceased patient is transported by ambulance, or a patient dies while on board an ambulance.

5.3.2 Incidence of deceased patients being conveyed by NHS ambulance

Ambulance services were asked for any information they had on the incidence of patients dying while in an NHS ambulance, or the number of deceased patients transported by them in the two years up to 2024. This is challenging to quantify, as there are differences in how the information is categorised and reported across ambulance services and it is not centrally reported. Most ambulance services provided some information but one was unable to provide any data:

> *"We have reviewed our incident reporting system and we have noted that we have had a very small number of patients die while being transferred and death confirmed (expected deaths). Given the nature of how we capture data this is challenging to quantify exactly but our incident reporting system has identified six cases where we transferred a deceased patient (adult)."*[7]

> *"A search of our computer aided dispatch system and electronic patient record found that in the last two years the Trust has responded to 17,744 patients who have been identified or diagnosed deceased either during the call or once ambulance crews have attended scene. The Trust has transported 461 deceased patients to another destination during the same period. We recorded that 127 patients died in the ambulance."*[8]

> *"Our Business Intelligence team report that there is no specific 'death in the back of an ambulance' flag/code within our data and there is no 'time of death' field that could be used to identify these cases. Therefore, it would not be possible using our data to put a precise figure on the number of deaths that occurred in the backs of ambulances over the previous two years as requested. On the second point, our Business Intelligence team have identified from our data that 592 patients transported by [the ambulance service] who were deceased over the past two years."*[9]

> *"The Trust does not currently capture this information in a way that could be interrogated and collated."*[10]

> *"From July 2022 to March 2024 there were 300 instances where there has been a recording of deceased and transported in our current electronic patient recording database where the patient outcome is categorised as Deceased and Transported. We changed our electronic patient recording database in July 2022 and therefore do not have records for the period prior to that easily available."*[11]

7 Written statement of A121, NHS ambulance service, April 2024.
8 Written statement of A115, NHS ambulance service, April 2024.
9 Written statement of A120, NHS ambulance service, April 2024.
10 Written statement of A119, NHS ambulance service, April 2024.
11 Written statement of A117, NHS ambulance service, April 2024.

> *"The Trust do not routinely capture/record data in relation to patients who die whilst in an ambulance, except for those which relates to an adverse events (patient safety incident). Even then these, patient safety incidents, are not specifically reported to indicate the death occurred whilst in an ambulance."*[12]
>
> *"999 calls are recorded on the Trust's Computer Aided Dispatch system (CAD), which is the software used to manage the calls. The manner in which they are recorded on the CAD means they cannot be extracted in the format requested because it is not a routine data field that the Trust records."*[13]
>
> *"[The ambulance service] does not currently collate or report the incidence of patients dying whilst in an ambulance or the numbers of deceased patients transported by the Trust. To address the Chairman's request [the ambulance service] has undertaken exploratory data linkage to understand the number of deceased patients the Trust transports combining incident data from within our computer aided dispatch system with electronic patient record data. This pilot project demonstrated initial feasibility in being able to combine data and demonstrated a low incidence of conveyance of the deceased by the Trust as would be anticipated in accordance with our policies and procedures and as I have outlined within this statement. The data demonstrated eight cases in a calendar month whereby the Trust transported a deceased patient to a hospital or hospital mortuary facility."*[14]
>
> *"Deceased patients transported by the ambulance service are only those who have died in a public place and the police have requested the ambulance service remove the deceased from scene; or patients who have died on route to hospital … Our computer aided dispatch system does not log the specific destination of deceased patients to the … Mortuary … Therefore, accurate figures of the number of patients transported is not available. However, a realistic estimate is 10 patients a year based on discussion with local mortuary staff."*[15]

Based on the information provided, the best estimation the Inquiry can make is that 1,700 deceased patients were transported by NHS ambulance services in the two years up to 2024. This estimate cannot be relied on due to the variance in data collection outlined above and the lack of a clear definition about whether the data includes both those patients who died while being transported and those who died prior to transportation. For context, 4.5 million patients were transported by NHS ambulance services in England in 2022/23 and 4.8 million in 2023/24.[16]

5.3.3 Measures taken to protect deceased patients by NHS ambulance services

The incidence of deceased patients being transported by ambulance appears to be low. It would therefore follow that there should be a low likelihood of the deceased being abused while they are being transported in this way.

12 Written statement of A114, NHS ambulance service, April 2024.
13 Written statement of A122, NHS ambulance service, May 2024.
14 Written statement of A123, NHS ambulance service, May 2024.
15 Written statement of A441, NHS ambulance service, July 2024.
16 NHS England, Ambulance Quality Indicators 2022/23 and 2023/24, NHS England website.

The opportunity for abuse would most likely occur while the deceased patient was in the back of the ambulance during transportation. It is common practice for ambulances to have two crew members. Nine ambulance services told the Inquiry that they had no policy in place stipulating where in the ambulance crew members should sit while the ambulance was transporting a deceased patient.

The Inquiry found variation in practice regarding whether or not a lone crew member would travel in the back of the ambulance with a deceased patient. Two ambulance services told us that a lone crew member would travel in the back of the ambulance in these cases. One ambulance service stated that it required both crew members to travel in the front of the ambulance. Two ambulance services stated that, at times, a lone police officer might travel in the back of an ambulance with a deceased patient.

The Inquiry also considered whether there would be an opportunity for someone to access an ambulance while it was parked with a deceased patient in the back. We asked Mr Mochrie this question, and he responded:

> *"You would know. Most of the vehicles now are a bit more fancy than they were when I worked on the road and they've probably got central locking in them and all of this kind of stuff but, no, you would know. You would definitely know if anybody approached the vehicle or went into the back of the vehicle if there wasn't central locking. So, I don't think that would be a concern. You would know if somebody breached the vehicle."*[17]

5.3.4 Adverse incidents

The Inquiry asked the NHS ambulance services for details of any adverse incidents involving deceased patients in the two years to 2024. All 11 responded. Of these, six did not report any adverse incidents involving the deceased that were relevant to the Inquiry's Terms of Reference.

Five ambulance services reported adverse incidents that did impact on the security and dignity of the deceased, the majority of which – nine cases – related to taking and/or sharing images of deceased patients:

- One ambulance service reported that an image of a deceased patient was shared between the paramedic on scene and another paramedic. This was managed through the service's disciplinary policy. The same ambulance service also reported that an ambulance crew had left the scene where there was a deceased patient before the arrival of police officers, and an instance of a deceased patient being left in an unsecured flat by an ambulance crew without there being a responsible adult present.[18]
- Another ambulance service reported that an ambulance crew had left a deceased patient exposed when transferring them to an NHS mortuary; and, in a separate incident, an ambulance crew had left a deceased person outside

17 Witness transcript of Mr Daren Mochrie, Chair, Association of Ambulance Chief Executives, February 2024.
18 Written statement of A115, NHS ambulance service, April 2024.

in public view. It also reported a case where a paramedic had messaged colleagues about a patient who had died.[19]

- The Inquiry was told of an incident in another ambulance service where a paramedic had attempted to steal money from a deceased patient. This was dealt with as a criminal matter by the police.[20]
- One ambulance service reported seven incidents of ambulance staff taking photographs of deceased patients or the circumstances surrounding their deaths – for example, ligatures or suicide notes. The photographs were taken using NHS digital devices and were included in the relevant electronic patient records. The Inquiry was told that this was not in line with the ambulance service's operational guidelines.[21]
- Another ambulance service told the Inquiry of a case where a student paramedic had taken a photograph of a deceased patient and shared it with other students via WhatsApp.[22]

What we have found

- The Inquiry has heard that data on how often deceased patients are conveyed in NHS ambulances and the reasons for this are not routinely collected. This makes assessment of risk difficult.
- The majority of NHS ambulance services do not have a policy setting out where ambulance crew members should sit when conveying deceased patients.
- Most of the adverse incidents relevant to the Inquiry's Terms of Reference that were reported by NHS ambulance services involved taking photographs of deceased patients or of the paraphernalia associated with their deaths. While this did not always appear to have been with malicious intent, the Inquiry considers that it compromised the dignity of the deceased.

19 Written statement of A122, NHS ambulance service, May 2024.
20 Written statement of A116, NHS ambulance service, April 2024.
21 Written statement of A123, NHS ambulance service, May 2024.
22 Written statement of A114, NHS ambulance service, April 2024.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 30
Data on how often deceased patients are conveyed in ambulances, and the reasons for this, should be routinely collected and reported to NHS England, and monitored to assess risk.

Recommendation 31
Every NHS ambulance service should have a policy setting out where ambulance crew members should sit when conveying deceased patients. This should include reference to the risk of abuse of deceased patients, as well as training requirements.

Recommendation 32
NHS ambulance services should also have policies regarding the security and dignity of the deceased, including when the deceased should be covered and/or secured. NHS England should monitor that such policies are in place.

Recommendation 33
Every NHS ambulance service must put policies in place regarding taking photographs of deceased patients, including any circumstances in which this may be required, and ensure that ambulance staff are aware of these and comply with them.

Recommendation 34
The Inquiry has focused its investigations into ambulance services on NHS ambulance services. However, the Inquiry considers that these recommendations could also be applied to independent ambulance services, including private ambulances.

Chapter 6:
Local authorities

6.1 Introduction

Local authorities have legal obligations in relation to appointing coroners and funding coroner services in their areas, as well as the provision of mortuaries, excess death and mass fatality planning, public health funerals and crematoria.

Often a lead authority provides the coroner service, staffed by local authority and in some cases police employees, on behalf of a number of local authorities in that area. In some areas of England, the lead local authority also provides a mortuary and post-mortem examination (PME) service – but, more often, the lead authority contracts with the NHS to provide those services.

There is no available national picture of the arrangements that local authorities have in place for mortuary and body storage services with the NHS and funeral directors, nor is there data on local authority-run body stores that do not have a Human Tissue Authority (HTA) licence.

It was therefore necessary for the Inquiry to identify and map the arrangements in place in England for the provision of mortuary and body store services by or on behalf of local authorities.

6.2 How we did our work

The Inquiry used a range of investigative methods in this module, balancing the need to conduct a thorough and detailed investigation with the need to progress at pace.

6.2.1 Questionnaire

The Inquiry issued a questionnaire to all 317 local authorities in England. The purpose of the questionnaire was to ascertain the full scope of mortuaries and body storage facilities that are overseen by local authorities in England. We asked:

- whether or not the local authority had responsibility for a mortuary, body store or similar facility – if so, the size and purpose of the facility, and whether it was HTA-licensed, permanent or temporary, operational or not in active use; and
- whether or not the local authority had contracts, agreements or arrangements in place with external organisations to provide mortuary or body storage facilities.

We received responses from 293 local authorities, a 92 per cent response rate. This included 100 per cent of upper tier local authorities (metropolitan districts, county

councils, unitary authorities and London boroughs).[1] Responses to the questionnaire showed that it was the upper tier local authorities that had responsibility for mortuary facilities.

We believe that no such data collection exercise has been conducted before, and that the questionnaire responses offer the best available indication of local authority mortuary and body storage arrangements.

6.2.2 Detailed review of a selection of local authorities

Of the 293 local authorities that responded to the questionnaire, the Inquiry selected 17 to assist its investigations in this module. These included:

- eight local authorities that provide an HTA-licensed mortuary:
  - five of which also provide the coroner service in that area; and
  - one that contracts with an independent body store provider for contingency storage; and
- nine local authorities that contract with the NHS for mortuary services, two of which provide (or have provided) body storage facilities.

We also invited the independent body store provider referred to above, which has contractual arrangements with one of the 17 local authorities, to assist in the Inquiry's investigations.

The criteria used to select the 17 local authorities from the questionnaire respondents included the following:

- geographical spread across England, both urban and rural;
- coverage of ethnically diverse communities;
- variety of facilities, including size and purpose;
- mortuaries/body stores that are HTA-licensed, as well as non-licensed facilities;
- compliance with HTA standards as set out in HTA reports; and
- information provided to the Inquiry through questionnaire responses that identified a local authority area as one that might be of particular relevance to the work of the Inquiry – for example, a local authority facing challenges around lack of capacity and using the funeral sector for contingent capacity.

These 17 local authorities and the independent body store provider were asked to submit documentary evidence to the Inquiry.

The Inquiry received and analysed over 400 documents from local authorities. The analysis informed the key lines of enquiry for interviews with 36 local authority representatives, including directors and senior managers, HTA Designated Individuals

1 Office for National Statistics (ONS), Upper Tier Local Authorities (April 2023) Names and Codes in the UK, 2 May 2024, ONS website.

(DIs), coroner service leads and Mortuary Managers. Evidence from the Inquiry's locality visits was also considered (see Chapter 10).

6.3 Our findings

The Inquiry used a thematic approach to its investigations, including considering the themes of the findings from Phase 1 and reviewing how these were evidenced in local authority settings.

This chapter is structured in three sections as follows:

- local authorities providing HTA-licensed mortuaries;
- body store facilities provided by local authorities; and
- local authority assurance of third-party providers of mortuaries and body stores.

6.4 Local authorities providing HTA-licensed mortuaries

In this section we explore the security controls, policies and procedures in place at local authority-provided mortuaries, and their effectiveness in protecting the security and dignity of the deceased. We also look at how local authorities have responded to review the security arrangements at their mortuaries since late 2021, when David Fuller's offending in the hospital mortuaries in Kent first came to public attention. Finally, we consider the effectiveness of managerial oversight and governance of local authority mortuaries.

6.4.1 Do the security controls in place in local authority mortuaries protect the security and dignity of the deceased?

An effective security system is designed to prevent unauthorised and inappropriate access, and includes a process of audit to support the identification of unauthorised and inappropriate access should other security controls fail.

In considering the effectiveness of security systems in local authority mortuaries, the Inquiry took a whole-system view, looking at the range and depth of external and internal security controls, as well as the process of audit, and the assurance and oversight of security at a senior level.

How is access restricted?

Unlike NHS hospital mortuaries, which are part of a wider hospital setting, mortuaries provided by local authorities are often standalone buildings. Some are situated close to, or alongside, the offices and courts of the coroner, while others are not. Of the eight local authorities assisting the Inquiry's investigations, six have standalone mortuary buildings.

All eight local authorities assisting the Inquiry's investigations restricted access to their mortuaries. However, the Inquiry found variation in who was permitted unsupervised access; this is explained below.

Contracted funeral directors collect and transport deceased people who are under the legal control of the coroner while investigations into their cause of death are carried out. These providers are usually contracted on behalf of the coroner by the lead local authority for the coroner service in that area. Given the manual handling involved, contracted funeral directors transporting the deceased often work in pairs.

It is not uncommon for contracted funeral directors to have unsupervised access, out of hours, to admit deceased people to local authority mortuaries, and this was the case at six of the eight local authority mortuaries assisting the Inquiry's investigations. We examined the security controls that were in place to facilitate this.

The Inquiry found that all six mortuaries permitting unsupervised access to contracted funeral directors restricted their access to a specific area within the mortuary, either to the fridge room or to fridges specifically for out-of-hours admissions.

Contracted funeral directors accessing these six mortuaries did so by a variety of means. In two of the six mortuaries, access was by key and fob to disable the alarm. At a third mortuary, access was by codes for the doors and alarm. A local authority manager told the Inquiry that the door code had been changed when they were notified that a member of staff at the contracted funeral directors had left their employment.[2]

Physical keys and codes alone do not provide effective means of access control because they can be more easily compromised. Keys can be lost or taken, and codes can be shared and potentially used by those seeking illegitimate access to a mortuary.

The Managing Director of one independent body store and transportation provider that is permitted to access two of the six mortuaries unsupervised, out of hours, to admit the deceased, told the Inquiry that the keys and other methods of entry for the various locations were kept in the locked glove boxes of the private ambulances used:

> *"They are in the callout vehicles because those call out vehicles are manned 24/7. They go home with the crew, so they stay in those vehicles, always, always. Yeah, I've got a spare set locked in my office, but they're always in the vehicles."*[3]

The Managing Director confirmed that the private ambulances were unattended when outside the operative's home address overnight, and that these arrangements were set out in the contractual agreements in place. The keys were not tagged but the Managing Director explained that *"Nobody knows what those keys are for",* if they were to be taken.[4]

Three of the mortuaries used electronic access, or swipe cards, for contracted funeral directors to access the mortuary. One of these had introduced a bolted shutter lock to

2 Witness transcript of A565, local authority manager, March 2025.

3 Witness transcript of A8, Managing Director, independent body store and transportation provider, March 2025.

4 Ibid.

the transportation provider entrance, with the key in a key safe, *"in the unlikely event of the corporate door entry system [swipe] failing"*.[5]

Another of the three mortuaries was moving from key access to individualised electronic access at the time of the Inquiry's investigations in mid- to late 2024. The DI told the Inquiry how they anticipated that the introduction of individualised swipe access, alongside audits of CCTV, would strengthen security in relation to unsupervised access:

> *"[W]hen we've got the swipe cards, the mag locks [magnetic locks] and the additional CCTV, then we will be in a better position to look at it there and then and go, 'Right, we know who's getting in because they've got to swipe in.' And the other thing that I'm going to introduce is it's not going to be a key say for two people, because they always come in twos because of the lifting, it's going to be each one needs to swipe in … So that's very much in my mind to make sure that we set up swipe cards and everybody has to swipe in, so I know exactly who's going in and out."*[6]

At the third mortuary where access by contracted funeral directors was by individualised electronic swipe cards, the DI told the Inquiry that they had moved from permitting the contractors to have several individualised cards to having one swipe card held in a key safe on site:

> *"So originally, we dispatched key cards to each funeral director. So, several key cards out to one funeral company that was scheduled to bring the deceased in but looked at the risk of having all of these cards floating around, we've taken them all back now and we've got the one key card that funeral directors can use, but it's stored in the lockbox outside the facility."*[7]

The DI explained that they conducted audits of access using CCTV footage:

> *"We also marry that up with CCTV and data on when deceased are admitted. So … a few that entered the building at midnight, did we see them on the camera? What did they do when they were here? … So yeah, that's part of our routine CCTV audit which takes place … every three months, I believe it is."*[8]

The director to whom this DI reports told the Inquiry of an incident involving funeral directors accessing the mortuary unsupervised, out of hours, to admit a deceased person without the prior knowledge or consent of the local authority. They were not the funeral directors contracted to provide the body transportation service, but had been asked by the contracted funeral directors to conduct the admission on their behalf. The local authority had no knowledge that this incident had taken place until the DI reviewed the CCTV footage. The director at the local authority told the Inquiry:

5 Briefing note to cabinet member, 16 July 2024.
6 Witness transcript of A352, Designated Individual, September 2024.
7 Witness transcript of A113, Designated Individual, March 2025.
8 Ibid.

> *"Well, I mean, there was a recent example, and I wouldn't term it a security breach, but [the DI] had flagged with me some concerns about one of our body contractors who had used a subcontractor to deliver a body rather than themselves, and he was surprised, having reviewed the footage, that they were able to access the building, etc. because, of course, [the DI] had only provided the access details to the contractor, and they provided those details, the code, you know, the door code details, etc. to allow this subcontractor to get in and deliver the body and leave. And [the DI] was not happy with that and has picked that up directly with the funeral directors concerned. But other than, you know, I wouldn't describe it necessarily as a security breach, but certainly, [the DI] was concerned that there was access by a third party that, you know, [the DI] wasn't fully aware of at the time. But as I say, that's been followed up, and [the DI] made me aware of that."*[9]

This was an incident where unauthorised persons accessed the mortuary unsupervised, and it is concerning that it was not recognised as such.

Incidents involving a serious security breach are required to be reported to the HTA as HTA Reportable Incidents (HTARIs).[10] Reported HTARIs are published by the HTA online. There is no published record of this incident being reported to the HTA by this local authority.

All six mortuaries permitting unsupervised access by contracted funeral directors had a process of audit to reconcile access against CCTV footage. The process of audit was introduced at three of these mortuaries following inspections by the HTA in 2023.

Two local authorities assisting the Inquiry's investigations did not permit contracted funeral directors to admit deceased people to their mortuaries unsupervised, out of hours. Instead, there were alternative arrangements involving the use of the contracted funeral directors' premises.

At one of these mortuaries, an on-call system operated whereby mortuary staff would attend the mortuary out of normal working hours to facilitate admissions, except in the early hours of the morning, when (for personal safety reasons) the deceased were held at the contracted funeral directors' premises until the mortuary re-opened.[11] At the other mortuary, there was no on-call system and the contracted funeral directors stored the deceased at their own premises until they could transfer them once the mortuary was open.

Both these local authorities had included the need for suitable storage facilities in specifications for the contracted providers. One of these specifications allowed the contracted provider to subcontract the transfer or storage of the deceased to another provider in an emergency.

It was not clear how, in an emergency, the contracted provider or local authority would obtain assurance that the subcontracted provider's premises or security arrangements

9 Witness transcript of A433, director, September 2024.

10 HTA, Disclosing information on incidents, HTA website.

11 Witness transcript of A564, Mortuary Manager, February 2025.

were suitable. Neither was it clear what type of situation would constitute an emergency.

The Inquiry considers later in this chapter how local authorities conduct oversight and assurance in relation to the providers they contract with.

Six of the eight local authority mortuaries in the Inquiry's sample were co-located in or located near the offices of the coroner and coroner's court. It can be necessary for staff working in the coroner service, such as coroner's officers who assist the coroner in their investigations, to attend post-mortems or to visit their local mortuary for purposes related to the investigation.

At two of the local authorities within the Inquiry's sample, coronial service staff held managerial positions in relation to the mortuary or were the HTA's DI. There can, therefore, be close working between the mortuary and the coroner service.

The Inquiry found variation between the eight local authorities as to whether coronial staff were permitted access to the mortuary. The Inquiry heard two examples of poor controls regarding coronial staff accessing mortuaries.

At one local authority, the Inquiry found that coronial staff had the means to access the mortuary unsupervised, but that this was subsequently removed. The minutes of a leadership and management meeting of the coroner and mortuary service held in July 2024 include the following as outcomes of a 'whole building review' of security and access:

- *"The keys in the possession of Coroner's Officers to the rear door of the mortuary are to be returned.*
- *The door from the staff room in the mortuary to the main mortuary corridor will be locked with fob access restricted to mortuary staff, [name] & [name].*
- *Coroner's Officers requiring access to the mortuary for identification purposes will require admittance by mortuary staff.*
- *CCTV will be regularly audited to ensure those in the mortuary have permission to be there.*
- *Access policies to the mortuary will be drafted."*[12]

It is concerning that such changes were only made in July 2024, almost three years after the crimes of David Fuller came to light.

Another local authority had similar arrangements in relation to ease of access to the mortuary by coroner service staff. The Inquiry was concerned to find, in the Standard Operating Procedure (SOP) covering security, the following instruction in relation to the opening and closing of the mortuary:

> *"The key for the courtyard door and the coroner's court door should be removed from their storage location in the key press and placed in the locks of the doors for mutual access, except on inquest days."*[13]

12 Leadership and management meeting minutes, 2 July 2024.
13 07 Safe Operating Procedure: Building facilities, 12 July 2022.

That such a practice is included in the security procedures for the mortuary is extraordinary.

At interview, the Inquiry was informed by a manager at this local authority that keypad entry had since been introduced between the coroner's court and the mortuary:

> *"Some of the things that have changed in my own tenure include keypads for the area between where our coroner court sits, and our own facility."*[14]

However, the Inquiry is concerned that leaving keys in locks was a sanctioned practice at least as recently as 2021, when this manager took up post. The Inquiry also notes that the SOP had not been updated to reflect this change.

Three local authorities assisting the Inquiry's investigations permitted unsupervised access to the mortuary by cleaners. At two of these mortuaries, the cleaner entered the facility using individualised electronic access (i.e. swipe card or fob). At the third mortuary, the cleaner had a fob and had limited access to parts of the mortuary where deceased people were not stored.

At one of these mortuaries, individualised electronic access was introduced in 2024 following inspection by the HTA. Prior to this, access was by key and was unaudited.

At that mortuary, the cleaner is listed as a person with responsibility for the opening and closing procedure of the mortuary in the SOP provided to the Inquiry.[15] The DI told the Inquiry that the cleaner accessed the mortuary only in working hours.[16] However, the mortuary staff stated that this was not the case and that the cleaner had access to the mortuary out of hours.[17]

The Inquiry observed on a visit to this mortuary that there were no restrictions to internal areas of the mortuary, such as the rooms where the deceased were kept in refrigerated conditions. The Inquiry was also told that, although the fridges containing deceased people could be locked, they were not locked overnight. Following inspection by the HTA, additional CCTV was installed inside the mortuary, including in the fridge room, and a process to audit CCTV was introduced. These actions significantly strengthened the security controls in relation to unsupervised access. Yet it is concerning that these risks and mitigating actions had not been identified by the local authority prior to the HTA inspection.

At another of the three mortuaries, the DI explained the controls in place for the cleaners:

> *"[B]ecause of the sensitivities of the site, the company that run or manage the cleaners have allocated two specific individuals that can clean this building, and if one of them is going on annual leave, you'd then on board, DBS [get a Disclosure and Barring Service check for], you know, whoever would be coming in to replace that individual over that course of time."*[18]

14 Witness transcript of A295, local authority manager, September 2024.
15 Secure access and exit to the mortuary, May 2024.
16 Witness transcript of A520, Designated Individual, November 2024.
17 Witness transcript of A563, senior anatomical pathology technologist, February 2025.
18 Witness transcript of A113, Designated Individual, March 2025.

The Inquiry could not find this arrangement or the controls in place to manage it in the security SOP we were provided with.[19]

The Phase 1 Report of the Inquiry shows how David Fuller, who was an electrical supervisor at Maidstone and Tunbridge Wells NHS Trust, normalised his presence in the mortuary.

All eight local authorities assisting the Inquiry's investigations told the Inquiry that they did not permit maintenance staff or contractors to access their mortuaries unsupervised. One of these had implemented this restriction in December 2021, when David Fuller's crimes in the mortuaries first came to public attention. Seven of the eight had SOPs supporting this policy.

All eight of the local authorities assisting the Inquiry had a protocol for visitor access (e.g. access by police, maintenance staff and contractors) to their mortuaries. Four local authorities had taken action since David Fuller's crimes came to light to strengthen their visitor protocols – for example, by introducing a visitor sign-in book.

What we have found

- All eight local authorities assisting the Inquiry's investigations restrict access to their mortuaries. However, at only one is unsupervised access restricted to mortuary staff alone.
- There is variation between the eight mortuaries in how coronial staff access the mortuary.
- At three mortuaries, cleaners are permitted unsupervised access. At six of the eight mortuaries, unsupervised access to a restricted area of the mortuary is permitted to contracted funeral directors.
- At three local authorities, contracted funeral directors access the mortuary using physical keys and/or keypad codes, and have means to disable the intruder alarm. All six local authorities permitting unsupervised access to contracted funeral directors conduct audits that reconcile CCTV footage against access. At three of these, the process of audit was introduced in 2023.
- Two of the eight local authorities do not permit contracted funeral directors to access their mortuaries unsupervised. Alternative arrangements include storage of the deceased at the providers' premises.
- The Inquiry has come across evidence of two security breaches: one involving funeral directors accessing the mortuary without consent; and one involving the sanctioned practice of leaving keys in the locks to enable ease of access for coronial staff.
- The Inquiry has found instances where Standard Operating Procedures did not reflect working practices, compromising the ability of mortuary staff to apply and adhere to security protocols.

19 Operations, including premises, facility, and security, version 1.6.

What security controls are used?

In this section we look more closely at the specific security controls in place at the eight local authority mortuaries chosen to assist the Inquiry's investigations. These include the external controls used to secure the mortuary and prevent unauthorised access, as well as controls to restrict movement within the mortuary and to identify inappropriate or unauthorised access.

The HTA monitors and inspects licensed establishments against published standards, including standards relating to security.[20] The standards are supported by guidance which, in relation to keeping premises secure, says that *"security arrangements should be robust, with effective mechanisms to strictly control access"*.[21] The guidance says that there should be a *"controlled-access system to monitor entry into the mortuary or body store facility, either during the day or outside working hours"*. The guidance also says that *"swipe-card access lists should be reviewed and updated regularly"*.[22]

Local authority mortuaries are situated in different locations: some in city centres, others in residential areas, and some in areas that are more densely populated than others. Unlike NHS mortuaries, which are part of a wider hospital estate with activity 24 hours a day, seven days a week, local authority mortuaries are often standalone buildings, although some are located close to, or alongside, coroner service offices and courts. Each mortuary has its own challenges and risks given its physical location. In determining what controls to apply, mortuaries are supported by HTA guidance.

All eight of the local authority mortuaries had an external intruder alarm system, and six also secured their grounds with a locked gate or barrier. All eight mortuaries had external CCTV. Three local authorities had recently upgraded their CCTV system following inspections by the HTA. Four had installed additional CCTV cameras externally.

At one of the eight local authority mortuaries, the external CCTV coverage was limited and did not extend to all access points to the mortuary; nor was the CCTV monitored.[23] An HTA inspection identified that the intruder alarm at this mortuary was not functional.[24]

Intruder alarms and live CCTV monitoring support a rapid response to incidents of unauthorised access. The Inquiry found disparity across the eight local authority mortuaries in the documented processes for responding to the intruder alarm if it was activated:

- Two had a written procedure that involved a member of mortuary staff attending the mortuary to assess the situation.
- At two local authorities, the security company would attend.
- At four local authorities, arrangements were not clear.

20 HTA, Premises, facilities and equipment standards, HTA website.
21 Ibid.
22 Ibid.
23 Witness transcripts of A293, Designated Individual, September 2024; A564, Mortuary Manager, February 2025.
24 HTA inspection report, HTA website.

Therefore, at four of the eight mortuaries, the documented procedure for responding to the intruder alarm was not well defined.

In relation to external CCTV, one local authority told the Inquiry that it was considering the introduction of live CCTV monitoring using its central control centre:

> *"We are talking to our control centre about whether we could have monitored CCTV … At the moment, our call centre is pretty new, and they've got this facility where if something is activated, it comes up on the screen. So, I'd quite like that on the access doors. So, at 03:00 in the morning, if something triggers it, it will come up into the centre of the screen. So, they'll look at it. So that's what we're talking to them about, and I suspect that's the way we'll go."*[25]

The Inquiry found that four of the eight local authorities had taken action to increase CCTV coverage, and three local authorities had upgraded their CCTV system following HTA inspections. There was recognition at one local authority that security processes, including CCTV, were outdated and required modernisation:

> *"It's a standalone site, yeah. It's not used, you know, the site is not used for anything else but the public mortuary. It's a sort of enclosed, walled, gated site. Admittedly, I think our processes have been a bit traditional and paper based, yes. And the CCTV system, you know, was ok. But it could be better sort of thing. And so, this was on the back of the HTA audit inspection, we were identifying things. And so, this is what we've done, we've put in a growth bid, to perform these improvement works and to bring us into the 21st century really."*[26]

The Inquiry recognises that optimal CCTV requirements differ across local authority mortuaries depending on their specific circumstances. However, it appears that there may be disparity in the extent of external CCTV arrangements. For example, one mortuary had eight external CCTV cameras, while another had six. A third, a large facility, did not have coverage of all access points to the mortuary, as identified by the HTA.[27]

When reconciled against individualised access control data, CCTV footage enables an effective process of audit.

Of the eight local authority mortuaries assisting the Inquiry's investigations, five had individualised electronic access controlling entry to the mortuary, and two were introducing these controls at the time of the Inquiry's investigations. The SOPs of four of the five local authorities evidence that the local authority mortuaries use this system of access control.

25 Witness transcript of A293, Designated Individual, September 2024.
26 Witness transcript of A353, local authority manager, September 2024.
27 HTA inspection report, HTA website.

At two of these mortuaries, there was individualised electronic access for entry but not exit: *"Only have swipe in, not swipe out."*[28] This meant that the local authority did not have a complete picture of activity, limiting the effectiveness of any audit process.

At one of the local authorities introducing individualised electronic access controls, the DI explained that this had followed an HTA inspection:

> *"Okay, so one of the HTA audit requirements when they came in, they identified that the access to the facility was a key access and we had – because people have come and gone … there was no way of identifying the control of access keys. Who've got keys? Have they left and have they still got keys? So, the requirements were that we needed to look at facilitating a key fob access, front and rear accesses, which we've done. But also, the fact that as part of that audit, there was no real audit arrangements in terms of who was in the building at any one time and who had accessed three weeks ago, and how long we keep that detail for. So, we've made those changes, and we've just completed the SOPs for the audit of the CCTV and access arrangements."*[29]

It is apparent that it necessitated an inspection by the HTA for the local authority to move from key entry to individualised electronic access.

Only one local authority in the Inquiry's sample of eight had key entry. Other security controls, such as an intruder alarm and external CCTV, were in place at this mortuary, although audit of CCTV footage was introduced only at the time of the Inquiry's investigations. The DI at this mortuary told the Inquiry that the local authority was considering the introduction of an electronic access control system such as swipe cards.[30]

Internal security controls in a mortuary provide an additional layer of security that, when applied with an effective process of audit, create additional barriers for people who might seek to do harm. They also reduce an over-reliance on trust in staff working in the mortuary.

All eight local authority mortuaries assisting the Inquiry's investigations in mid- to late 2024 had taken, or were at that point taking, action to strengthen their security controls. This was particularly evident in relation to internal controls.

Of the eight local authorities assisting the Inquiry's investigations, seven had CCTV within the mortuary, facing the fridges that contained deceased people.

Of the seven mortuaries that had CCTV, three had CCTV inside the post-mortem room. At one of these, the CCTV was to facilitate viewings of PMEs, and at a second, the CCTV did not record footage and was for observation purposes only.

28 Witness transcript of A293, Designated Individual, September 2024.
29 Witness transcript of A520, Designated Individual, November 2024.
30 Witness transcript of A113, Designated Individual, March 2025.

At the third mortuary, the CCTV faced the double-ended fridges that could be opened from within the post-mortem room. This local authority had reviewed its security controls in late 2021, when David Fuller's crimes in the mortuaries became publicly known. The local authority provided the Inquiry with a briefing document, dated 2021, that explains that additional CCTV was installed so that all fridges and freezers were covered, including in the post-mortem room:

> *"1. Additional Measures to be explored.*
>
> *The measures below will be explored to prevent such an awful incident occurring at [mortuary name] and reassure bereaved families that their loved ones are being treated with respect and dignity in our care.*
>
> - *Review CCTV camera coverage to extend to all fridges and PM [post-mortem] rooms.*
>   - *Action – Install an extra set of CCTV cameras in the fridge area to monitor access to the second set of fridge and freezers."*[31]

The DI explained to the Inquiry that the CCTV faced the fridges that opened into the post-mortem room:

> *"Yeah, we have really, really tightened up our security since the minute we heard about the Fuller incident a couple of years ago, we did a full review of our security at the mortuary, and we made some immediate changes. We increased the number of CCTV cameras, for example, we now have 16 in every single area of the mortuary. There are no blind spots whatsoever. That mortuary footage is reviewed by myself on a monthly basis … We do have them [CCTV cameras] in the postmortem room. They are facing the fridges. We have pass-through fridges, and the camera in the postmortem room faces those doors. It doesn't record any other information at all, any other part of the postmortem room."*[32]

Not all mortuaries assisting the Inquiry's investigations had double-ended fridges that opened into the post-mortem room. However, the Inquiry found that, at four mortuaries, double-ended fridges were accessible from within the post-mortem room and there was either no CCTV in the post-mortem room or the CCTV was for live monitoring only.

One local authority assisting the Inquiry's investigations had no CCTV anywhere inside its mortuary. Both the DI and the director expressed uncertainty about how CCTV could be used within the mortuary without compromising the dignity of the deceased:

> *"[W]e've asked whether we can have CCTV in the rooms. We've asked on a … what's the word I would like to use here? Principle. Can it be done, rather than we would do it because we're thinking about the balance about whether it's appropriate or not, in terms of respect for the bodies and where that CCTV would go because we've got a massive control centre with CCTV across the whole of the city. And that's where our CCTV is monitored. And we need to decide … and hopefully the Fuller Inquiry will direct us, which would make it easier where the balance is about, you know, respect*

31 Briefing document for Lead Councillor, 9 November 2021.

32 Witness transcript of A426, Designated Individual, September 2024.

and dignity for the deceased … Whether we can put other mitigations against the risk, such as, you know, locking the fridges at night. What else can we do that may not be as much as CCTV, but would give us an extra element of reassurance? So, all of that thinking about what the risk is, therefore, what the mitigation is, whether the mitigations are enough without putting CCTV in, and the CCTV, if that didn't then create its own risks in some way."[33]

The Inquiry recognises that some local authorities are concerned about the use of CCTV within mortuaries and the risk of compromising the dignity of the deceased. However, the Inquiry considers that it is a vital measure in preventing crimes like those committed by David Fuller from happening again. In line with HTA guidance, safeguards should be put in place to mitigate the risk from inappropriate access or use of the CCTV images.

Individualised electronic access controls, such as swipe cards, provide greater transparency around who is accessing a mortuary, as well as their movement within it. When used alongside a process of audit, they not only prevent unauthorised and inappropriate access but reduce reliance on trust in those working in the mortuary.

The Inquiry found that, of the eight local authority mortuaries assisting its investigations:

- Two did not use individualised electronic access controls to restrict movement within the mortuary.
- One had electronic access controls to the changing room doors.
- Two had installed individualised electronic access controls to additional areas within the mortuary, including the post-mortem room.
- One had introduced electronic access within the mortuary for the first time.

The DI at one local authority acknowledged the reliance they placed on trust and reflected on how that trust could be misplaced, as shown by the actions of David Fuller in the mortuaries in Kent:

"The thing I reflected on most is the fact that he [David Fuller] managed to mislead people. So, you judge somebody by what you believe you see. You know, the most notable thing in there is 'I trusted him to take me to the car on a dark night, and yet he was a murderer.' You know, don't beat around the bush. He's done horrible things, and a single female said, 'I trusted him to take me to the car' … But I don't know what to do in the sense that I trust my APTs [anatomical pathology technologists], and it's horrible to say you don't trust somebody … it's a really difficult thing. Really difficult, because it has such monumental consequences. You know, I was afraid that somebody would release the wrong body. That's always been my biggest fear, you know? Yeah, that's my reflection. It's very sobering."[34]

33 Witness transcript of A422, director, September 2024.

34 Witness transcript of A293, Designated Individual, September 2024.

At another mortuary, the former Mortuary Manager lived on site:

> *"[T]he previous mortuary manager lived on site. And so that, you know, [they were] in complete control of anybody gaining access into the yard or the building."*[35]

Living accommodation above a mortuary is not, in itself, a concern, if there is a robust process in place to audit access to the mortuary. However, this mortuary was taking action only in mid- to late 2024 to replace key entry with individualised electronic access controls, and there was no process of audit in place to reconcile external CCTV footage with use of the alarm key fob. It was therefore not possible to know if the mortuary was being accessed inappropriately by authorised personnel. Despite this, the DI told the Inquiry that they felt the mortuary was as secure as it could have been at the time David Fuller's crimes came to light in 2021:

> *"**Q:** And you mentioned that you've taken a lot of measures to improve security post your HTA inspection. Did you take any measures to improve security after the Fuller incidents at all?*
>
> ***A:** It was already, as I say, we was one of the few that got CCTV in the postmortem. The Designated Individual then was the previous Mortuary Manager. And I think it's important to say that the mortuary has also got living accommodation above it. So, there is always somebody on site. So, if there was a fridge breakdown in the middle of the night and an alarm went off, the Mortuary Manager would come down and let the people in. So, to say was it increased, I don't see how we could have increased it any better than we already had it at that time."*[36]

An over-reliance on trust, the perception that the threat to the security of the deceased comes from outside, and a failure to consider the possibility that staff working in the mortuary could do harm were observed by the Inquiry in other settings it investigated. The Inquiry believes that these are also evident in some local authority mortuaries.

35 Witness transcript of A353, local authority manager, September 2024.

36 Witness transcript of A352, Designated Individual, September 2024.

What we have found

- All eight local authorities have taken action to strengthen the security controls in their mortuaries. However, some have had more to do than others to upgrade, increase or introduce security controls.
- Multiple actions have been taken to strengthen internal controls – for example, to restrict movement within the mortuary, or to increase or introduce CCTV. These actions indicate a previous focus on external controls to prevent unauthorised access, and a lack of consideration of the risk of inappropriate access or behaviour by those working in the mortuary.
- Not all local authorities have CCTV within the mortuary. Not all local authorities have CCTV covering all fridges containing deceased people, including in the post-mortem room. These local authorities cannot be assured that crimes such as those committed by David Fuller are not taking place.
- In some local authorities, mortuary staff are permitted in certain circumstances to handle the deceased when they are working alone. Some local authorities have not considered and mitigated risks to the deceased in these working arrangements.
- There is hesitation and uncertainty about how to use CCTV within the mortuary, and in particular in the post-mortem room.
- There is disparity in local authority arrangements for responding to incidents of unauthorised access. In some local authorities, procedures for responding to incidents of unauthorised access are not clear.
- The Inquiry has found instances where Standard Operating Procedures do not reflect the security controls in place.

6.4.2 Local authorities' response to David Fuller and actions to improve the security and dignity of the deceased

In this section we look at how the eight local authorities assisting the Inquiry's investigations responded following David Fuller's offending in the mortuaries at hospitals in Kent coming to light in late 2021. We also consider their response to the HTA's revised standards on the dignity of the deceased, published in 2022, and the results of the HTA's Evidential Compliance Assessment exercise in 2024.

The Inquiry considered to what extent local authorities had reviewed their mortuary security arrangements in light of David Fuller's offending.

In December 2021, one local authority briefed its statutory accountabilities board, summarising the mortuary security controls in place, the measures that had been identified as necessary to strengthen security, and others that could be considered.[37]

37 Statutory Accountabilities Board security update, December 2021.

This local authority shared a series of briefing documents with the Inquiry that show it took measures to strengthen security in late 2021 and 2022.

The December 2021 briefing paper explains that, in addition to David Fuller's crimes coming to light, the local authority was prompted to review mortuary security following a letter from the Minister of State for Building Safety and Fire at the then Department for Levelling Up, Housing and Communities (DLUHC). The letter was issued on 8 November 2021 to local authorities and draws attention to HTA guidance in relation to security. The letter is similar to that issued by NHS England (see Chapter 1) to NHS trusts with responsibility for mortuaries and/or similar facilities, but does not specify actions to take. The DLUHC letter states:

> *"I am writing to draw your attention to the Human Tissue Authority's (HTA's) Code of Practice and licensing Standards in relation to post-mortem examination.*
>
> *As I am sure you are aware, the Human Tissue Authority (HTA) is the regulator which oversees the licensing and inspection of facilities where post-mortem examinations are carried out, including those aspects of security relevant to their remit.*
>
> *I would like to take this opportunity to encourage all Local Authorities who have a responsibility for mortuaries or similar facilities to review the HTA Guidance. I have no doubt that you will want to take any necessary steps to ensure that your organisation's policies and practices are compliant."*[38]

The Inquiry came across no evidence that any other local authority assisting the Inquiry's investigations was prompted to take action by the letter from DLUHC.

The Inquiry is aware that two other local authorities took some measures to improve mortuary security around the time that David Fuller's offending came to light.

A senior manager at one of the eight local authorities told the Inquiry that they had introduced additional security controls in the mortuary since taking up post in 2021, though it was not clear what prompted the changes:

> *"Some of the things that have changed in my own tenure include keypads for the area between where our coroner court sits, and our own facility. Also, the night area whereby our contracted funeral directors are able to access our fridges is alarmed via a little, what are they called, a little fob. So, only they can gain access without setting the alarm off."*[39]

A DI at another local authority told the Inquiry: *"A while ago, not recently, I asked for there to be CCTV cameras on every entrance and exit of the [building]. That got done, brilliant."*[40] Again, the specific prompt for and timing of this action were not clear, but it indicated that some local authorities had considered strengthening their security controls.

38 Lord Greenhalgh, Minister of State, DLUHC, Letter to local authorities with responsibility for a mortuary and/or similar facilities, 8 November 2021.

39 Witness transcript of A295, local authority manager, September 2024.

40 Witness transcript of A430, Designated Individual, September 2024.

In September 2022, the HTA published an update to its PME licensing standards and guidance to *"reinforce the importance of establishments considering all risks to the dignity of the deceased"*.[41] The updated licensing standards and guidance introduced requirements in relation to security audits: *"Audits should include checking of CCTV as well as records of mortuary access."*[42]

The HTA's guidance in relation to standard PFE1(e) – *"Security arrangements protect against unauthorised access and ensure oversight of visitors and contractors who have legitimate right of access"* – states:

> *"Swipe card access lists should be reviewed and updated regularly. Records of access (electronic and paper-based) and CCTV footage should be regularly audited to ensure adherence to relevant policies and procedures. Anyone entering the mortuary should have a legitimate right of access and audits should scrutinise the purpose, frequency and duration of access and be particularly alert to unusual patterns, times of entry or other unexplained or suspicious activity which must be investigated immediately."*[43]

The updated licensing standards and guidance gave local authorities an opportunity to review their security arrangements and take action to strengthen security, particularly in relation to audits.

However, the fact that HTA inspections in 2023 and 2024 identified necessary actions to strengthen security at six of the eight local authority mortuaries assisting the Inquiry's investigations suggests that the HTA's update in 2022 had limited impact.

At the six local authority mortuaries that were inspected by the HTA in 2023 and 2024, major shortfalls relating to security were found at five, and a minor shortfall at one. In the main, the areas of non-compliance related to the lack, or inadequacy, of oversight of access to the mortuary and/or security audits.

The shortfalls identified by the HTA indicate that, where actions had been taken by some local authorities to strengthen security, they were not fully comprehensive. It was also the case that, in some local authorities, limited action had been taken to strengthen security since the crimes by David Fuller came to light in late 2021.

In spring 2024, the HTA wrote to DIs at establishments holding an HTA post-mortem sector licence asking them to complete an Evidential Compliance Assessment. This was to enable the HTA to assess *"compliance against the PM [post-mortem] sector licensing standards regarding mortuary security arrangements"*.[44]

At two of the eight mortuaries assisting the Inquiry that were not inspected by the HTA against standards relating to security[45] in 2023 or 2024, the Evidential Compliance Assessment was the means through which necessary actions to achieve compliance with security requirements were identified.

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41 HTA, Human Tissue Authority publishes an updated version of Post-mortem Examination Licensing Standards and Guidance, 27 September 2022, HTA website.

42 HTA, *Post-mortem Examination Licensing Standards and Guidance*, version 3, September 2022, p.10.

43 HTA, Premises, facilities and equipment standards, PFE1(e), HTA website.

44 HTA, Email to DIs titled 'Human Tissue Authority Evidential Compliance Assessment – Mortuary Security', 3 May 2024.

45 HTA, Post-mortem licensing standards and guidance, PFE1(d) and (e), December 2024, HTA website.

The HTA's Evidential Compliance Assessment of security found that only one of 19 local authority-provided mortuaries that completed the assessment[46] was compliant. Eight became compliant only after receiving advice and guidance from the HTA, and ten were not compliant.

Eight of the 19 local authorities that completed the Evidential Compliance Assessment were those assisting the Inquiry's investigations. Of these eight, only one was compliant, two became compliant only with advice and guidance from the HTA, and five were non-compliant. This demonstrates again that the majority of the local authority mortuaries assisting the Inquiry's investigations had failed to respond to the HTA's updated licensing standards and guidance in 2022.[47]

Aside from one local authority where a new-build mortuary was designed using 'Secured by Design' principles,[48] [49] only one of the eight local authorities assisting the Inquiry's investigations had arranged for a specialist security contractor to review its security arrangements. This local authority told the Inquiry that it was *"carrying out a full review of building security arrangements in light of incidents such as that of David Fuller and recent security concerns within the court system"*.[50]

The Inquiry did identify examples of local authorities taking a more proactive approach to their security arrangements. However, for the majority of the eight local authorities assisting the Inquiry's investigations, the prompt to strengthen security at their mortuaries was the regulator, the HTA.

One local authority DI told the Inquiry that being able to point to security enhancements as necessary to maintain regulatory compliance was an important lever through which they could obtain funding, without which they felt they would struggle to implement specific enhancements to security.

The Inquiry cannot say to what extent this may be the case in other local authorities, though we are mindful of the financial pressures experienced by some local authorities. The Inquiry also heard that the implementation of security enhancements could take time due to internal processes:

> *"I think my frustration is the length of time it takes to get things done, put in place."*[51]

And:

> *"So, the HTA audit that was undertaken in November. It took some time to get some of the recommendations put in place … There was an allocation of funding that we*

46 Two of the 21 HTA-licensed local authority mortuaries did not complete the HTA's Evidential Compliance Assessment.

47 HTA, *Post-mortem Examination Licensing Standards and Guidance*, version 3, September 2022.

48 Witness transcript of A113, Designated Individual, September 2024.

49 Secured by Design, a police security initiative that works to improve the security of buildings and their immediate surroundings, Secured by Design website.

50 CCTV and building security review, July 2024.

51 Witness transcript of A430, Designated Individual, September 2024.

needed to bid for in terms of capital funding to get that work done. So that took a little bit of time to get sorted."[52]

What we have found

- In 2023 and 2024, the Human Tissue Authority identified security-related shortfalls at all eight mortuaries assisting the Inquiry's investigations, with some having more to do than others to achieve compliance with regulatory requirements. This indicates that, where actions had been taken by some local authorities to strengthen security, they were not fully comprehensive. Some local authorities had taken little or no action prior to shortfalls being identified by the Human Tissue Authority, indicating that some local authorities have struggled to identify measures necessary to strengthen security.
- Most local authorities assisting the Inquiry's investigations have taken a piecemeal approach to the security arrangements in their mortuaries. Only one local authority has instigated a review of security involving specialist security input.
- The Inquiry has heard that funding for security enhancements is easier to secure if they are a regulatory requirement. The Inquiry has also heard that implementing security enhancements can be delayed by local authority procedures.

6.4.3 Oversight and assurance arrangements in relation to mortuary security

Given the level of non-compliance in relation to security shortfalls identified by the HTA in 2023 and 2024, and the disparity in how the eight local authorities assisting the Inquiry's investigations have responded since David Fuller's offending in the mortuaries in Kent came to light, the Inquiry wanted to understand the oversight and assurance arrangements in relation to mortuary security that are in place at the eight local authorities.

As well as supporting the identification of unauthorised and inappropriate access, audits provide assurance to those overseeing a mortuary that security controls are being applied and adhered to by mortuary staff.

The Inquiry found that, at five of these local authorities, actions relating to audits of CCTV had been or were being taken – either following HTA inspections in 2023 and 2024, or, for those not inspected in this period by the HTA against the relevant security standards, around the time of the Inquiry's investigations.

The Inquiry found that actions to introduce or strengthen audits of access – for example, installing electronic access to additional internal areas of the mortuary – had been taken by seven local authorities.

52 Witness transcript of A520, Designated Individual, November 2024.

The Inquiry found variation in relation to the audits being conducted. For example:

- At one local authority, the DI and a manager had received training in the use of CCTV and conducted audits of access to the mortuary on dates and times selected at random – during the day, out of hours and at the weekend.[53]
- A DI at a second local authority reviewed CCTV of out-of-hours access on dates selected at random. This DI also reviewed internal movement within the mortuary.[54]
- At another local authority, audits of CCTV were undertaken of out-of-hours access by the contracted funeral directors. However, audits of movement within the mortuary were not undertaken.[55]
- At another local authority where there was no CCTV and no access controls within the mortuary, there were only audits of access to the external door, and not within the mortuary.[56]

Where local authorities are not conducting audits of internal CCTV, they cannot be assured that crimes like those of David Fuller are not occurring in their mortuaries. This was acknowledged by a director at one of the eight local authorities, although they were unsure whether auditing was being undertaken at the mortuary they oversaw:

> *"I know that we have extensive CCTV at the facility, both internally and externally, including in the post mortem room and in the fridge area. I think when I was reflecting on this issue in terms of the question that you're particularly interested in, I'm not necessarily satisfied that it would necessarily prevent a repetition of a Fuller-type incident at our facility, because first and foremost, the CCTV that we have is monitored by our CCTV control room, but we would only ever get to see that on request. So, you know, if you had an individual like Fuller operating down there, the only real way of having complete assurance would be that there would be someone reviewing the CCTV footage at the end of the week. Do you know what I mean? And I'm not doing that. I don't know if [the DI is] doing that, but it seems to me that having CCTV is a potential deterrent, but of course, it depends as well on the assurance someone at the other end is looking and monitoring, and I'm not sure that that necessarily takes place."*[57]

The Inquiry found that, at four of the eight local authorities, security audits were reported to a level above the DI. At three local authorities, security audits were not routinely reported outside the mortuary, but anything of concern identified during the audit would be. At one local authority it was not clear whether the security audits were reported.

53 Witness transcript of A430, Designated Individual, September 2024.
54 Witness transcript of A426, Designated Individual, September 2024.
55 Witness transcript of A565, local authority manager, March 2025.
56 Witness transcript of A293, Designated Individual, September 2024.
57 Witness transcript of A433, director, September 2024.

Only three of the eight local authorities provided documentary evidence that procedures for the conduct of security audits were included in the SOPs for the mortuary, and/or examples of completed audits.

HTA-licensed establishments in the post-mortem sector are required to report serious incidents to the HTA. These are known as HTARIs and are classified by the nature of the incident, including 'serious security breach', which is of relevance to the Inquiry's Terms of Reference. HTARIs must be reported to the HTA within five working days of the incident occurring or being discovered.

In a two-year period, 14 HTARIs of all classifications, including serious security breaches, were reported to the HTA by the 21 licensed mortuaries provided by local authorities in England.[58] Only one of these HTARIs was reported as a serious security breach. That HTARI did not occur at any of the eight local authority mortuaries assisting the Inquiry's investigations.

In interviews with the 23 DIs, managers and directors involved in the management and oversight of the eight local authority mortuaries, we asked if any security breaches had occurred. The Inquiry was informed of two incidents involving a breach of security, at separate mortuaries, that were not reported to the HTA, as explained below.

The first involved an external fire door to the mortuary being left open:

> *"[W]e left the fire door open and it was only for a matter of hours, but a fire door was left open. One of the coroner's officers noticed and was able to contact us via an out of hours phone. It wouldn't have been a fire door that was accessible to the public, but it was still open. So, yeah, that was something that we recognised and put some steps in place to ensure we had a process for opening and closing the facility in a way that we were able to satisfy ourselves that that wouldn't be happening again."*[59]

The second incident involved unauthorised access to a mortuary out of hours. The funeral directors contracted on behalf of the coroner to transport the deceased had arranged for another funeral director to conduct an out-of-hours admission of a deceased person without the consent or knowledge of the local authority (see 'How is access restricted?' in section 6.4.1). Despite the concerns of the DI, the incident was not reported to the HTA.

It is concerning that neither incident was formally reported to the HTA. Given that only one HTARI involving a serious security breach was reported in a two-year period by local authority mortuaries, and that we came across the two incidents described above, we believe that there may be other security-related incidents that have not been reported.

58 HTA, Disclosing information on incidents, quarterly reports, postmortem sector reported incidents, Q1 2022/23 to Q4 2023/24, HTA website.

59 Witness transcript of A295, local authority manager, September 2024.

This belief is further strengthened by the findings of the HTA at an inspection of one of the eight local authority mortuaries. This inspection identified that the SOP for reporting incidents and HTARIs had not been reviewed for several years; staff were unaware of the SOP and the incident reporting form; and there was no incident reporting system. The DI could not therefore assure themself that staff knew how to report incidents, or that when incidents occurred they were reviewed and lessons learned actioned.[60]

Seven of the eight local authorities either told the Inquiry or provided documentary evidence of a process whereby incidents would be looked at to identify lessons learned and to improve processes. Only two of the eight local authorities told the Inquiry that incidents would be included on some form of local authority incident reporting system.

At five of the eight local authorities, we heard that incidents in the mortuary would be notified to director level. We were also told that, at three local authorities, incidents would not routinely be reported higher than director level unless it was judged that there was a risk of reputational damage, or the local authority was likely to receive complaints.

It is evident that there is variability in how local authorities respond to incidents in their mortuaries, and that not all incidents are being reported to the HTA when they occur.

Mortuaries licensed by the HTA are expected to have documented policies and SOPs governing all aspects of licensed activity. This includes access to the mortuary: *"Access to the mortuary should be strictly controlled with clear policies and procedures which protect bodies from harm and breaches of confidentiality."*[61]

The HTA's guidance says that SOPs *"should be a clear and accurate representation of an existing procedure or process"*. There should be a process of regular review by someone other than the author of the SOPs, with version control, and a system for recording that staff have read and understood the SOPs, among other requirements.[62]

All eight of the local authorities assisting the Inquiry's investigations provided SOPs relating to security and access. The Inquiry found variation in how the eight local authorities documented their policies and procedures in relation to security.

The Inquiry found variability in the level of detail provided in the SOPs in relation to restrictions on access and the security controls in place. In addition, not all SOPs made it clear where responsibility lies for mortuary security, the application of security controls, and routes of escalation.

Of the eight local authorities, only four provided security SOPs that made clear who had written and authorised them. At four local authorities, it was not clear that there was a process of authorisation for the SOPs.

60 HTA inspection report, HTA website.

61 HTA, Post-mortem licensing standards and guidance, GQ1, December 2024, HTA website.

62 Ibid.

What we have found

- Not all local authorities are conducting audits of CCTV inside their mortuaries, and they cannot therefore be assured that crimes like those of David Fuller are not occurring in their mortuaries. This indicates that there has been insufficient consideration by some local authorities of the risk that deceased people might be harmed by those working inside the mortuary, either deliberately or through non-compliant working practices.
- Shortfalls identified by the Human Tissue Authority in 2023 and 2024 related to oversight of access to the mortuary and/or security audits. This indicates little or no appreciation of the value of audits to identify both unauthorised and inappropriate access, and to reduce an over-reliance on trust in those working within the mortuary.
- Not all local authorities are identifying and reporting breaches of security to the regulator when they occur. Only one security-related Human Tissue Authority Reportable Incident was reported by local authorities in a two-year period. It is possible that there may be under-reporting of security-related incidents.
- While at five of the eight local authorities incidents are reported to director level, we have also heard that, at three local authorities, they are not routinely reported to a higher level within the local authority unless there is reputational risk. Only two of the eight local authorities have some form of internal incident reporting system where incidents in the mortuary are reported.
- There is variation in how the eight local authorities document their policies and procedures in relation to security. The Inquiry has identified instances where Standard Operating Procedures are inaccurate, lack detail or are incomplete.

6.4.4 Management arrangements of the mortuary

All eight of the local authority mortuaries assisting the Inquiry's investigations had a technically trained Mortuary Manager or senior APT. However, the Inquiry found variation as to whether the technically trained Mortuary Manager or senior APT was also the DI. At four of the eight local authority mortuaries assisting the Inquiry, this was the case, but at the other four the DI role was the responsibility of a local authority manager.

The DI has personal legal responsibility under the Human Tissue Act 2004 for ensuring the mortuary is fully compliant with HTA standards. In Phase 1, the Inquiry found that the DI's ability to influence and bring about change was limited at Maidstone and Tunbridge Wells NHS Trust. The Inquiry looked at whether this was also the case at HTA-licensed mortuaries provided by local authorities, and examined other challenges the DIs might be experiencing in the eight local authorities assisting the Inquiry's investigations.

At the time of the Inquiry's investigations, at four of the eight local authorities the DI role was filled by a local authority officer with wider responsibilities and no technical training in the work of the mortuary.

There was variation across these four local authorities in the level of seniority of the DI:

- At two, the DI was a senior officer at head of service level, reporting to a director.
- At two, the DI was a manager below head of service level and did not report directly to a director.

Of the two DIs below head of service level, one managed both the coroner's court and the mortuary, while the other managed bereavement services. In both cases, the DI directly line managed the technically trained Mortuary Manager or senior APT. Both DIs attended meetings with mortuary staff and spent time in the mortuary to varying degrees. One of the two DIs gave their reflections on the benefits of the separation of the DI and technically trained Mortuary Manager/senior APT roles:

> *"[O]ne of the reasons why I am the DI as opposed to the Mortuary Manager is we think that distinction is quite important to have. So, for myself, there's no sort of conflict if you like. So, if a mortuary manager themselves was a Designated Individual, they may be reluctant to report an HTARI, and some may be tempted to try and cover it up. From my point of view, I don't have those kinds of concerns, and in fact, it actually helps me, because I deal with all the complaints for the mortuary and the coroners."*[63]

The Inquiry found a similar arrangement at the second of the four local authorities with a DI below head of service level. The DI had recently taken on the role. This DI reported to a head of service, below assistant director level. The DI told the Inquiry that they spent a significant proportion of their time, *"60% to 70%"*, working inside the mortuary, and that they felt *"extremely stretched"* managing the mortuary alongside their other managerial responsibilities.[64] They also spoke of the importance of the separation of the technically trained Mortuary Manager/senior APT and DI roles. However, they did not appear to feel fully supported, and expressed concern about the personal legal responsibility that came with the DI role, given their relatively junior managerial status:

> *"I do struggle … I say glad I took it on, it was a case of the HTA saying, '… we think you are the better person to take this on.' Now, I understand from the previous Mortuary Manager being the Designated Individual that isn't, what's the word … it's not – I'm trying to think of the correct word. It's, they like checking their own work. So I can understand that me being the DI is a good thing. Do I feel supported internally? No. No. One of the things I find strange is that a DI is personally responsible. That I find strange when you've got Chief Execs, Directors, Assistant Directors, you know, Heads of Service and me. I find that strange how I could be personally responsible for somebody else's actions. I don't think, if I'm being honest, I don't think that's fair … Am I happy I've got it? I think so. And I say that I think so, because people are listening."*[65]

63 Witness transcript of A426, Designated Individual, September 2024.
64 Witness transcript of A352, Designated Individual, September 2024.
65 Ibid.

As noted above, at two other local authorities the DI role was held by a head of service – for example, the Head of Environmental Services – with a wide-ranging portfolio of services and responsibilities. Neither of these two DIs directly line managed staff in the mortuary. One of the two DIs was three reporting levels above the staff in the mortuary, while the other was two levels above. In both reporting chains there was a manager overseeing the operation of the mortuary who reported directly to the DI or was one step removed.

The Inquiry heard from one of these DIs that time and competing pressures were a factor in how much attention they could provide to the mortuary service. When asked if they felt close enough to the mortuary to fulfil the role of DI and ensure that the mortuary was compliant with HTA requirements, they said they felt that they were, but that their main challenge was having sufficient time to oversee the mortuary:

> *"Yes. Time wise, it's difficult … Influencing and changing the culture and the SOPs and everything, not a problem, we can do all of that. Time is an issue, as it is in all jobs now."*[66]

This DI told the Inquiry that some aspects of mortuary oversight, such as audits of staff compliance with SOPs, had not taken place due to other pressures:

> *"We used to do more audits, but since we've reduced in numbers and the workload's gone up, we do less audits … it comes down to we have lots of pressures, particularly around Covid, and some of these things just stopped and they haven't been reinstated."*[67]

This DI told the Inquiry that another limiting factor of their effectiveness as DI was finance. This was not in relation to lack of access or influence, as they felt they had the support of their director, but was due to the local authority's financial situation.[68]

The second DI, who was a senior manager, was asked if they had enough time to fulfil the role of DI. They said that they had confidence in the staff within the mortuary and the local authority managers below them to manage the mortuary:

> *"I think I've got a great team. I've got two fantastic technicians. [The Bereavement Services Manager] manages the team. [The head of service] oversees from a strategic and manager … and I've got confidence that we're managing the facility in the way that it should be, with respect and dignity, and if I didn't have that confidence, then I would do something about it."*[69]

This DI did not attend mortuary governance meetings but had weekly meetings with the two local authority managers below them, who oversaw the mortuary service. The DI explained that they had access to a weekly directorate leadership meeting where matters relating to the mortuary could be raised. The DI also chaired an operational health and safety group, which reported to a strategic health and safety

66 Witness transcript of A293, Designated Individual, September 2024.
67 Ibid.
68 Ibid.
69 Witness transcript of A520, Designated Individual, November 2024.

board. The DI explained that this access to senior officers in the local authority meant they could try to overcome barriers to progress.

Both DIs reported to a director in the local authority, with whom they had regular contact. One told the Inquiry that they felt well supported and that they could approach the Chief Executive of the local authority if necessary.

The other DI also felt supported by senior officers within their local authority, and gave an example of having their support in securing funding for improvements in the mortuary:

> *"100%. And I think an example of that is the [funding] that we needed to carry out the repairs and recommendations as part of the HTA recommendations, and that was supported by senior managers and the money was secured."*[70]

All four of the non-technically trained DIs told the Inquiry that they had taken on the role of DI in an unplanned way after previous DIs had left the organisation or could no longer fulfil the role. One acknowledged that this was a risk, given how 'niche' the role was, as there was no planned succession for it among other local authority officers.

All four were aware of their regulatory responsibilities as DI. A view from one DI was that the legal responsibility for compliance with HTA regulatory requirements should lie with the local authority, as this would place the imperative on them rather than the DI personally. Chapter 11 explores this issue further.

What we have found

- Local authority officers at differing levels of seniority hold the position of Designated Individual. Some Designated Individuals are more removed from the direct reporting line for the mortuary service than others.
- Designated Individuals in senior positions within the local authority feel able to influence change. However, there are limitations to their role in securing funding where financial resources are limited and needs are not directly linked to a regulatory requirement.
- Where the Designated Individual is a local authority manager outside the mortuary, this can increase the visibility of the mortuary among senior officers within the local authority.
- There is variation among those who hold the position of Designated Individual at a more junior managerial level in how well they feel supported.
- Some but not all Designated Individuals expressed concern about the amount of time they have to oversee the mortuary, given other competing responsibilities.

At four of the eight local authorities assisting the Inquiry's investigations, the technically trained Mortuary Manager or senior APT was the DI.

70 Ibid.

There was variation across the four local authorities in the seniority of the officer to whom these DIs reported:

- At one local authority, the DI reported to a director. This DI was shared across two of the four local authorities. At the other local authority where they were DI, they reported to a more junior officer.
- At the other two of the four local authorities, the DI reported to local authority managers two or three levels below the director.

This variation was illustrated in the shared DI arrangement between two of the local authorities assisting the Inquiry's investigations. Here, one individual fulfilled both the technically trained Mortuary Manager and DI roles at the mortuaries provided by two local authorities. However, the DI had very different reporting lines at each of the local authorities. At one, the DI reported directly to a director, while at the other the DI reported to *"middle management"*:

> *"[B]ecause I report to a director, I get access to the director level of individuals, so for example, most senior health and safety individuals in the council, public health, etc, etc. [and at the other local authority] middle management over there. So, in order to get, you know, my needs met faster, I have to then communicate up … you know, why this is important, then they will communicate up to someone senior if I need more support. So, they just work differently, to be honest."*[71]

The DI told the Inquiry that, at the local authority where they reported to a director, the senior leadership was interested and engaged in the mortuary service. The DI told the Inquiry that, alongside their director, they met with the coroner on a regular basis. However, the Inquiry observed that the director was largely reliant on the DI to ensure the mortuary service was compliant with regulatory requirements:

> *"**Q:** How do you assure yourself that [the DI] is following the relevant protocols and HTA requirements, for example?*
>
> ***A:** Well, other than the HTA raising concerns, I mean, I'm also on that licence as a [Licence Holder]. So, the two of us are on there, and I, you know, also have a relationship with the HTA. But other than that, you know, I'm wholly reliant on [the DI] as the mortuary manager.*
>
> ***Q:** So how do you, as a local authority, assure yourself that the staff are following the standard operating procedures?*
>
> ***A:** Well, again, I'd be reliant on [the DI] to ensure that that's taking place. I mean, I know that we've provided you [with] a number of our standard operating procedures, and these have been worked up over time, sometimes as a result of issues being flagged by the Human Tissue Authority.*
>
> ***Q:** Can you explain how you would go about identifying any risks around security, and how you would then subsequently manage any risks that you'd identified?*
>
> ***A:** Again, from my perspective, I would be kind of wholly reliant on [the DI] as the manager to satisfy [themself] about the security arrangements."*[72]

71 Witness transcript of A113, Designated Individual, September 2024.

72 Witness transcript of A433, director, September 2024.

The director told the Inquiry that they looked to biennial audits of the mortuary service by professional auditors and inspections by the HTA to identify any issues with the operation of the mortuary.[73] However, it was clear that there was considerable reliance on the DI. While this arrangement enabled the DI to have direct access to senior officers, and therefore better lines of direct communication and personal influence, the Inquiry questions whether an important tier of management assurance was missing.

At the second local authority where this individual was the DI, the mortuary did not appear to be as visible to senior officers. The DI reported to a local authority manager two management levels below the director. The manager told the Inquiry that there was no routine reporting in relation to the mortuary (though the Inquiry is aware that a quarterly report has subsequently been introduced) and that, although they took issues relating to the mortuary to their head of service, it was not clear to them if these would be reported any higher:

> *"[W]hat I do is if I have issues, I take them to my head of service. Whether head of service escalates beyond that, I'm not entirely sure."*[74]

At this local authority, it was apparent that the DI did not have the same lines of direct communication with director-level officers and the same level of personal influence.

The DI told the Inquiry that they felt well supported in their dual role: *"I do feel adequately supported by my management, and they're aware of all of my challenges and concerns."*[75]

Both of the two other technically trained DIs said they felt supported in their role as DI.[76]

At one of these local authorities, changes had been made to assurance arrangements following an HTA inspection. Quarterly compliance meetings had been introduced between the DI and the Coronial Services Manager, and with the director.

The Coronial Services Manager told the Inquiry that they felt it was important to make a distinction between operational and corporate responsibility for maintaining compliance with the statutory requirements of the HTA. However, while we have seen that other local authorities have made this distinction by having a non-technically trained DI at a reporting level above the staff in the mortuary, at this local authority the DI was the senior APT:

> *"[O]n a day-to-day basis it's [the senior APT], on a corporate basis it's [the director], and you have to have that split. Because [the senior APT] is doing the work, [they] cannot mark [their] own homework … So, from an operational procedure, [the senior APT] writes the SOPs, [and] says, 'This is how I want to run it' and we will only intervene if we think that exposes the council to too much risk. Or doesn't fulfil any of our statutory obligations or places the dignity and care of the deceased or their loved ones at risk."*[77]

73 Ibid.
74 Witness transcript of A295, local authority manager, September 2024.
75 Witness transcript of A113, Designated Individual, September 2024.
76 Witness transcripts of A424, Designated Individual, September 2024; A430, Designated Individual, September 2024.
77 Witness transcript of A453, Coronial Services Manager, September 2024.

At this local authority, the director was two management levels above the DI. While the DI met weekly with their direct line manager, they only attended meetings with the director on a *"case by case basis"*.[78] The DI's main contact with the director appeared to be limited to the quarterly compliance meetings, which had only recently been introduced.

The DI was unsure of reporting lines above the director and had little contact with senior officers at the local authority, telling the Inquiry that a visit to the mortuary by senior officers a couple of years earlier was *"the first time ever I've known"*:

> *"I'm clear in that it [reporting] goes further up the chain … But I don't know the direct steps as to whether that's directly from [the director] to the leader of the council or not."*[79]

The DI at this local authority appeared to have limited ability to influence or make decisions, with decisions being taken above them. The Coronial Services Manager told the Inquiry:

> *"I think in some areas [the DI] will probably say [they are] frustrated and would want to do things in a slightly different way. But we understand the corporate risk and how that fits."*[80]

Similarly, at another local authority, the key relationship appeared to be between the director and the head of service, rather than the director and the DI:

> *"**Q:** Could you explain for us where responsibility lies for ensuring that the mortuary complies with HTA requirements?*
>
> ***A:** Ok, so on a day-to-day basis that lies with … as the Head of Service and the licence holder … If there was an issue … it would sit with me … I would have those discussions with [the Head of Service], and I get the assurance from [the Head of Service]."*[81]

This director explained that they had weekly one-to-one meetings with the head of service. It was the head of service who provided assurance that SOPs were compliant and who reported to the relevant local authority committee on a monthly basis. It was the DI who held personal legal responsibility for ensuring the mortuary was compliant with HTA requirements, but the director did not acknowledge this.

What we have found

- There is variation between the four local authorities in the seniority of the local authority officer to whom the technically trained Designated Individuals report. Some Designated Individuals have limited contact with senior officers and limited ability to influence or make decisions.
- Only at one local authority does the technically trained Designated Individual report to director level. This arrangement enables the Designated Individual to have better lines of communication and personal influence. However, the Inquiry has observed an over-reliance on the Designated Individual to ensure compliance with Human Tissue Authority standards.

78 Witness transcript of A423, director, September 2024.
79 Witness transcript of A424, Designated Individual, September 2024.
80 Witness transcript of A453, Coronial Services Manager, September 2024.
81 Witness transcript of A429, director, September 2024.

The HTA corporate Licence Holder does not bear the personal legal responsibility of the DI to ensure compliance with HTA requirements, but they have other obligations. The Licence Holder has the right to apply to the HTA to vary the licence and to substitute another person as DI. The HTA's preference is for the Licence Holder to be more senior than the DI.

At all eight local authorities assisting the Inquiry's investigations, the named Licence Holder was more senior than the DI. However, there was variability in the seniority of the named Licence Holder. At four local authorities, the named Licence Holder was at director level. At the remaining four local authorities, the named Licence Holder was below director level – and, at one of these, the named Licence Holder was below head of service level. At this local authority, the Licence Holder told the Inquiry that there was no routine reporting in relation to the mortuary, and it was not clear if issues relating to the mortuary would reach director level.

Where the Licence Holder is at a lower managerial level, this may impact the visibility of the mortuary within the local authority.

The role of the DI is also discussed in Chapter 11.

What we have found

- Arrangements for the role of the Designated Individual and the named Licence Holder vary considerably across local authorities providing mortuary services licensed by the Human Tissue Authority.
- In some local authorities, the legal responsibility for meeting the Human Tissue Authority's statutory requirements that comes with the Designated Individual role is held at a junior managerial level, potentially impacting the visibility of the mortuary within the local authority.
- Organisational hierarchies can impact the Designated Individual's access to senior officers and their ability to influence change and decision-making. Designated Individuals in some local authorities have significant personal legal responsibility but limited ability to effect change.
- Some Designated Individuals feel isolated, with little or no training in their role.
- Regardless of whether the Designated Individual is technically trained or not, there is a need to assist them with robust governance and assurance processes to ensure they are adequately supported. Peer networks provide an opportunity for both local authority managers and technically trained Designated Individuals to access support and technical guidance.

6.4.5 Governance of the mortuary and where scrutiny takes place

Local authorities operate according to one of three models of governance: a leader and cabinet; a committee system; or executive arrangements with a directly elected mayor.[82] All three models were represented in the eight local authorities assisting the Inquiry's investigations. In general, it is the role of officers of the local authority to manage and deliver policies and services, while elected councillors provide leadership and direction and scrutinise the delivery of services.[83]

We asked the eight local authorities assisting the Inquiry's investigations to provide evidence of discussions at local authority committee meetings of the issues raised by the David Fuller case. None of the eight local authorities provided this documentation. This indicates that there has been no discussion at council committee meetings attended by elected members of the matters raised by the David Fuller case, or of any implications for mortuary services, at any of the eight local authorities.

In relation to scrutiny of the mortuary service by elected members, three of the eight local authorities told the Inquiry that issues related to the mortuary were not routinely reported to any council committees.

A manager at one of these three local authorities told the Inquiry:

> *"I've never taken anything to any committee about the running of the mortuary … it's a well-established service and our governance is our governance. I've not necessarily taken anything above my head of service in terms of mortuary management. If we need to try and get bids for money, I might take a report to a committee for the allocation of funds, but I don't … regularly take anything to anyone other than my head of service."*[84]

This manager later told the Inquiry that a routine quarterly report on the mortuary had subsequently been introduced, and that this went to the corporate management team and beyond to elected members:

> *"In terms of reporting, so it's a new thing, it's not something that we did previously, but we take a quarterly report … up to corporate management team, which is the chief exec and corporate directors, then through to [elected members]. We report number of cases, number of postmortems and sort of several bits of analysis of some of the data related to the mortuary, HTARIs, etc. so anything that pops up that would be of value to that report is included."*[85]

An assistant director at another of the three local authorities acknowledged that the mortuary was not scrutinised at any committee. They told the Inquiry that they felt this needed to be addressed, but were unsure where scrutiny would best take place:

> *"[A]t the moment, there is no committee that the mortuary gets raised at … I think that has to be done as a priority, because it doesn't matter what the business model is, it still needs to be an accountable committee, I think, to be overseeing what's*

82 Good Governance Institute, *Local government governance explained*, January 2022.
83 Ibid.
84 Witness transcript of A295, local authority manager, September 2024.
85 Witness transcript of A295, local authority manager, March 2025.

happening … I think Scrutiny, Overview and Scrutiny could be the sensible place. Because ultimately, that's what they're there for is to really dig deep into a service to really understand and ask the difficult questions. Because, you know, as officers, you can give a glowing sense of a service when, actually, it could be quite broken underneath. So, Scrutiny call it in and have a look. Having said that, Scrutiny would only look at it once a year. So, we perhaps need a more operationally focused committee for that to fit in. Whether that could be Health and Safety, whether that could be Safeguarding, I think we just need to think about that a little bit more, and then get the wheels in motion."[86]

At the mortuary operated by this local authority, the HTA identified critical and major shortfalls against its standards during an inspection.[87] The assistant director told the Inquiry that, due to the reputational risk, they had escalated the outcome of the HTA's inspection to their director and the Chief Executive and had provided a written briefing to the relevant cabinet member. However, the findings of the HTA inspection and the actions the local authority took to achieve regulatory compliance were not subject to scrutiny within the local authority's committee structure.

Local authority officers at four of the eight local authorities told the Inquiry that matters relating to the mortuary would be discussed at committees:

- At two of these local authorities, discussion would be at the audit committee. However, an officer at one of these local authorities told the Inquiry that the mortuary would only be discussed if professional auditors concluded there was low assurance of the service.
- At the other two local authorities, matters would be discussed at relevant committees. However, an officer at one of these local authorities told the Inquiry that this would only happen if matters were judged to require escalation. An officer at the second local authority told the Inquiry that matters such as the outcome of regulatory inspections were not raised at the committee.

At one of the eight local authorities, it was not clear if the mortuary would be discussed at any committees.

One of the four local authorities mentioned above operated to a committee system of governance. Here, local authority officers with oversight of the mortuary reported regularly to a committee. A director explained that the head of service (who reported to the director) met monthly with the full committee to report on matters in relation to the services that they oversaw, including bereavement services, coronial services and the mortuary.[88]

86 Witness transcript of A442, assistant director, September 2024.
87 HTA inspection report, HTA website.
88 Witness transcript of A429, director, September 2024.

Despite these regular meetings, the director told the Inquiry that the mortuary was not discussed frequently at the committee. In addition, while matters that impacted the mortuary (such as the introduction of the statutory medical examiner system) had been discussed in recent months, an HTA inspection of the mortuary that identified major shortfalls against the HTA's standards had not been discussed:

> *"It's not reported into committee currently, actually.*
>
> ***Q:** Is that something that will be considered?*
>
> ***A:** I think if we have an inspection, we should present – because it's a public report anyway. So, there's no reason why we shouldn't take a report to our committee to put that into the public domain to make them aware. So yeah, I think that's something that we could well introduce."*[89]

The directors at two of the four local authorities told the Inquiry that the mortuary would be scrutinised by the audit committee. One of these directors explained that, although the mortuary service was audited by professional auditors *"at least every two years"*, it would be scrutinised by the audit committee only if the audit identified a low degree of assurance:

> *"[T]he audit findings can give reasonable assurance, no assurance, limited assurance, you know, or high assurance. If we're in the realms of low or no assurance at all, then those would be red flagged and would be reported to the audit committee for member oversight as well. And that is a statutory committee, audit committee, the name would suggest have oversight of audit reports and would be particularly focused on those that are not providing sufficient assurance back to the authority."*[90]

The director advised us that, in eight years in their role, they had not been aware of *"any audit reports on the mortuary service that have raised significant concerns or provided, you know, any sort of concerns that would raise members' interest in focusing on the mortuary particularly"*.[91]

The director at the second local authority advised that audits of the mortuary by professional auditors were provided to the audit committee. The director advised that, in addition to the audit committee, matters relating to the mortuary reached elected members through the relevant cabinet member.

Cabinet members are elected councillors appointed to cabinet and have portfolio responsibility for specific areas of local authority services, including the mortuary. Cabinet members provide oversight and can escalate matters to the leader of the council or to the elected mayor if they consider it necessary.

Seven of the eight local authorities assisting the Inquiry had a relevant cabinet member with portfolio responsibility for the mortuary. However, not all seven local authorities had a regular reporting process that provided assurance in relation to the mortuary to the relevant cabinet member. The Inquiry found that two did not.

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89 Ibid.

90 Witness transcript of A433, director, September 2024.

91 Ibid.

At one of these, the director told the Inquiry that, following an HTA inspection that had identified a number of shortfalls, and the subsequent introduction of strengthened assurance processes, regular briefings to the relevant cabinet member were to be introduced:

> *"I think we are pretty much agreed, and we will make recommendations to make sure that there is a standard reporting process going into the cabinet member … and we're also talking about that going up a level, above me, into exec director level."*[92]

The remaining five local authorities with a relevant cabinet member told the Inquiry that there was regular engagement with the relevant cabinet member, through briefings, meetings or both. However, there was variation in how assurance in relation to the mortuary was provided:

- Two local authorities told the Inquiry that a monthly report was provided to the relevant cabinet member; one of these provided written briefings demonstrating that the mortuary was routinely reported to the cabinet member as a standing item. Matters reported included actions taken to strengthen security, staffing and HTA inspections.[93]
- At another local authority, the director described an arrangement whereby the relevant cabinet member was briefed on a weekly basis on matters across their portfolio that required approval.[94]
- Two other local authorities told the Inquiry that regular meetings were held with the relevant cabinet member, with matters relating to the mortuary raised when necessary.[95]

The relevant cabinet member may have a wide portfolio comprising a number of areas of local authority responsibilities and services, as explained by a director at one of the five local authorities:

> *"The whole of the resources of the authority fall under this particular portfolio lead, which is primarily focused on sort of back-office services, finance, legal, audit, insurance, those sorts of things, but because the mortuary service sits within my suite of services, it also comes under that resources portfolio lead."*[96]

The director went on to say that discussions in relation to the mortuary might be brief and not operationally focused:

> *"So what I was saying was that our cabinet portfolio lead is primarily concerned about the income that the mortuary is able to generate … less so about the sort of operational service delivery down there. I mean, that's not to say [they are] not interested … but with all the other aspects of my role, we don't tend to dwell too much on the mortuary, it's a small part of the overall bigger picture."*[97]

92 Witness transcript of A423, director, September 2024.
93 Briefing note for cabinet member for the public realm, July 2024.
94 Witness transcript of A512, director, November 2024.
95 Witness transcripts of A422, director, September 2024; A433, director, September 2024.
96 Witness transcript of A433, director, September 2024.
97 Ibid.

A director at another local authority explained that discussions with the relevant cabinet member encompassed both the coroner service and the mortuary. The focus was on ensuring that these were adequately resourced to meet the needs of local communities – for example, through access to pathologists and the provision of digital autopsy.[98]

The nature and breadth of the portfolio of the relevant cabinet member depend on how the local authority structures and organises its responsibilities and services – for example, into directorates. As this is for each local authority to determine, there is variation across local authorities as to where in the organisation the mortuary is placed.

What we have found

- The Inquiry has found no evidence that matters raised by the David Fuller case, or any implications for the delivery of the mortuary service, have been discussed at council committees of elected members in any of the eight local authorities assisting the Inquiry.
- Matters relating to the mortuary are not reaching committees of elected members in some local authorities. The Inquiry has found evidence that, in one local authority, inspections by the Human Tissue Authority are not being reported to committees of elected members, despite the mortuary being a regulated service.
- There is variation in the assurance provided to the relevant cabinet member (where local authorities operate this model of governance), with matters relating to the mortuary raised by exception in some local authorities.

Across the eight local authorities assisting the Inquiry's investigations, there was variation in where the mortuary service was placed within local authority governance structures. In some local authorities, the mortuary sat alongside services in relation to the environment or communities, such as waste, parks, estates and open spaces, cemeteries and bereavement services, leisure and libraries. In others, the mortuary sat alongside health and safety, regulation and enforcement, public safety or democratic services.

The Inquiry has made no assessment of where the mortuary is best placed within local authority organisational structures.

In the documentation provided to and interviews conducted by the Inquiry, only one of the eight local authorities demonstrated involvement by the Director of Public Health. This related to their attendance at two meetings where the mortuary was discussed, as set out later in this chapter. This is surprising, given the Director of Public Health's role in relation to public health protection and emergency preparedness. The Inquiry also noted very limited evidence that governance of the mortuary service was aligned with other health-related regulatory activity within local authorities.

98 Witness transcript of A422, director, September 2024.

An HTA-licensed mortuary service is a complex, statutorily regulated service. While it is the DI who is responsible for ensuring compliance with the statutory and regulatory requirements, they have to do so within the governance framework of the local authority.

The Inquiry heard more than once that local authority managers had no knowledge of or expertise in running a mortuary service. One director told the Inquiry that, wherever the mortuary was placed in local authority governance structures, the manager overseeing it would be reliant on those working in the mortuary:

> *"I'm wholly reliant on … the mortuary manager. I've got no operational knowledge in terms of how that facility would run operationally. I'm not an APT. I'm a local government lawyer that happens to manage this particular service, and this service doesn't always sit underneath a lawyer. It can sit in a whole range of other services, potentially, and whoever ultimately has that line management responsibility would be in exactly the same position as me."*[99]

Three local authorities assisting the Inquiry had experienced inspections by the HTA where the regulator identified non-compliant working practices, such as leaving deceased people in unrefrigerated conditions overnight and conducting evisceration prior to external examination. These findings demonstrate how reliance on those working within a mortuary can be misplaced and can compromise the security and dignity of the deceased.

Some of the mortuaries assisting the Inquiry's investigations were small facilities with very limited staff numbers, and some had longstanding members of mortuary staff who had worked in the mortuary for a considerable time. In these circumstances, and given the lack of technical knowledge and expertise of local authority managers overseeing mortuary services, it was concerning that the Inquiry heard at a seminar for DIs that there were limited opportunities for continuing professional development.[100] This is discussed in more detail in Chapter 11.

While the Inquiry observed some evidence of learning from others – for example, at meetings of Mortuary Managers in a particular area, or local authority managers across a coroner area – there was little evidence of engagement across local authority mortuaries at a governance level. Some of the eight local authorities assisting the Inquiry had considered organising a peer review of their mortuary, but only one had arranged for this to take place. The Inquiry heard of a sense of isolation in relation to HTA-licensed mortuaries provided by local authorities:

> *"I always think in public mortuaries, you're a little bit out of the loop. Maybe hospitals you've got a bit more of a communication network. But for me, public mortuaries, you're a little bit on your own as a DI."*[101]

An HTA-licensed mortuary service is akin to providing a clinical service. However, local authorities do not have the sort of governance structures that underpin the delivery of

99 Witness transcript of A433, director, September 2024.

100 Inquiry seminar for Designated Individuals, November 2024.

101 Witness transcript of A424, Designated Individual, September 2024.

clinical services within the NHS, nor the routine presence of senior executives with clinical training and expertise as seen in a hospital setting.

Without this governance framework, it is essential that local authorities have robust governance and assurance arrangements in place to ensure the delivery of a high-quality and statutorily compliant service. The Inquiry considers the governance of the mortuary service by officers of local authorities in the next section of this chapter.

What we have found

- There is variation in where the mortuary is placed within local authority governance structures.
- The Inquiry has seen limited evidence that governance of the mortuary service is aligned with other health-related regulatory activity within local authorities.
- Some local authority managers have no knowledge of or expertise in the running of the mortuary service and are overly reliant on staff working in the mortuary. This means that non-compliant working practices that compromise the security and dignity of the deceased may not be identified.
- There is limited evidence of engagement at a governance level across local authority Human Tissue Authority-licensed mortuaries, and a sense of isolation at some. At the time of writing, only one local authority had arranged for a peer review of their mortuary.
- Local authorities do not have the sort of governance structures that underpin the delivery of clinical services within the NHS.

It is the role of officers of the local authority to manage and deliver policies and services as determined by the elected members.

We asked the eight local authorities assisting the Inquiry to provide minutes of governance meetings concerning the mortuary:

- Three local authorities did not provide any minutes or documents relating to oversight of the mortuary within the local authority.
- Five local authorities provided documents relating to meetings held at mortuary level that were attended by the DI:
  - One local authority also provided documentation relating to meetings attended by managers (below director level) who oversaw bereavement services, the coroner service and the mortuary.
  - Two local authorities also provided documents of meetings regarding the coroner service, where matters relating to the mortuary were discussed.

Only one local authority provided documents relating to discussions about the mortuary by local authority officers at senior leadership level. These discussions were in relation to the publication of the Inquiry's Phase 1 Report and an HTA inspection of the mortuary.

This local authority shared the minutes of a Strategic Leadership Team meeting where a briefing took place on the lessons learned following publication of the Phase 1 Report.[102] The meeting was attended by the Chief Executive and directors of the local authority, including the Director of Public Health. It was chaired by the Director for Audit, Fraud, Risk and Insurance, who, the minutes report, asked that the action plan resulting from the HTA inspection be brought to a subsequent meeting.

The local authority also provided the minutes of a meeting of a statutory accountabilities board in December 2021, where a report was received on *"the measures in place and changes made as part of a review of security of mortuaries following a serious incident in Kent"*.[103] This meeting was chaired by the Chief Executive and attended by director-level officers of the local authority, including the Director of Public Health.

The director at this local authority told the Inquiry that they received assurance in relation to the mortuary service through monthly briefings, as well as internal audits and inspections by the regulator.[104] The local authority was the only one of the eight to provide evidence of having arranged a peer review of the mortuary.

In interviews with local authority managers, the Inquiry heard that matters relating to the mortuary reached director level at seven of the eight local authorities. At these seven local authorities, matters relating to the mortuary were discussed at meetings between the director and the staff below them who oversaw the mortuary service, or were included in written briefings to the director. At the eighth local authority, it was not clear if matters relating to the mortuary reached director level. However, the Inquiry was subsequently made aware that a quarterly report on the mortuary had been introduced.

We heard that directors had regular contact with senior leadership at five local authorities. At all five, matters relating to the mortuary were reported above director level when this was judged necessary – for example, when there was an issue or an event, such as an HTA inspection.

At one local authority, the assistant director prepared a monthly briefing for the director that included *"anything of note"* on the mortuary, which the director used to brief the Chief Executive and the relevant cabinet member.[105] For example, the outcome of an HTA inspection that identified critical and major shortfalls was escalated to the director, Chief Executive and relevant cabinet member *"because we have a process where if there's anything that's likely to impact our reputation, so reputational damage or anything else, we have to escalate it"*.[106]

The directors at two local authorities told the Inquiry that they had frequent contact with the senior leadership of their local authority and the relevant cabinet member, and that matters relating to the mortuary would be discussed if needed.

102 Strategic Leadership Team (Assurance), April 2024.
103 Statutory accountabilities board – DRAFT notes and actions, December 2021.
104 Witness transcript of A425, director, September 2024.
105 Witness transcript of A442, assistant director, September 2024.
106 Ibid.

At one of these local authorities, the director said in relation to HTARIs:

> *"It depends on the nature of it. If I felt that it was something that the chief exec or the leader or the relevant portfolio [lead] needed to be sighted on, then I would obviously sight them on it. But that would be a judgment call for me."*[107]

The director explained that the outcome of regulatory inspections by the HTA would be made known to senior leadership if they felt this was necessary – for example, if there was reputational risk:

> *"Depending on the nature of the issues that the HTA has flagged, I mean, if we're dealing with something relatively minor, it would be [the DI] producing evidence to me that all the issues that have been raised have been responded to, and then getting evidence that the HTA have signed off on that and are comfortable, content, that the actions have been properly closed off … If it's more of a sensitive issue, e.g. in relation to some of the concerns they'd raised around fridge controls, I did flag that at the time with the Chief Executive and with the leader, because we were concerned about any adverse publicity around that."*[108]

The director at the second local authority told the Inquiry:

> *"I will brief the cabinet member of … any issues of concern. I would then write a briefing paper to the [Strategic Director] … or to the Chief Executive to consider at our corporate leadership team if [they] needed to be concerned. I'd write a briefing paper to the … Director of Finance if I need to and I would alert the leader [of the council] through informal cabinet or cabinet, it depends what the issue is."*[109]

The DI at this local authority told the Inquiry that there was no routine reporting to senior leadership in relation to the mortuary, and that matters were raised by exception.

At another local authority, the Corporate Director felt that they were not adequately sighted on important matters relating to the mortuary.

The Corporate Director explained that key performance indicators (KPIs) and milestones for statutory services provided by the council were reported to the corporate management team on a quarterly basis, and beyond to elected members. The Corporate Director had been in post for only eight months, but said that they had not seen any such reports relating to the mortuary:

> *"I've not seen anything in my eight months that would give me assurance that we're meeting our statutory duty in our mortuaries."*[110]

An inspection by the HTA prior to the Inquiry's interviews identified critical and major shortfalls at this mortuary. The Corporate Director had been briefed on the inspection, saying that *"there was something … raised recently, and I think that was dealt with at a*

107 Witness transcript of A433, director, September 2024.
108 Ibid.
109 Witness transcript of A422, director, September 2024.
110 Witness transcript of A432, Corporate Director, September 2024.

local level", but had not seen the report itself. They felt they should have received a more detailed report.

The Inquiry was subsequently told that a quarterly report on the mortuary had since been introduced, which was seen by the corporate management team.[111]

What we have found

- While directors have frequent access to senior leadership, there is no routine reporting in relation to the mortuary above director level in some local authorities. In these, matters in relation to the mortuary are reported by exception – for example, when there is reputational risk or an event such as a Human Tissue Authority inspection.
- Despite the mortuary being a regulated service, the reports of regulatory inspections are not visible to senior leadership in all local authorities providing a Human Tissue Authority-licensed mortuary.

The HTA's post-mortem standards require that *"all aspects of the establishment's work are governed by documented policies and procedures"*.[112] Regular review or audits of the mortuary SOPs are essential to ensure that the working practices of the mortuary are compliant with the HTA's requirements. The HTA's guidance in relation to standard GQ1(d) says:

> *"Regular review of SOPs will help to prevent incremental departure from written processes with passing time and allow establishments to identify improvements."*[113]

In addition, HTA standards require that there is a documented schedule of audit to ensure that staff are working in compliance with the SOPs.[114]

A regular schedule of audit of the SOPs, and staff compliance with them, can provide assurance to senior managers that the mortuary service is operating in ways that are compliant with the regulatory standards. However, the Inquiry found that the results of audits reached assistant director or director level in only three of the eight local authorities assisting the Inquiry's investigations.

In interviews, the Inquiry was told that audits of the mortuary SOPs were undertaken in six of the eight local authorities assisting the Inquiry's investigations. At three of these, we heard that there had been significant work in recent years to review and update the SOPs following HTA inspections.

In its most recent inspections of the eight mortuaries assisting the Inquiry, the HTA identified critical and major shortfalls in relation to SOPs[115] at six mortuaries. At five of

111 Witness transcript of A295, local authority manager, March 2025.
112 HTA, Post-mortem licensing standards and guidance, GQ1, December 2024, HTA website.
113 HTA, Post-mortem licensing standards and guidance, GQ1(d), December 2024, HTA website.
114 HTA, Post-mortem licensing standards and guidance, GQ2(a), December 2024, HTA website.
115 HTA, Post-mortem licensing standards and guidance, GQ1, December 2024, HTA website.

the eight, it also identified major shortfalls in relation to a schedule of audit to check compliance with the SOPs.[116]

A director at one local authority told the Inquiry that they and another manager had been *"working really hard for the last 2, 2.5 years to put measures in place to get the service operating procedures into a better place"*. The director explained:

> *"[O]ne of the recommendations from the HTA inspection both in [year] and [year] was that the service operating procedures are in place, but they are written and audited by the same … person i.e. [the DI]. And so there have been measures put in place to make sure they're reviewed, I believe by [another manager] as well."*[117]

The director also explained that they sought assurance from the manager reporting to them that all SOPs for the services in their portfolio, including the mortuary, had been reviewed:

> *"We have an annual governance framework … that we use in the local authority that means that each year I talk to [the managers who report to the director] about service operating procedures. I don't necessarily check them all, but I will say to [them] 'are your service operating procedures up to date?' I will sample some, but that's across all of my services … but each year the [managers will] just provide me with that assurance that I can say, yes, as part of our annual governance, service operating procedures are up to date, emergency plans are up to date, business continuity is up to date and so on."*[118]

At a second local authority, strengthened assurance processes had been put in place following an HTA inspection that identified critical and major shortfalls. Among these shortfalls, the HTA found that procedures to monitor the condition of the deceased, and to ensure suitable follow-up action where the condition of the deceased had deteriorated, were not contained within the body storage SOP, with increased risks of damage to the deceased.[119]

The Coronial Services Manager explained that one critical shortfall *"was around lack of robustness in a couple of SOPs",* yet told the Inquiry:

> *"I'm fairly comfortable and confident in the SOPs because they tend to be quite easy to write. If you're clever you just do a bit of cut and pasting from someone else that you know runs a good mortuary and then you just kind of [personalise] that, just to make sure it's focused."*[120]

The Coronial Services Manager told the Inquiry that a schedule of review of the SOPs had been introduced:

> *"So, the HTA audit last year, I think, triggered a review of a number of the SOPs … What we've now got is a process where we go, 'These are the ones that are due for*

116 HTA, Post-mortem licensing standards and guidance, GQ2, December 2024, HTA website.
117 Witness transcript of A429, director, September 2024.
118 Ibid.
119 HTA inspection report, HTA website.
120 Witness transcript of A453, Coronial Services Manager, September 2024.

review in the next quarter'. They need to be done one month before the end of that quarter, so that when I come and do my audit, I can go on there and go 'That's there'. So, all the SOPs now sit in one place. We've pulled together a standard register of them all, so we actually know when everything is due for that, and we just put a marker in everyone's diary, 'Reviews due'." [121]

This local authority's strengthened assurance processes involved the introduction of quarterly compliance meetings at director level, attended by the DI and the Coronial Services Manager, where the performance of the mortuary and its compliance in relation to HTA requirements were reviewed:

"So, the whole idea is we have that quarterly compliance in one place. [The director], as a representative of the corporate body then has a real understanding actually, where we are, and we agree the actions … But also, that's a way of linking it back to [the DI], so [the DI] sits in now so [the DI] can understand that context of the work that we do." [122]

*"**Q:** Was anybody in the council listening to issues of compliance around HTA then?*

***A:** Yes, but not to the same extent as now. So I met [the Coronial Services Manager's] predecessor on a weekly, sometimes fortnightly basis, and we would go through those broader HTA standards … I think the approach that we're developing now, I think the important point that [the Coronial Services Manager] mentioned is pulling that altogether, so it's in one place, and there's a coherent and absolutely clear standard, and a rhythm, if you like, going forward, in terms of weekly, monthly and quarterly."* [123]

At a third local authority, an HTA inspection identified critical and major shortfalls that included, again, a lack of documented procedures such as monitoring the condition of deceased people in the mortuary. It also identified non-compliant working practices relating to the inappropriate storage of deceased people prior to PME.[124]

Three of the shortfalls related to findings from a previous inspection five years earlier, indicating a failure to address those shortfalls and introduce more robust assurance processes to ensure that working practices in the mortuary were compliant.

These findings came as a surprise to the relatively new assistant director:

"I thought we would have some recommendations to improve practice. But, yeah, I was quite shocked by the extent of what they [the HTA] brought to our attention." [125]

The lack of documented procedures and the non-compliant working practices identified by the HTA could have been picked up by the local authority through a process of audit. However, the assistant director told the Inquiry that, prior to the HTA inspection, regular audits of compliance with the SOPs had not been carried out:[126]

121 Ibid.
122 Witness transcript of A453, Coronial Services Manager, September 2024.
123 Witness transcript of A423, director, September 2024.
124 HTA inspection report, HTA website.
125 Witness transcript of A442, assistant director, September 2024.
126 Ibid.

*"**Q:** We've read the inspection report from the HTA visit last year, and they picked up that bodies were being left unrefrigerated overnight before a postmortem. Were you already aware that that was happening? Or was it a surprise?*

***A:** It was a surprise. I wasn't aware of that.*

***Q:** And presumably the audits that could have picked that up weren't in place at the time?*

***A:** They weren't."*[127]

At a fourth mortuary inspected by the HTA, critical and major shortfalls were identified. Some of the major shortfalls related to documented policies and procedures. The HTA found that not all mortuary procedures had a documented policy in place; nor was there consistency between policies and working practices.

Neither the local authority nor those working in the mortuary had identified that important body storage procedures, specifically formal monitoring of the condition of deceased people in the mortuary, were not being undertaken, thereby compromising the dignity of deceased people.

Other major shortfalls were related to the governance and quality systems in the mortuary.

Prior to the HTA inspection, the Inquiry interviewed the DI and the director at this local authority. The DI told the Inquiry that reviews of the SOPs had been undertaken, but acknowledged that there had been insufficient consideration of where the SOPs were lacking:

"Yes, the reviewing of the SOPs is done on a rolling basis, applying ourselves to – have we got gaps? … And I think the application of management time to actually consider whether we've got other SOPs, I don't think we've put enough into that. So that's where I would say that the problem is."[128]

The DI explained that the local authority was seeking to appoint someone to take responsibility for the writing and review of the SOPs.

While the DI and director described a close working relationship, where matters relating to the mortuary would be made known to the director very quickly, there was no process of assurance in relation to compliance:

*"**Q:** Outside of the HTA inspection cycle, is there a regular sort of compliance update that gets produced, shared? And where does it get shared?*

***A:** There isn't a compliance update, but [the DI] will tell me of the things that he thinks we're not compliant with that we need to address … I don't think we carry out specific reviews of the whole of the mortuary to see whether it's HTA compliant. But when something occurs that we know will not be compliant, we seek to address that issue."*[129]

127 Ibid.

128 Witness transcript of A293, Designated Individual, September 2024.

129 Witness transcript of A422, director, September 2024.

It is evident that the lack of a regular process of audit meant that areas of non-compliance with regulatory standards and guidance were not being identified at this local authority.

Of great concern is the fact that a number of the major shortfalls related to findings identified at a previous inspection, indicating longstanding, continued non-compliance with regulatory standards and a failure to adequately address known non-compliance.

What we have found

- The Human Tissue Authority has identified a considerable number of serious shortfalls relating to governance of the mortuary through documented policies and procedures in inspections of some local authority mortuaries.
- In some local authorities, the same failings are being identified inspection after inspection, indicating continued and longstanding non-compliance with regulatory requirements.
- Some local authorities are not auditing compliance of their Standard Operating Procedures with regulatory requirements, or staff compliance with the Standard Operating Procedures, and therefore cannot be assured that the security and dignity of the deceased are not being compromised through non-compliant working practices.
- Serious shortfalls, including non-compliant working practices compromising the security and dignity of the deceased, are not being identified in some local authorities because of inadequate assurance processes.

Coroners are independent judicial office holders who investigate certain types of deaths. While the coroner is conducting their investigation, the deceased are under their legal control. However, the coroner does not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of the deceased under their control.[130]

Local authorities have a legal obligation to provide sufficient administrative staff, coroner's officers and accommodation to the coroner so that they can carry out their functions.[131] 'Accommodation' is interpreted to include mortuaries. Often, local authorities in a coronial jurisdiction come together in a consortium arrangement to fund the services required by the coroner. In these circumstances, a lead local authority provides, or contracts with others to provide, the services required by the coroner, including mortuary and post-mortem services, on behalf of the other local authorities. However, some local authorities that provide an HTA-licensed mortuary for use by coroners are not the lead local authority for the coroner service.

130 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.200.

131 Coroners and Justice Act 2009, section 24.

Of the eight local authorities assisting the Inquiry's investigations that provided an HTA-licensed mortuary service, five were the lead authority for the coroner service, and three were not.

In this section, we look at what assurance is given to the coroner in relation to HTA-licensed mortuaries provided by local authorities. We consider if the means of providing assurance is different where the local authority providing the mortuary service is not the lead authority for the coroner service; and we consider the visibility of the mortuary service to the Senior Coroner.

We started by looking at whether the reports of HTA inspections and HTARIs were made known to the Senior Coroner.

Of the eight local authorities assisting the Inquiry, five provided an HTA-licensed mortuary service as well as the coroner service. They told the Inquiry that the outcome of HTA inspections was made known through meetings between local authority managers and the Senior Coroner. However, there was variation in how structured or formal those arrangements were.

At one of the local authorities, the Inquiry was told that the HTA report was not shared with the coroner or coroner service: *"They would be aware of the inspection/HTARI but we do not routinely send them the reports."*[132] Instead, the director informed the Senior Coroner of issues relating to the mortuary at monthly meetings:

> *"So, certainly over the last eight years, where we have had some issues or concerns around operations in the mortuary, they are fully discussed with the coroner, for obvious reasons, so that [they] can satisfy [themself] from the coroner's perspective that, you know, there are no additional concerns that [they] would wish to raise or maybe want to contribute to the narrative … both myself and the coroner operate on a principle of no surprises. You know, we are both invested, clearly, in the successful delivery of the wider coronial service, and the mortuary's an integral part of that."*[133]

Arrangements were more structured at another local authority, where fortnightly meetings were held involving the Senior Coroner, coroner's officers and local authority managers who oversee the mortuary, as well as the DI:

> *"And at that meeting we also have what we call an MoU, Memorandum of Understanding, which states that if there are any issues, we first bring them to that meeting. So, if the coroner has any issues regarding accommodation, we'll discuss that at that particular meeting under the terms of that agreement, and then it's for me to now review what requests are and take them back to the local authority."*[134]

At another local authority, the Senior Coroner chaired a monthly 'leadership and management meeting' involving managers who oversaw the coroner and mortuary services.[135] A director at this local authority explained that, not only was the Senior

132 Witness transcript of A113, Designated Individual, September 2024.
133 Witness transcript of A433, director, September 2024.
134 Witness transcript of A439, assistant director, September 2024.
135 Leadership and management meeting minutes, 2 July 2024.

Coroner aware of any HTA reports, they were personally involved in the response to the HTA.[136]

Of the three local authorities that were not the lead local authority for the coroner service, two told the Inquiry that they communicated with the coroner through meetings of the consortium of local authorities for their coroner area. These meetings were held three or four times a year, and were facilitated by the lead authority for the coroner service.[137]

A manager at one of these three local authorities told the Inquiry that, within their coroner area, there were two meetings of the consortium of local authorities: one chaired by a manager of the coroner service, and one chaired by the Senior Coroner.[138] The manager explained that the Senior Coroner was interested in incidents involving deceased people under their legal control, and the results of investigations into these incidents:

> *"He'll go through those reports. He will then make any assessments that he needs with regards to you know, what can we do to improve and things like that."*[139]

However, the manager was unsure whether there was a requirement to share HTA reports: *"I don't know whether that goes to him or whether it's our responsibility to give that to him."*[140] The DI at this local authority confirmed to the Inquiry that the report of a recent HTA inspection, which had identified two major shortfalls (one of which related to non-compliant working practices involving evisceration prior to PME), had not been shared with the Senior Coroner:

> *"No. I haven't done that. Whether there's a requirement to do it, I don't know. But I've never, you know, it's individual to the provision that's in [the local authority], and the facility is managed by us in all its regulations."*[141]

At the third of these three local authorities, the Inquiry was told that HTA reports were not shared with the Senior Coroner:

> *"No, not as far as I'm aware. I definitely haven't shared them [HTA reports] with them, no. But what we do is we have regular consortium meetings, and I would've shared the information at that meeting just to say we've had the HTA, here's a couple of the issues they may have found. Sort of just for information sharing and just to ensure that they're aware of some of the processes or problems we might've had. But I wouldn't have directed any of the information to the Coroner about the HTA inspection, no."*[142]

The consortium meetings that this local authority attended were not chaired by the Senior Coroner, but were attended by the Coroner Service Manager or a coroner's

136 Witness transcript of A429, director, September 2024.
137 Witness transcripts of A352, Designated Individual, September 2024; A562, local authority manager, February 2025.
138 Witness transcript of A562, local authority manager, February 2025.
139 Ibid.
140 Ibid.
141 Witness transcript of A520, Designated Individual, November 2024.
142 Witness transcript of A295, local authority manager, September 2024.

officer.[143] It was therefore not clear if the verbal summary of HTA inspections reached the Senior Coroner in this coronial jurisdiction, or if it included the level and nature of the shortfalls identified by the HTA. However, the Inquiry notes that the DI felt supported by the Senior Coroner and spoke of a good working relationship with the coroner service, which was geographically close to the mortuary.[144]

In relation to HTARIs, six local authorities told the Inquiry that these were reported to the coroner and/or coroner service. This was the case in two of the three local authorities that were not the lead authority for the coroner service. However, a manager at one of these three local authorities told the Inquiry:

> *"[I]f it was a HTARI where we might have a case of accidental damage [to the deceased] or something like that, I'm not entirely sure that we would raise that or escalate that to the Coroner."*[145]

Aside from daily interaction at an operational level between mortuary and coronial service staff, all three of the local authorities that provided an HTA-licensed mortuary but were not the lead authority for the coroner service told the Inquiry that their main link with the coroner service at a managerial oversight level was the consortium meetings. We heard that this was the forum in which matters relating to the mortuary service were raised and discussed. However, this link appeared to rely on the local authority managers attending these meetings to raise issues; in addition, as shown, important matters such as non-compliance identified by the HTA or incidents resulting in harm to deceased people might not be made known. The means of assurance at the three local authorities that were not the lead authority for the coroner service were therefore more limited.

The Inquiry considered if the level of interest taken by the Senior Coroner impacted the visibility of the mortuary.

Managers at the five local authorities that also provided the coroner service spoke of good working relationships with the Senior Coroner, with one director describing the Senior Coroner as *"very, very, very interactive and engaged"*.[146] At another of these local authorities, the director described the relationship with the Senior Coroner, both operationally and strategically, as follows:

> *"So, [the DI] as the mortuary manager, has a very operational … day to day relationship with the coroner. Whereas [the head of service] has a much more strategic relationship with the coroner as well in terms of the coroner's involved in discussions around relocation [of the mortuary] and how we can work with … teaching hospitals, how we can work within the local authorities, for instance."*[147]

The director explained how the Senior Coroner, alongside the head of service, had attended a meeting locally about the future of pathology and histopathology services to understand the NHS proposals and communicate the requirements of the coroner

143 Witness transcript of A565, local authority manager, March 2025.
144 Witness transcript of A113, Designated Individual, March 2025.
145 Witness transcript of A295, local authority manager, September 2024.
146 Witness transcript of A423, director, September 2024.
147 Witness transcript of A429, director, September 2024.

service.[148] The DI at this local authority described the Senior Coroner as *"very interested"* and *"really moving us forward"*.[149]

In contrast, managers at two of the three local authorities providing an HTA-licensed mortuary that was contracted by the coroner service in their area but was not the lead local authority for the coroner service told the Inquiry:

> *"We speak to all the Coroner's Officers and to the administration team, but we don't necessarily have much to do with the coroner."*[150]
>
> *"**Q:** How interested is the coroner in [this] mortuary? Have they visited?*
>
> ***A:** Not since I've been managing the service … [around five years]."*[151]

The Inquiry heard that this had been the case at the third local authority too, where *"the previous coroner didn't have a lot to do with actually how we operated"*.[152] However, the recently appointed Senior Coroner had visited the mortuary three times within a year, and was interested in the service:

> *"And [the Senior Coroner] is so interested in the mortuary it is refreshing and, well, wonderful. [The Senior Coroner] just wants to be involved … wants to know what's going on and anything we do."*[153]

We believe this demonstrates how the visibility and effectiveness of HTA-licensed mortuaries provided by local authorities can also be influenced by the level of interest taken by the Senior Coroner in the mortuary service.

What we have found

- Some Senior Coroners are better informed than others about the regulatory compliance of local authority Human Tissue Authority-licensed mortuary services caring for deceased people under their legal control.
- Some Senior Coroners do not see Human Tissue Authority reports following inspections of the mortuaries caring for deceased people under their legal control. Some Senior Coroners are not informed of Human Tissue Authority Reportable Incidents occurring in local authority-provided mortuaries.
- The means through which assurance is provided to the coroner where the local authority provides a mortuary service but is not the lead local authority for the coroner service can be more limited. This contrasts with the arrangements in place at local authorities that also provide the coroner service, with more frequent meetings and close engagement with the Senior Coroner.
- Although coroners do not have a duty relating to the deceased people in their control, some Senior Coroners are more engaged than others in the mortuary services providing care to the deceased people under their legal control.

148 Ibid.
149 Witness transcript of A430, Designated Individual, September 2024.
150 Witness transcript of A295, local authority manager, September 2024.
151 Witness transcript of A520, Designated Individual, November 2024.
152 Witness transcript of A442, assistant director, September 2024.
153 Witness transcript of A352, Designated Individual, September 2024.

Recommendations

The Inquiry makes the following recommendations to local authorities providing mortuaries licensed by the Human Tissue Authority (HTA).

Restrictions on unsupervised access

Recommendation 35
There should be a process to routinely review who is permitted to access the mortuary unsupervised.

Recommendation 36
Where unsupervised access is permitted for a legitimate and unavoidable purpose, there should be individualised electronic access controls to enter the mortuary and restrict access to specific areas of the mortuary, such as the post-mortem room. There should be a requirement to 'swipe to exit' to ensure that all activity is auditable. There should be no shared electronic access controls.

Recommendation 37
Where people other than mortuary staff are visiting the mortuary during working hours, for example contractors, cleaners and other visitors:

- Access must be limited to specific areas required for the purposes of their work or visit.
- They must be supervised when working in areas where there is access to deceased people, for example in the fridge or post-mortem rooms.
- Their attendance must be recorded and audited.

Recommendation 38
Where mortuary staff are permitted to work alone in the mortuary, there should be a review of lone working policies, including consideration of activities involving direct handling of the deceased, alongside mitigations that can be put in place to safeguard the security and dignity of the deceased, such as CCTV.

Recommendation 39
Routine and regular audits of security must be conducted, encompassing both access to and exit from the mortuary and movement within it, including the post-mortem room. Access data must be reconciled against CCTV footage. Audits must be reported to the Designated Individual and head of service or equivalent.

Security controls

Recommendation 40
Immediate steps must be taken to commission a specialist strategic review of the systems in place to protect the deceased, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of:

- the systems in place to identify unauthorised access to the facility;
- the strength and effectiveness of barriers to prevent unauthorised access to the facility;
- the systems in place to identify any inappropriate access to the deceased; and
- how CCTV is used, including its monitoring and any audits undertaken.

Recommendation 41
There must be no reliance on keys and keypad codes alone to secure access to the mortuary.

Recommendation 42
Fridges and freezers containing deceased people must be locked at all times, with appropriate key security in place.

Recommendation 43
CCTV must be installed inside the mortuary facing all doors and access points, the reception area and the doors of all fridges containing deceased people, including where these are accessible from within the post-mortem room. Local authorities must put appropriate safeguards in place to maintain the security and dignity of the deceased in relation to the monitoring of CCTV. CCTV footage should be regularly reviewed. This should be done by mortuary staff where it is of a sensitive nature.

Recommendation 44
Arrangements for responding to incidents of unauthorised access must be reviewed and incorporated into Standard Operating Procedures.

Recommendation 45
All policies and procedures in relation to the security of the mortuary must be accurately and comprehensively reflected in a single security Standard Operating Procedure.

Local authority oversight and governance of the mortuary

Recommendation 46
There must be a process to ensure that, where there is a requirement for funding to strengthen mortuary security, it is expedited and considered at the highest levels within the local authority.

Recommendation 47
There must be an investigation into the root cause of each security breach. Each incident, the investigation and action plan must be reported to director level within the local authority as a minimum. Serious security breaches must also be reported to the relevant cabinet member and/or committee of elected members.

Recommendation 48
There must be audits of the mortuary Standard Operating Procedures and compliance with Human Tissue Authority requirements, undertaken annually as a minimum, with a clear record of authorisation by the Designated Individual, head of service or equivalent. Audits of staff compliance with the Standard Operating Procedures must be undertaken at least annually, with the results of the audits reported to the Designated Individual and head of service or equivalent.

Recommendation 49
There must be a review of the management and oversight arrangements for the mortuary service, taking into consideration who is appointed as the Designated Individual, their direct contact with the mortuary, level of influence within the local authority, and attendance at governance forums. In particular:

- Local authorities must ensure that the Designated Individual has enough time and resource to fulfil their statutory responsibilities, including time for learning and development.
- The Designated Individual must have access to director-level officers in the local authority. The Designated Individual must also be able to directly raise issues in relation to the mortuary at the highest level within the local authority if they deem it is necessary.
- Where the Designated Individual is non-technically trained, a senior anatomical pathology technologist must fulfil the Mortuary Manager role to ensure that there is sufficient technical experience within the mortuary.
- The Designated Individual must attend regular, documented meetings at mortuary level. The Designated Individual must also attend governance forums where the mortuary is discussed and scrutinised.
- In line with Human Tissue Authority guidance, the named Licence Holder must be at a more senior level than the Designated Individual (e.g. director level or higher) and have a clear understanding of the Human Tissue Authority's statutory requirements and the role of the Designated Individual.

Recommendation 50
The mortuary service must be treated in the same way as other regulatory services within local authority reporting structures:

- The mortuary must be visible to scrutiny at the relevant statutory committee, with regular reporting.
- Key performance indicators must be identified and must include the results of audits of compliance with Human Tissue Authority requirements.
- Inspections by the Human Tissue Authority and Human Tissue Authority Reportable Incidents (HTARIs) must be reported to the relevant statutory committee, and actions to achieve compliance monitored.

Recommendation 51
The mortuary service must be reviewed by professional auditors at least biennially, with the results of the audit reported to a formal committee regardless of the level of assurance. Local authorities must arrange a peer review of the mortuary service at least every three years.

Recommendation 52
All relevant reports and incidents concerning the mortuary must be made known to the lead local authority manager for the coroner service (and the Senior Coroner if they wish to see these reports). Local authorities that are not the lead authority for the coroner service must also share these reports and incidents with the coroner service lead in that coroner area.

Recommendation 53
The implementation of these recommendations must be reported to the relevant statutory committee.

6.5 Body store facilities provided by local authorities

6.5.1 Introduction

Responses to the Inquiry's questionnaire for local authorities indicate that there are ten body stores provided by local authorities in England. However, nine of these were not in active use at the time of the Inquiry's investigations.

Most of the ten body stores were commissioned and used during the COVID-19 pandemic. Some have not been used since, but have been retained to support local resilience to excess death scenarios. Others have been established since the pandemic to support local resilience, as determined by local resilience forums,[154] multi-agency partnerships established to meet the obligations of the Civil Contingencies Act 2004.

154 Local resilience forums are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act 2004.

Local authorities have a legal obligation to provide emergency body storage as part of their responsibilities under the Civil Contingencies Act 2004. The Inquiry did not look specifically at emergency mortuary facilities, though in some areas the body stores provided by local authorities serve the dual purpose of aiding the response to mass fatality scenarios and providing contingent capacity when there is strain on available capacity locally.

The Inquiry found that there was variation in the operating models of the body store facilities – for example, in the categories of deaths that the body store accommodated, as well as in the staff who operated the body store.

An HTA licence is not required where the activities being undertaken are not regulated activities under the Human Tissue Act 2004 – for example, where there is body storage only, not PME. An HTA licence is also not required where storage is 'incidental to transportation', which means that the bodies of deceased people can be stored while transport is arranged from one place to another for a licensed activity such as PME. The HTA guidance says that this should be for no longer than seven days.[155]

There are circumstances in which a body store may require an HTA licence. These include cases where the bodies of deceased people may be held longer than seven days prior to PME,[156] such as in circumstances like those described in relation to body store two in section 6.5.4. However, where this is not the case, facilities that only store the bodies of deceased people are not regulated by the HTA. The only regulatory body that might inspect these facilities is the Health and Safety Executive (HSE), which does so from the perspective of the safety of the staff operating the facility. Chapter 11 considers the current regulatory framework in relation to the deceased.

6.5.2 How we did our work

Of the ten local authorities that provided body stores, the Inquiry chose four with differing operating models to assist our investigations. These included the one local authority with an operational body store and three with body stores not in active use. The four were:

- an operational body store, unlicensed by the HTA and operated by local authority staff;
- a body store not in active use, licensed by the HTA when operational and operated by coroner service staff;
- a body store not in active use, operated by coroner service staff when in use; this body store's local authority subsequently chose to provide a new-build HTA-licensed facility; and
- a body store not in active use, provided by a local authority and operated by the NHS when in use.

We received documentary evidence of the policies and procedures in place to protect the security and dignity of the deceased in these body stores.

155 HTA, Licensing exemptions, 3 May 2024, HTA website.
156 Ibid.

Analysis of these documents informed the key lines of enquiry for interviews with seven local authority representatives, including directors, senior managers, coroner service leads and local authority managers of the body stores.

The Inquiry considered whether the arrangements in body stores provided by local authorities, including management oversight and assurance, protected the security and dignity of the deceased. Our findings are set out in sections 6.5.3 to 6.5.6.

6.5.3 Body store one – an operational, unlicensed body store operated by local authority staff

This body store operated alongside a transportation service (covering part of the local authority area) that collected the bodies of deceased people whose deaths had occurred in the community and had been referred to the coroner. The body store also provided contingency storage for local hospitals at times of high demand.[157]

Both the body store and the transportation service were provided by the local authority, which was the lead authority for the coroner service in that area.

The body store and transportation service had been operational since 2023. Factors in the local authority's decision to provide these services included pressures on available mortuary space locally, and increased costs of contracted provision for transportation of the deceased in part of the local authority area.[158] The local authority managers overseeing the service drew on their experience and assets acquired during the COVID-19 pandemic when establishing the service.[159]

The bodies of deceased people were not held at the body store for longer than seven days once the coroner had decided that PME was required.[160] This was in line with the HTA's licensing exemptions where storage is incidental to transportation, as explained above.[161]

If the bodies of deceased people were showing signs of decomposition, those operating the body store sought guidance from local NHS mortuary staff, in conjunction with the coroner service where necessary, on whether to transfer them to freezer storage or expedite for PME if this was required.[162] If no PME was necessary, in some cases the bodies of deceased people might be held for an extended period of time while enquiries were made to ascertain if a publicly funded funeral was required.

As the service became established, the local authority engaged with local partners involved in care after death, including NHS hospital mortuary staff, the Senior Coroner and the mortality management group, which included members of the Integrated Care Board (ICB), the police and public health protection staff.[163]

157 Depositing of deceased patients into the mortuary at [place name], version 1, 1 August 2024.
158 Witness transcript of A365, Head of Coroner Services, September 2024.
159 Witness transcripts of A440, Team Leader, September 2024; A434, Operations Resilience Manager, September 2024.
160 Witness transcript of A440, Team Leader, September 2024.
161 HTA, Licensing exemptions, 3 May 2024, HTA website.
162 Witness transcript of A440, Team Leader, September 2024.
163 Witness transcript of A365, Head of Coroner Services, September 2024.

Security

The body store had capacity for around 115 deceased people. It was located on an industrial estate but was fenced off and screened from public view. Access to the site was through a gate, controlled electronically using a code or fob. Once on site, access to the body store was by key, though there were plans to digitalise this.[164] The Team Leader explained how they had learned from the Inquiry's Phase 1 Report and now had only one key to the body store, stored in a key safe that was covered by CCTV.[165]

CCTV also covered access to the site and the entrance to the body store. A live feed of the CCTV was shown in the office of the Team Leader, and access to the footage, including remote access, was restricted. There was no process of regular audit but there was live monitoring and the footage was retained and looked at retrospectively if required.[166]

There was no CCTV inside the body store. The security policy states that this *"remains under review"*.[167] The Team Leader told the Inquiry that other security measures mitigated the need for internal CCTV within the body store. These measures included the use of unique serial-numbered seals to secure the body bags in which the bodies of the deceased people were placed. It was not possible to open a body bag without breaking the seal, and there would therefore be evidence of any tampering with the deceased. These procedures were captured in a SOP.[168] There was no lone working at the body store:

> *"[T]wo members of staff will go there, break the seal, and then reseal when it's done. So, on the patient record form there will be a contemporaneous record kept of the seal numbers, when they were broken, why they were broken and then replaced … twice a week at the moment, a supervisor will go into the mortuary with another, and they will literally check every seal on every body bag to make sure they are intact. So, we kind of have got that security from end to end, also within our mortuary we just work on numbers. Every patient we collect gets a unique number, so if you walk into our mortuary and look at the boards on the columns where the patients are stored, all you will see are numbers. There will be no names, no genders, so it will just be sealed body bags with seals. We do write the patient number on the end of the body bag as well, so they're all linked so we have got absolute continuity."*[169]

The Head of Coroner Services at the local authority explained that, if maintenance work was required within the body store, the bodies of the deceased people would be transferred to a temporary facility on site to eliminate any risk to their security and dignity:

> *"Where we have things like contractors on site, because obviously mechanics need servicing, you know, all bodies are always removed from their current location and securely held in something like a Flexmort [flexible mortuary storage] and locked away when any servicing is taking place."*[170]

164 Ibid.
165 Witness transcript of A440, Team Leader, September 2024.
166 Ibid.
167 Mortuary security, version 1.0, 21 June 2024.
168 Security of patients, version 1.0, 21 June 2024.
169 Witness transcript of A440, Team Leader, September 2024.
170 Witness transcript of A365, Head of Coroner Services, September 2024.

The local authority recruited permanent staff to operate the facility, and most had prior experience of work in the funeral sector. A bank of casual staff supported the service when there were peaks in activity. All staff were DBS checked, and consideration was being given to bringing the frequency of these checks into line with those of other local authority employees, such as social workers.[171]

Staff were trained on how to comply with the body store's policies and procedures, and staff without experience of working in the funeral sector initially shadowed more experienced staff.

The Head of Coroner Services explained how the local authority was investing in the staff working in the service and making efforts to ensure their work was visible and valued:

> *"What we're looking at doing, and I've even looked at low level APTs so kind of pathology technician type qualifications, and investing in these people whilst there is a need for us to be continuing this service, because we put a lot of security protocols in place, we put a lot of scrutiny in place of the individuals down to [telematics] in their vehicles, you know, CCTV on site. We really scrutinise everything from the hours they're claiming for, to their location when they're out on jobs, we make sure they sign off when they're on jobs. But the flip side of that really has to be investing in them as well … So, we have trauma and kind of occupational health lines in for them as well, because they're not just a cog in a machine. They really are part of the wider corporate work that we're doing … So, we've done a lot of work to kind of change that."*[172]

Governance

The managers overseeing the body store and transportation service told the Inquiry that they drew on a number of sources to develop their policies and procedures. These included the HTA to understand best practice, and the Senior Coroner to understand the requirements of the service. They also benefited from the technical expertise of APTs at local NHS hospitals. The Inquiry was told that the SOPs for the service *"follow HTA requirements as much as we can"*.[173] One of the managers said:

> *"[W]e are trying to make sure that if we needed a HTA licence, we could get it tomorrow because we're doing it to that standard. When we're dealing with the hospitals, we follow their procedures, all our procedures we run through the hospitals and one of the managers there we make sure that everything is above board, and we did all of that before we got going as well."*[174]

The Inquiry was told that the SOPs would be audited on a yearly basis in line with local authority policy. One of the managers acknowledged that processes were still *"evolving"*, and when asked where audits of the SOPs (and staff compliance with them) were reported, reflected that, although senior managers at the local authority were sighted on the SOPs, processes around audit could be further formalised.[175]

171 Ibid.
172 Ibid.
173 Witness transcript of A440, Team Leader, September 2024.
174 Witness transcript of A434, Operations Resilience Manager, September 2024.
175 Ibid.

The Team Leader explained that they had used the HTA as a guide when designing the incident reporting system, but that incidents were also reported through the local authority's health and safety reporting procedure. One of the local authority managers explained that they had observed that some staff with experience of working in the funeral sector did not appear to have the same appreciation for learning from incidents or near misses:

> *"It would appear that in the private funeral director world, they don't care so much, is the way I'm going to put it. So, when something happened they may have mentioned it, they may not. But nothing was ever followed up and done. And here … we had an incident … one of the trolley wheels fell off the side of one of our ramps coming out [of the body store]. Small incident. To them it was like 'oh well, it happened'. And they couldn't understand why we wanted to investigate it and have an outcome and make sure it didn't happen again … So that is something we've learnt and we're learning a lot actually through this process that you didn't quite realise that that funeral director area was so unregulated, there's so much goes on that no one seems to worry about."*[176]

Oversight and assurance

Both of the relevant local authority directors with an oversight role in relation to the body store were described as taking a close interest in the service.[177] Daily reports on capacity at the body store were shared with local authority managers and the coroner service, as well as the NHS hospitals locally that provided mortuary and PME services on behalf of the coroner. The reports informed capacity across the coroner area.[178]

The Team Leader described their role overseeing the operation of the facility on a day-to-day basis as similar to that of the HTA's DI. They explained how good governance of the facility had an impact on the quality of the service:

> *"[I]t is that whole kind of HTA sort of thing in terms of not only checking the paperwork, the forms, how they are completed, how the mortuary register is managed, it comes down to patient checks, condition checks, right down to equipment checks being done weekly, mortuary cleaning regimes with set procedures and monthly clean, deep cleans and all of that sort of … all signed off … So, yes that sort of governance sort of stance at the ground level right through to how the staff look after the vehicles, how they look after the mortuary, how do they look after the kit and hopefully that then sort of sets the standard for how we want to look after the patients, if that makes sense."*[179]

176 Ibid.
177 Ibid.
178 Ibid.
179 Witness transcript of A440, Team Leader, September 2024.

The body store had been audited by professional auditors:

> *"We've brought internal auditing in as well, so we have an audit report around ways to improve practices there. Headlines are really about digitalisation where we possibly can. Digitalisation being kind of the key thing because it's quite a paper-based industry and one of the things I've been really keen to drive, so much so that I've put three of my Exec Office team into it, is a fully auditable record of everything that's in place in terms of the assets we've got, who is being contained within those assets at any point in history … So, digitalising that so that the council can report in a way that it does in every other part of its services is one of the key recommendations of audit, and something we're investing quite heavily in."*[180]

The Inquiry was told that the outcome of the audit was known to the local authority's audit and governance committee.[181]

The body store had also been visited and audited by the local authority's health and safety officials.[182]

Involvement of the coroner

A manager of the body store and transportation service described the Senior Coroner as being positively engaged:

> *"The coroner has … actually been telling everybody else this is how you want to be. You know in [the local authority area], I've got this service, and it is marvellous. So, [the Senior Coroner] is well on board with, you know, where we've got [with] it … this is exactly the service that [the Senior Coroner] wanted. [The Senior Coroner] wanted [their] own internal hands-on style service which [they have] almost got."*[183]

They described having direct contact with the Senior Coroner:

> *"We do get problems from time to time which are sort of coronial problems. When we do get problems, [the Senior Coroner] is generally straight on Teams, talking through issues."*[184]

The service was viewed favourably by the coroner's officers:

> *"Bearing in mind we don't cover … all of [the local authority area] … but yes all of the coroner's officers that are out there dealing with our service now have found it a much simpler process in terms of the paperwork, toing and froing and releasing and passing of information."*[185]

The Head of Coroner Services explained that there had been interest in the service from other coroner areas: *"We have been talking to other coronial areas as well who've been interested in what we've stood up and whether they could replicate it."*[186]

180 Witness transcript of A365, Head of Coroner Services, September 2024.
181 Ibid.
182 Witness transcript of A440, Team Leader, September 2024.
183 Witness transcript of A434, Operations Resilience Manager, September 2024.
184 Ibid.
185 Ibid.
186 Witness transcript of A365, Head of Coroner Services, September 2024.

6.5.4 Body store two – a body store not in active use, HTA-licensed when operational, operated by coroner service staff

This body store was a converted warehouse located on local authority land, with capacity for up to 330 deceased people. The body store was operational in the winter period 2022 to 2023, and was not in active use at the time of the Inquiry's investigations.

The facility was licensed by the HTA while it was operating, although regulated activities such as PME were not conducted there. The licence was granted because the bodies of deceased people were likely to be stored for longer than seven days prior to PME.[187]

The purpose of the body store was to support the response to mass fatality scenarios, as well as to increase local capacity at times of pressure. When capacity in local NHS hospital mortuaries reached an agreed threshold, the operating model for the body store was to accommodate deceased people whose deaths were being investigated by the coroner, after the PME had been conducted.[188]

The Coroner Service Manager at the local authority told the Inquiry that the body store had become operational because severe pressures at local NHS hospitals meant they had closed their mortuaries to those who had died outside the hospitals, creating delays with PMEs. Capacity was under such strain that deceased people were being held at the body store prior to PME.

The HTA, with which the local authority had consulted, had granted an emergency licence, given the length of time deceased people were potentially being held at the body store prior to PME.

The Coroner Service Manager took on the role of DI, which they acknowledged was *"an enormous responsibility"* in ensuring that the regulatory requirements were met.[189] The HTA provided a Corrective and Preventative Action (CAPA) Plan that the local authority used to ensure that the right policies, procedures and governance were in place to operate the body store.[190]

When operational, the body store was staffed by people working for the coroner service, including the Coroner Service Manager. The local authority also drew on staff who had assisted during the COVID-19 pandemic, including firefighters and police. Technical support was provided by an APT, who assisted the Coroner Service Manager and the body store supervisor to conduct checks of the condition of the deceased people in the facility:

> *"I identified as the DI, but we also brought in an experienced APT each week, who came to carry out body condition checks with myself … It was either myself or it was*

187 HTA, Licensing exemptions, 3 May 2024, HTA website.
188 Witness transcript of A366, Coroner Service Manager, September 2024.
189 Ibid.
190 Ibid.

> *my body store supervisor, who was a coroner's officer … It was not ideal. It's not something I would've wanted to do, but we needed to do it."*[191]

The body store was operational from 8am to 4pm. Outside these hours, funeral directors contracted on behalf of the coroner service to transport deceased people whose deaths occurred in the community were not permitted to access the body store unsupervised to admit the deceased.

The Coroner Service Manager told the Inquiry:

> *"One thing we wanted to avoid was not [sic] having deceased held with our funeral directors, because I've got no control over the storage and the care of the deceased."*[192]

However, there were times when the local NHS hospital mortuaries could not facilitate overnight or weekend admissions. In these circumstances, the bodies of deceased people were held at the premises of the contracted funeral directors.

The Coroner Service Manager told the Inquiry that they had attained assurance that the contracted funeral directors were caring for the deceased in ways that protected their security and dignity. This had been done through the contractual requirements and visits to their premises, as well as feedback from others, including the police and hospital mortuaries. The Inquiry considers how local authorities attain assurance in relation to other providers in section 6.6.

The body store had not been required operationally since 2023, due to work undertaken by the local authority, coroner service, NHS and ICB to improve the local system for managing how deceased people were transported and stored.[193]

The Inquiry was told that the feasibility of making provision for a digital autopsy facility alongside the body store in the long term was being considered:

> *"We have a very good facility at … the body storage facility. We have invested … into that facility to make sure that it's fully fit for purpose. So, our plan is to look at how we can maximise the use of that facility, specifically for us that is looking at digital postmortem provision. So, how we can reduce the number of invasive postmortems where they might not be required, and how we can, I think, provide a better service both for bereaved families, but also in terms of dignity for the deceased, not requiring invasive postmortems when they're not required. And also, you know, in terms of the service for our faith communities."*[194]

The Coroner Service Manager explained that this plan aligned with the requirements of the Senior Coroner to transform the service and reduce the requirement for invasive PME.[195]

191 Ibid.
192 Ibid.
193 Ibid.
194 Witness transcript of A431, assistant director, September 2024.
195 Witness transcript of A366, Coroner Service Manager, September 2024.

Security

The Coroner Service Manager explained the security arrangements in place for the body store:

> *"Getting into the main warehouse, card access only. As I say, lock and key to the units. Then no-one was even allowed into the car park unless they were authorised under card access. It is a shared building … the other part of the building has Highways. It's a hub, it's a drop-in hub, but they didn't have access to our side of the building, and we would manage that and the security … because the building wasn't alarmed at night. We had to have security on duty till the next morning, till the new members of staff came in."*[196]

The refrigerated units were lockable, with the keys held in a key safe in the office. Only the body store supervisor and the Coroner Service Manager had access to the key safe.[197]

CCTV covered the access road, the car park, the body collection and release area, and the front of the refrigerated units. The CCTV was monitored live and footage was retained for 31 days. When the body store was in operation, both the CCTV and access were audited. The Coroner Service Manager explained that an audit of the CCTV had identified that the security guard who was responsible for monitoring the temperature of the refrigerated units was not doing this. Remote temperature monitoring of the refrigerated units subsequently negated the requirement for a security officer to conduct checks.[198]

The SOPs for operation of the facility indicate that deceased people were stored in body bags. However, the facility did not appear to use a uniquely coded seal.

All staff were DBS checked to enhanced level.[199] There had been no lone working in the body store when it was operational.

When the body store was operational, staff received training in the operation of the facility, manual handling, cleaning, and the wearing of personal protective equipment. Arrangements were put in place to support staff welfare, including access to emotional support, acknowledging the nature of the work they were undertaking in the body store.[200] Contact with the deceased was minimised as far as possible and in line with the SOPs.[201]

Governance

SOPs for the operation of the body store included security, condition checking, receipt and release of the deceased, incident reporting and risk assessment. The assistant director with responsibility for the body store explained how the policies and procedures for the facility had been developed:

196 Ibid.
197 Ibid.
198 Ibid.
199 Witness transcript of A431, assistant director, September 2024.
200 Witness transcript of A366, Coroner Service Manager, September 2024.
201 Daily operations Standard Operating Procedure, version 1.3, 23 November 2023.

> *"[T]he standard operating procedures were informed by HTA requirements, they were essentially written with [the Coroner Service Manager, as DI] with appropriate advice [from NHS mortuary APTs locally] … We also had advice from medical professionals within the ICB, who also helped us with our standard operating procedures. They were also shared with the Senior Coroner … because the deceased are within his jurisdiction, to make sure that he was sighted and had a good understanding of those standard operating procedures. They were then shared with myself to make sure that I had an appropriate understanding in terms of governance and accountability."*[202]

The SOPs had been shared with the HTA.

The assistant director told the Inquiry how governance of the facility through well-documented policies and procedures was key to providing the new service.

The assistant director explained that the Coroner Service Manager *"was very, very heavily on-site"* to provide management oversight, *"particularly because it was the first time, we as a service had run that facility"*.[203]

The Coroner Service Manager, as DI, reported on a weekly basis to the assistant director. Matters relating to the body store were discussed at a monthly senior leadership meeting chaired by the Senior Coroner:

> *"Also, we have our senior leadership team meeting, which the Senior Coroner chairs, and he would be kept informed. In fact, [the Senior Coroner] visited the site to see what was happening, to reassure himself that his deceased under his jurisdiction were being cared for correctly."*[204]

Matters arising from this meeting fed into the directorate senior leadership team within the local authority, and through that to the corporate leadership team.[205] The assistant director explained that a risk register was held at service level but that emerging risks were escalated to the corporate leadership team and the Chief Executive of the local authority when required.[206] The assistant director told the Inquiry that the body store was visited by the elected member with responsibility for the coroner service and the relevant executive director.

6.5.5 Body store three – a body store, not in active use, operated by coroner service staff when in use

The Inquiry interviewed the Head of the Coroner Service, who told us that, following the COVID-19 pandemic, temporary mortuary facilities had been replaced with semi-permanent structures to house the body store. This was to mitigate historically insufficient capacity locally and to support the response to mass fatalities.[207]

202 Witness transcript of A431, assistant director, September 2024.
203 Ibid.
204 Witness transcript of A366, Coroner Service Manager, September 2024.
205 Written information provided by A366, Coroner Service Manager, October 2024.
206 Witness transcript of A431, assistant director, September 2024.
207 Witness transcript of A294, Head of the Coroner Service, September 2024.

The body store was operational between December 2022 and February 2023. It was brought into operation when an agreed threshold in local capacity had been reached. The body store's operating model was to care for deceased people after PME had been conducted or where investigation by the coroner was not required. Deceased people were transferred to the body store by transport arranged either by an NHS trust or by the funeral directors contracted by the coroner service to provide transportation.

The body store could accommodate almost 200 deceased people. When operational, it was staffed by coroner's officers who received annual training. According to the SOPs, assistance with manual handling was provided by the police and/or firefighters.[208] The Head of the Coroner Service explained that the local authority worked *"in a hugely collaborative way"* with APTs at two local NHS hospital mortuaries. The SOPs for the body store had been written in collaboration with them, and in line with HTA guidelines.

The Head of the Coroner Service explained that, as the coroner's officers staffing the body store were not technically trained, there were limitations in terms of the deceased people who could be accommodated in the body store. For example, the body store did not store parts of the deceased, deceased people who were decomposed, bariatric or infectious, or deceased children.

HTA guidance on body storage says that *"bodies should be moved into frozen storage after 30 days in refrigerated storage … or before, depending on the condition of the body"*.[209] The Head of the Coroner Service explained:

> *"[W]e count down in terms of the HTA principles, in terms of 30 days. But essentially, the staff, unless there's a need to do so wouldn't open the body bag because everything's done with a tag on the outside."*[210]

This contrasts with body store two in the Inquiry's sample, where coroner service staff undertook condition checks with the support of technically trained mortuary staff.

The Inquiry was told that, when the body store was in operation, the on-site security guard was initially required to enter the refrigerated units to conduct temperature checks out of hours. However, remote monitoring of the fridge temperatures had been introduced, negating the requirement for the security guard to conduct these checks.[211]

Access to the body store was controlled by a key that was stored in the staff office on site. The body store was secured with fencing and locked gates, and there was external CCTV, which was monitored by an on-site security guard 24 hours a day, seven days a week when the body store was operational. There was no CCTV within the refrigerated areas. There was a policy prohibiting lone working.

The body store was to be replaced with a new-build, HTA-licensed mortuary provided by the local authority. Drivers for this decision included: the need for greater resilience;

208 Temporary storage facility training – training manual, 1 February 2024.
209 HTA, Guidance on body storage, HTA website.
210 Witness transcript of A294, Head of the Coroner Service, September 2024.
211 Ibid.

an improved service for bereaved families; and efficiencies in cost in relation to paying third parties for mortuary services and transportation. The new-build mortuary would, where appropriate, enable the use of non-invasive PME as a first-line intervention to identify cause of death. The Head of the Coroner Service explained that the recommendations of the Inquiry's Phase 1 Report in relation to security had been considered while designing the new facility.[212]

6.5.6 Body store four – a body store not in active use, provided by a local authority and operated by the NHS when in use

The Inquiry interviewed an assistant director with responsibility for the coroner service, who explained that the local authority's body store facility was intended to provide resilience locally. However, it had been operational only during the COVID-19 pandemic.[213]

When operational, it was staffed and managed by an NHS trust with which the local authority had contracted to provide mortuary and PME services. The operating model of the facility, in terms of the deceased people who could be accommodated there, was determined by the NHS trust. Staff worked in accordance with the SOPs of the NHS trust's hospital mortuary service.

When asked how the local authority attained assurance when a third party provided the body store service, the assistant director explained that the facility was operated by technically trained mortuary staff, working in accordance with the policies and procedures of the HTA-licensed service provided by the NHS trust. They explained that the Head of the Coroner Service had also attained assurance through regular contact with the HTA-licensed provider. They acknowledged their reliance on the technically qualified staff:

> *"[A] lot of our assurance, I suspect, stems from who we ask to operate the facilities … in terms of their operating procedures and all the necessary obligations they have in order to attain a HTA licence … As a local authority, I think the level of expertise in terms of the operation of such facilities does mean that knowledge is not routinely available in a local authority. And that became quite apparent as well during the COVID-19 pandemic, when we set up the public mortuary. Quite clearly, there are people who should be operating these particular facilities. And there are people perhaps who, you know, whilst they can add some value in certain aspects, you know, we are reliant on people who can ensure that the sort of dignity and respect of the deceased is maintained at all times."*[214]

The body store was located on a secure, gated site with CCTV and an intruder alarm. When it was in operation, access was restricted. The assistant director told the Inquiry that security arrangements at the body store would be reviewed should the body store be brought back into operation, because of the passage of time since it had last been operated, and in light of the David Fuller case.

212 Ibid.
213 Witness transcript of A428, assistant director, September 2024.
214 Ibid.

What we have found

- Some local authorities operate body stores to provide resilience where there is insufficient capacity for the storage of deceased people locally.
- At times of pressure on local capacity, the bodies of deceased people are transported to alternative locations. At times, this can mean deceased people are stored within premises that are not regulated.
- A Human Tissue Authority licence is not required where regulated activities are not being carried out. However, there are circumstances in which a body store may require an emergency Human Tissue Authority licence – for example, where deceased people are being held longer than seven days prior to post-mortem examination.
- Where a body store is not licensed by the Human Tissue Authority, there is no regulatory oversight of the care provided to the deceased.
- While the HTA and local partners, including NHS hospital mortuaries, may provide technical guidance and support, local authority managers have described a lack of guidance available to them when setting up a body store service.
- There is a lack of standardisation in the policies and procedures in place to protect the security and dignity of the deceased when they are being cared for in body stores.

Recommendations

The Inquiry makes the following recommendations to local authorities providing a coroner service or body store.

Recommendation 54
Local authorities providing a coroner service must review plans for the provision and operation of contingent body storage, in collaboration with local organisations providing mortuary services.

Recommendation 55
Local authorities providing an unlicensed body store must be prepared to comply with the Human Tissue Authority's standards and guidance where applicable, in the event that a Human Tissue Authority licence is required to enable activities outside Human Tissue Authority licensing exemptions.

Recommendation 56
Where local authorities provide an unlicensed body store, they should do so in line with this Report's recommendations to local authority providers of licensed mortuaries.

6.6 Local authority assurance of third-party providers of mortuaries and body stores

6.6.1 Introduction

Local authorities have a legal duty to provide resources to the coroner to enable them to carry out their judicial functions.[215] This includes the provision of mortuary and PME services. It also includes transportation of the deceased to and from mortuaries and other providers, such as those providing digital autopsy services, while the coroner's investigations into the cause of death are carried out.

Some of the providers that local authorities contract with are regulated by the HTA to carry out licensed activities – for example, NHS trusts providing regulated activities such as PME. Others are not regulated, including funeral directors contracted to provide transportation of the deceased. In some areas, funeral directors also store the bodies of deceased people on behalf of local authorities. Digital autopsy providers are also unregulated if they do not undertake regulated activities.

In this section, the Inquiry considers how local authorities attain assurance that the providers they contract with protect the security and dignity of people after death.

6.6.2 How we did our work

All 17 local authorities invited to assist the Inquiry's investigations had agreements in place with other providers. We interviewed 36 local authority managers across these 17 local authorities, and asked them about the arrangements in place to attain assurance that these providers were delivering care in ways that protected the deceased. We also received and analysed over 400 documents provided by local authorities.

In addition, we interviewed the Managing Director of an independent body store and transportation provider that had several contracts with local authority, NHS and hospice organisations for the transportation and storage of the deceased.

The findings from the evidence we reviewed are set out in sections 6.6.3 to 6.6.5.

6.6.3 HTA-licensed providers – NHS trusts

Of the 17 local authorities assisting the Inquiry, nine had arrangements in place with NHS trusts to provide mortuary and PME services on behalf of the coroner.

These nine local authorities were also the lead authority for the coroner service in their area. The managers we interviewed described frequent interaction between the coroner service and the NHS providers on a day-to-day operational level.

Managers at six of the nine local authorities told the Inquiry that they met the NHS providers they contracted with frequently. At the remaining three local authorities, it was unclear if this was the case. Of the six that met with the NHS providers frequently,

215 Coroners and Justice Act 2009, section 24.

there was variation in how these meetings were described in terms of their formality. At one local authority, the Senior Coroner attended meetings with the relevant NHS trust,[216] while at another, meetings were held at director level.[217] Managers at two other local authorities described less formal but close working relationships and regular conversations.[218] One of these told the Inquiry:

> *"I meet with their pathology manager quite regularly. I speak to the mortuary manager every other day as well, so we have quite a good communication network. But we are on site quite a bit over there."*[219]

This local authority's contracted NHS trust had undergone an inspection by the HTA that had identified major shortfalls.[220] The manager said that they were aware of the outcome and that the trust had not *"provided me with the findings officially"*, but that they had discussed these with the Pathology Manager at the trust. The manager indicated that only findings that impacted the ability of the provider to deliver the service would lead to a more formal approach being taken:

> *"It's more of a conversation. I think if there was anything whereby, they weren't allowed to operate anymore because the HTA deemed their facility not suitable, then it would be more of a formal because we would have to move our service elsewhere, but it is more of a conversation."*[221]

Despite the close day-to-day interaction between the coroner service and NHS providers of mortuary services, the Inquiry found that managers at three local authorities were unaware of the outcome of HTA inspections that had identified shortfalls against the regulatory standards.

The Head of Coroner Services at one local authority was not aware of the outcome of an HTA inspection at one of the contracted NHS providers that had identified major shortfalls against the HTA standards. They said that they would have expected to be made aware, given the requirement for transparency between local partners:

> *"**Q:** Do you expect to be made aware if the provider is not compliant with HTA requirements?*
>
> ***A:** So, I would under our Mortality Management Group Governance arrangements. The reason I would consider it a successful partnership is because of that transparency and that ability to support each other at times of need … we would expect them to be fully compliant. In terms of reviewing that compliance, I think there's more work that's needed."*[222]

216 Witness transcript of A327, Coroner Service Manager, September 2024.
217 Witness transcript of A355, director, November 2024.
218 Witness transcripts of A294, Head of the Coroner Service, September 2024; A346, Coroner Service Manager, September 2024.
219 Witness transcript of A346, Coroner Service Manager, September 2024.
220 HTA inspection report, HTA website.
221 Witness transcript of A346, Coroner Service Manager, September 2024.
222 Witness transcript of A365, Head of Coroner Services, September 2024.

The Head of the Coroner Service at another local authority also said that they expected to be told of the outcome of HTA inspections at their contracted providers, given their regular interaction:

> *"**Q:** Would they inform you about an HTA inspection report? Is there anything in place to monitor that?*
>
> ***A:** No, I catch up with them regularly. We have regular kind of conversations. As I say, we work really quite closely together. So, if something is going on, they would let me know."*[223]

However, they were unaware of an HTA inspection that had identified major shortfalls against the HTA standards:

> *"I think I should have been made aware … I think it is within the contract in terms of the duty for them to notify us and by us, I would mean that to be myself and [the Senior Coroner]."*[224]

The draft contract for the provision of mortuary services provided to the Inquiry by this local authority includes requirements for the provider to be licensed by the HTA, and to *"maintain standards sufficient to meet HTA licensing requirements"*.[225] However, there is no specific requirement in the draft contract to notify the local authority of the outcome of inspections by the HTA.

In both cases, the managers at the local authorities were surprised not to have been made aware of the non-compliance identified by the HTA, indicating that the mechanisms in place were not effective in ensuring that this information was shared.

In relation to the notification of serious incidents or HTARIs, there was a range of responses by the managers we spoke to. One Head of the Coroner Service told the Inquiry that there was *"no automatic system"* of notification but that, although they did not believe incidents had always been notified to the local authority in the past, this had improved.[226] A Coroner Service Manager at another local authority said that their contracted providers were *"very, very proactive at reporting. They do it straight away."*[227]

An assistant director with responsibilities for the coroner service at one local authority told the Inquiry that there was no formal reporting mechanism for the contracted provider to notify the coroner service of serious incidents.[228]

The Inquiry found that, in two local authorities, assurance in relation to the quality and performance of the mortuary service contracted from NHS providers was sought in a structured way.

For example, a director at one local authority told the Inquiry that they had introduced strengthened assurance processes shortly after becoming the accountable executive for the coroner service and for the mortuary service's contract. Prior to this, they said,

223 Witness transcript of A294, Head of the Coroner Service, September 2024.
224 Ibid.
225 Mortuary and storage contract – new – 24-25 draft, no date.
226 Witness transcript of A294, Head of the Coroner Service, September 2024.
227 Witness transcript of A327, Coroner Service Manager, September 2024.
228 Witness transcript of A428, assistant director, September 2024.

"there wasn't really sufficient scrutiny" and *"there wasn't appropriate oversight"* of the contract. Shortly before the director became the accountable executive, an HTA inspection of the NHS provider had identified a significant number of shortfalls against HTA standards, while the Senior Coroner *"had concerns around the condition of bodies being dealt with through post mortems"*.[229]

To improve contractual oversight and in response to the HTA's findings, the director had introduced regular meetings with the relevant director and manager of the mortuary service at the NHS provider. In addition, the NHS trust had started compiling a monthly 'mortuary assurance report', which went to both the trust's quality committee and the local authority director. The report included: the results of security audits; a statement in relation to compliance; the latest position in relation to the audit schedule of the SOPs; details of any HTARIs; and activity in relation to body condition checks, among other performance metrics.[230] In addition, the director told the Inquiry:

> *"I am due to take an annual report on the mortuary to our corporate management team … We've never done that before, but because this is a statutory duty and because the chief exec is very clearly sighted on this, we think that that's the appropriate way for us to, at the most senior level, have oversight of this contract."*[231]

The monthly assurance report and annual report described by the director offered a greater level of assurance than some local authorities received when they directly provided their own HTA-licensed mortuary service.

The director went on to explain that they were considering how assurance could be provided to the Senior Coroner in relation to the mortuary service:

> *"I do think that there is value in the senior coroner having some involvement in the regular performance, monitoring and oversight of the mortuary contract … we just need to figure out how, because the senior coroner doesn't work for the council and isn't part of our governance in that way, because she's very, very busy. It's not as simple as well, we'll escalate it to here. I need to find a way that works for her to be involved and have the oversight that she wants and sees fit without trying to make her into a local authority officer or a contract manager. So, it's figuring out the mechanism."*[232]

An assistant director at another local authority explained the approach to assurance in relation to their contracted providers and how that involved the Senior Coroner:

> *"So, the contractual arrangements are solely with the local authority, but that is in partnership with the senior coroner. What I think we have done successfully, is that we've worked very hard to build a good relationship, a very good, constructive working relationship with the senior coroner and that's been both about building trust, openness, having that shared accountability and … the frameworks where we can have those discussions in the right way. So, for example, we have a monthly senior leadership team meeting with the senior coroner, the area coroner, myself, the Service*

229 Witness transcript of A355, director, November 2024.
230 Mortuary assurance report QC, October 2024.
231 Witness transcript of A355, director, November 2024.
232 Ibid.

Manager. That's the kind of meeting where we go through kind of any risks, issues, we go through all of our kind of jointly agreed performance indicators, we go through the budget, you know all of these things which you know, might seem straightforward things but I think when you have that type of unique relationship there, as a local authority we are funding and providing the resources for the service, but the coroner has full, you know, kind of independence. So, we have to make sure that we have the spaces where we are, I think, working collaboratively but also making joint decisions around the right way to approach any particular risks or issues. Sometimes that might be the senior coroner saying, 'I would like to speak to the Chief Executive of this hospital'. Sometimes it's about us as a local authority, saying, 'Actually we need to tighten up our contract management here. We need to make sure that we're going out and visiting these mortuaries on an operational basis.'"[233]

The assistant director told the Inquiry that, as part of the local authority's contract with the NHS providers, they were notified of any inspections and action plans arising, and these were considered at the monthly meetings with the Senior Coroner. However, the assurance they sought went beyond this:

"So, it's very easy to kind of say, 'Yes this action plan has been completed, here's our assurance', but I think when you're dealing particularly in this type of setting with deceased persons, there is something about having an additional level of assurance, so that might mean our Service Managers going out to visit the mortuary themselves. They have weekly contractual meetings with the Mortuary Managers. They have then a more formal quarterly meeting with often the Chief Operating Officer of [the pathology services provider] and so, you know, all of that is then fed into our monthly meetings."[234]

Both the assistant director and the Coroner Service Manager at this local authority told the Inquiry that in 2024 a decision had been made to pause the use of the mortuary run by one of the contracted NHS providers due to ongoing concerns relating to staffing and premises. This provider had given assurances that action would be taken. However, *"the Senior Coroner took the decision that, until all the concerns had been fully addressed, all coronial bodies were to be removed"*, and "*no coronial post mortem examinations were to take place there until the issues had been resolved*".[235]

The Senior Coroner sought assurance from the NHS trust that the HTA would be notified both of the concerns raised and the Senior Coroner's decision to remove deceased people under the legal control of the coroner to an alternative mortuary. Following a further HTA inspection of the mortuary, which found the provider to be compliant with HTA standards, the mortuary was once again used for coronial cases.[236]

The assistant director told the Inquiry:

"[F]or us both in terms of the Senior Coroner and his judicial function and us as a local authority, we deemed that risk too great to continue to use that [mortuary] until we

233 Witness transcript of A431, assistant director, September 2024.
234 Ibid.
235 Letter from A366, Coroner Service Manager, to the Inquiry, 23 January 2025.
236 Ibid.

had the appropriate assurances that the mortuary was fit for purpose and that our concerns had been fully addressed."[237]

The Coroner Service Manager confirmed that the Senior Coroner was routinely informed of any HTA inspections conducted at the three mortuaries contracted by the coroner service, and that the assurances given by the contracted provider were required by the Senior Coroner themself. This included *"a requirement that [the contracted provider] proactively inform the Senior Coroner of any reportable incident in the mortuary"*.[238]

A letter to the Inquiry from the Coroner Service Manager makes clear that this Senior Coroner was very much involved in ensuring that the deceased people under their legal control were cared for by suitable, regulatorily compliant services:

"All decisions about the use of a particular mortuary for the purposes of coronial post mortems are made by the Senior Coroner, not the Local Authority."[239]

The arrangements at this local authority, and the earlier example where a monthly assurance report had been introduced, demonstrate how some local authorities and coroners have put in place strong assurance processes that provide greater transparency and open communication, and enable the local authority and the Senior Coroner to have greater confidence in the delivery of the contractual arrangements.

The director who had introduced strengthened assurance processes at one local authority told the Inquiry that they would have found national-level guidance helpful as they did so, as well as guidance in relation to oversight by elected members of the council:

"I think it would be helpful for local government for there to be guidance or best practice for how you do this … It is very unclear how the provision of the statutory mortuary service and how councils reassure themselves around that is being seen by the elected members, who are ultimately the democratic representatives who are responsible for that function, amongst many others. When I took this over, it wasn't in anyone's portfolio. And when I've looked around, that is incredibly common … There's either the Local Government Association who could provide guidance, or when there's statutory duties through parliament legislation, there's often civil service guidance … I'm happy with where we are, but we've got there because we're doing it ourselves. It would have been so much better if I was able to go, well, look, this is what's recommended."[240]

The Inquiry received a statement from the Local Government Association (LGA) that confirmed it was not aware of any such guidance; nor had it produced any guidance in relation to contracting with other providers for mortuary services.[241]

237 Witness transcript of A431, assistant director, September 2024.
238 Letter from A366, Coroner Service Manager, to the Inquiry, 23 January 2025.
239 Ibid.
240 Witness transcript of A355, director, November 2024.
241 Written statement of LGA, October 2024.

What we have found

- There is variation between local authorities in the robustness of the approach they take to obtaining assurance from contracted providers of mortuary services.
- Although coroners do not have a duty relating to the deceased people in their control, some Senior Coroners are very involved in ensuring that the deceased are cared for by mortuary services that are compliant with regulatory standards.
- Some local authorities do not have effective mechanisms to ensure that they are made aware of the outcome of regulatory inspections and the compliance of their contracted providers with regulatory standards.
- In the absence of formal reporting mechanisms, local authorities rely on contracted providers to notify them of serious incidents.
- There is a lack of guidance available to local authorities when contracting with external providers of mortuary services.

6.6.4 Funeral directors – transportation and storage

The funeral sector plays an important role in transporting deceased people whose deaths are being investigated by the coroner from their place of death in the community to a mortuary, while investigations into the cause of death are conducted.

There are also circumstances in which the deceased may need to be transported to other locations, sometimes outside the local authority area – for example, for a specialist PME. In addition, funeral directors may be asked to provide storage for the deceased; the circumstances in which this may happen are described below.

Typically, local authorities make contractual arrangements or agreements for transportation to be conducted by funeral directors. It is usually the lead local authority for a coroner service that contracts these services, though some local authorities make their own arrangements. These contractual arrangements sometimes include the storage of deceased people.

All 17 of the local authorities assisting the Inquiry's investigations had agreements in place with funeral directors. Six of these local authorities had arrangements for transportation only, while ten local authorities had arrangements that also covered some element of storage at funeral director premises. In some cases, this was for limited periods of time – for example, where a mortuary was closed to admissions overnight – while in other cases arrangements included the use of funeral director premises as contingency storage. At the 17th local authority, contracted funeral directors' premises were routinely used to store deceased people as part of a triage pathway. The Inquiry explores this arrangement in more detail later in this section.

The Inquiry found the following terms in the six agreements setting out arrangements:

- Four require the funeral director to be a member of a trade association, such as the National Association of Funeral Directors or the National Society of Allied and Independent Funeral Directors.
- Where the funeral director is not a member of a trade association, three also allow, in exceptional circumstances, the provider to be an *"established supplier"* with a *"proven record of quality service and customer care"*.[242]
- One specifies that the service provided is to be *"in accordance with the Code of Practice as set out by the National Association of Funeral Directors"*.[243] The funeral sector is unregulated, and compliance with the codes of practice of the trade associations is voluntary.

Of the six agreements seen by the Inquiry, four include KPIs:

- All four have KPIs relating to the response times for collections and transfers undertaken by the funeral director.
- One of the four includes a KPI relating to any *"issues"* affecting the *"quality of the service"*.[244]
- One makes specific reference to a KPI in relation to the *"number of incidents involving the handling of the deceased"*.[245]
- Two make explicit the requirement for monthly reporting by the provider.

In interviews with representatives from the 17 local authorities, managers at three local authorities told the Inquiry that assurance of the performance and quality of the service was gained through meetings with the funeral director. Managers at six local authorities told us that visits were conducted to the relevant funeral director's premises. For example:

> *"We have actually visited our contracted funeral director and our local authority funeral director, and we have conducted our own informal inspections of their premises."*[246]
>
> *"Going on visits, making sure again that we are seeing for ourselves, in terms of how deceased are cared for, what the facilities are like. You know, what are the quality of the transportation vehicles?"*[247]

One of these managers spoke about 'triangulating' feedback from people who came into contact with the funeral director during the course of their work, such as NHS hospital mortuary staff and the police, as well as feedback from families of the deceased, to support their evaluation of the quality and performance of the contracted provider:

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242 Tender for the removal and storage of the deceased from the community (conveyancing contract), 31 July 2024.
243 Provision of coroner transport services, invitation to tender, schedule 1 – specification, no date.
244 Ibid.
245 Performance monitoring, no date.
246 Witness transcript of A426, Designated Individual, September 2024.
247 Witness transcript of A431, assistant director, September 2024.

> *"It's almost like triangulation really. We have a relationship with the ops managers for each of the three [funeral director] providers. We've obviously got the mortuary management side with CCTV coverage and body condition checks when the deceased goes into the mortuary … We also have feedback from the Police. I have regular meetings with the Police. I meet with them every quarter. So hopefully, if there's any issues, I've always got that triangulation across and, obviously, feedback from the family at the home. If there is a concern, families will raise with the coroner's office if they're concerned about how their loved one was managed by the funeral directors."*[248]

Another manager pointed out that the funeral director working on behalf of the coroner in their local authority transferred deceased people to a number of mortuaries within the coroner area, and feedback from staff and others at those locations contributed to the assessment of performance and quality.

Not all local authorities contract with only one or two funeral directors. One Coroner Service Manager told the Inquiry how they had adapted their approach from contracting with a single funeral director to utilising all the funeral directors within the area that had chosen to sign up to a service level agreement.

The Coroner Service Manager told us that all the funeral directors on the rota were members of a trade association. They also stated that, for any new provider:

> *"[T]he Coroner's Officers will visit and do an inspection of the premises, of their cold storage facility, of their vehicles and of their operation basically – their premises have to be secure, safe and appropriately controlled."*[249]

One assistant director told the Inquiry that the security and dignity of deceased people were taken very seriously while they were under the legal control of the coroner:

> *"Absolutely, these are coronial deceased. So, we are very clear that if there is anything, it needs to be reported back to both of us as a service, but equally importantly to the senior coroner so they are able to take any action that they see fit."*[250]

However, it is concerning that not all of the six agreements seen by the Inquiry make it explicit that any physical injury to a deceased person is to be reported to mortuary staff and/or the coroner service. Four of the six agreements make this clear, but two do not.

Representatives at three local authorities told the Inquiry of incidents involving injury to deceased people while they were in the care of funeral directors. One of these incidents involved a single funeral director operative attending to collect a deceased person when the trolley being used collapsed:

> *"It was identified there that really, we should have had two funeral directors collecting him to make sure that – to limit that risk. And during the investigation as*

248 Witness transcript of A366, Coroner Service Manager, September 2024.
249 Witness transcript of A346, Coroner Service Manager, September 2024.
250 Witness transcript of A431, assistant director, September 2024.

well, we discovered that the trolley was insufficient really. So, what we decided was that we would make sure that there was a standardised quality of trolley that meant that people could get used to the mannerisms of that trolley, if you like, so they could predict how it would behave, reducing the risk of the trolleys tipping off and people falling off them."[251]

In addition, the local authority introduced a condition check of the deceased *"upon collection and again upon delivery … following transit to a new location"*.[252]

Another incident involved injury to a deceased person's jaw, which was identified during PME. The injury had occurred after death:

"So, haemorrhages only occur when someone receives an injury and they're alive. This individual obviously received this injury and they were dead. So, we flagged this up with the contracts manager and funeral directors who said, 'Oh, yes, we did drop them, and we didn't think that we need to tell you about it.'"[253]

This incident is particularly concerning as the funeral directors did not report it. This suggests that there may have been other incidents resulting in harm that were not reported. We understand that the agreement with this funeral director came to an end due to other allegations of poor practice.

Storage of the deceased in the funeral sector

Four local authorities assisting the Inquiry had arrangements with their contracted funeral directors for storage on more than an exceptional basis – for example, where the funeral director was contracted to provide publicly funded funerals on behalf of the local authority.[254]

A DI at one of these local authorities explained that there was an agreement with a funeral director for contingency storage while refurbishment work was being carried out at the local authority mortuary. The agreement included funeral director operatives checking the condition of deceased people:

"And we've been and checked their fridges … we've been out to their premises and looked at them, and this contract is also asking them to do regular condition checks and to make sure that we get that information should we need to use them. So, that is built into this contract as well that they are carrying out regular checks, and then that information is fed back to us."[255]

The Inquiry interviewed the Managing Director of an independent body store and transportation provider that provided storage to several organisations, including one of the local authorities assisting the Inquiry's investigations. The Inquiry looked at how

251 Witness transcript of A562, local authority manager, February 2025.

252 Response to complaints investigation, 16 July 2024.

253 Witness transcript of A113, Designated Individual, March 2025.

254 Publicly funded funerals are provided by local authorities for people who have passed away and have no next of kin, or whose next of kin, relatives or friends are unable or unwilling to make the necessary arrangements for a funeral.

255 Witness transcript of A352, Designated Individual, September 2024.

the contractual arrangements and assurance processes were described by both the independent body store and the contracting local authority.

The Managing Director told the Inquiry that, when they tendered for contracts, they were required to explain their processes for ensuring the *"respect and dignity of the deceased"*. They were usually visited annually by those contracting with them, either ahead of winter (when contingency storage was more likely to be needed) or ahead of contract renewal.[256]

A local authority manager who managed a contract with this provider told the Inquiry that they met the Managing Director on a quarterly basis to review any issues that had arisen. There was no requirement within the contract for regular reporting: *"We don't actually. We should, but we don't, no."*[257] This was confirmed by the Managing Director, who told us that there might be weekly activity reports, but nothing beyond that.[258]

Another local authority had an agreement with a funeral director to provide storage for up to 28 deceased people. This was for deaths that occurred in the community that were unexpected but not suspicious, subject to specific criteria. The provider was part of the triage pathway for deaths in the community, providing a holding facility while it was determined whether investigations into a death were necessary. The Coroner Service Manager said:

> *"We also have an offsite facility, which is run by the coroner contracted undertaker. We have a pathway map in [place name], which is predominantly a multi-agency pathway map, which is signed up to by ambulance, police, and the coroner service, where deceased that die out in the community are triaged, assessed as to where they need to go … So, they are brought to the triage area, to the storage area for hopefully a short period of time, a couple of days whilst the coroner officers make enquiries with the GP to ascertain whether a cause of death can be given. If a cause of death can be given, a coroner contracted undertaker will then release directly to the FD [funeral director] instructed by the family. If that can't – so if a cause of death cannot be given, they will be conveyed straight to the hospital. And that will be for the examination."*[259]

The Coroner Service Manager explained that, while the funeral director was not licensed by the HTA, they operated in accordance with the relevant standards:

> *"[T]he expectation is that they do not have to be fully HTA compliant with the full list, because they do not fall, I think, under the licensed premises. But there are still standards that need to be met … So, for example, the conditions of storage. So, temperature, refrigeration, access, security. So, there's still expectations and standards that need to be met."*[260]

256 Witness transcript of A8, Managing Director, independent body store and transportation provider, September 2024.
257 Witness transcript of A565, local authority manager, March 2025.
258 Witness transcript of A8, Managing Director, independent body store and transportation provider, March 2025.
259 Witness transcript of A327, Coroner Service Manager, September 2024.
260 Ibid.

This funeral director played an important role in management of the deceased locally. The Coroner Service Manager explained that they received a twice-daily report from the provider that detailed all the deceased people held with them:

> *"So, I scrutinise that to ensure that it is accurate and that full details are provided. Because it's essential that the team here know exactly where the deceased are."*[261]

In relation to assurance, the Coroner Service Manager said:

> *"I normally visit once per year. I visited with the service director … we did a full tour of the site. Again, an inspection. But it's the quarterly meetings that we have as part of the tender document, the contract. We have all of our standards in there. So, I think if there's anything that comes to light, again, they have to report any incidents to me within a certain period of time … I would then investigate. If there's anything that comes out of that that I'm concerned about, I will likely attend the site, inspect, and then meet with them."*[262]

The Coroner Service Manager acknowledged that they *"rely and depend"* on providers such as the funeral directors, given the insufficient storage capacity locally:

> *"So, I think capacity has always been a challenge … And that isn't only in [the local authority]. I would imagine that is every single coronial jurisdiction probably up and down the country. And it's probably the case also, I think, for the [NHS] Trust. Even more so now with the implementation of the new death reform system and the medical examiner, which means that sometimes there can be a delay in reviewing notes and providing the cause of death. So, that will impact, possibly our triage area and the time that deceased need to spend there. But also, the release and turnaround of deceased from the Trust … And it's always a concern, which is why we work very closely with the hospital to ensure that there is a trigger plan, activation plan, so that we do not reach that critical capacity situation. Which could, I guess, always potentially mean that the deceased are not stored within those two areas, which could risk the standards of storage. So, choice of provider. So, we have only really got one Trust within the county … And therefore, we have also factored in storage out of the Trust to store our deceased as well."*[263]

The Inquiry is aware that, in an inspection of a mortuary provided by another local authority assisting the Inquiry's investigations, the HTA identified that there was frequent use of funeral directors to store the deceased prior to PME. In addition, storage was frequently exceeding the seven-day licensing exemption. This was a critical shortfall.[264]

261 Ibid.
262 Ibid.
263 Ibid.
264 HTA inspection report, HTA website.

One local authority director told the Inquiry that they felt the use of funeral directors was a risk because of the level of trust involved:

> *"I think that the contract with a funeral director is a risk. I don't know what the alternative is, but you know, we contract, and we put a lot of faith in, you know, a well-established funeral director to take care of deceased and deliver them safely to the mortuary for us out of hours."*[265]

This was echoed by another manager, who told the Inquiry that they felt local authority managers did their best in relation to assurance, despite a lack of specialist knowledge and expertise:

> *"I think it's fair to say that again, we are – the local authorities, with the coroner service – we are not experts in the Tissue Act. We are not undertakers, funeral directors, mortuaries. So, we all do our best with the information to hand, the guidance regarding storage of deceased to ensure to the best of our ability that they're kept secure, and safe, and protected, and that standards are then met. But again, we're not experts in that field."*[266]

The Inquiry found that two local authorities assisting the Inquiry's investigations now provided their own body transportation service.

One of these had established a transportation service for community deaths that operated alongside a body store. The director explained that one factor in deciding to introduce this local authority-provided service was the significantly increased costs charged by funeral directors locally.[267]

The second local authority directly provided another coroner area with transportation to and from its mortuary for deceased people requiring invasive or non-invasive PME:

> *"[I]t enables us to be more attractive to potential other commercial opportunities where the issue of transporting bodies is an issue that needs to be addressed. So, we've invested in, as I say, the two vans and we've taken on staff."*[268]

Staff employed in these roles received training and worked in pairs.[269]

265 Witness transcript of A429, director, September 2024.
266 Witness transcript of A327, Coroner Service Manager, September 2024.
267 Witness transcript of A365, Head of Coroner Services, September 2024.
268 Witness transcript of A433, director, March 2025.
269 Ibid.

What we have found

- Funeral directors play an integral role in local arrangements for management of the deceased on behalf of the coroner.
- Some local authorities use funeral directors to store deceased people, mainly in exceptional circumstances or for contingency purposes, but in some cases as part of local arrangements for management of the deceased. This can involve monitoring the condition of the deceased.
- Local authorities take their assurance from the terms of the agreements in place, meetings with providers and visits to their premises, and stakeholder feedback.
- There have been incidents of harm to deceased people in the care of funeral directors. The reporting of incidents relies on the integrity of staff working within funeral directors.

6.6.5 Digital autopsy

Digital autopsy is a non-invasive type of PME that uses scans to assess organs and tissues and establish a cause of death.

Of the 17 local authorities assisting the Inquiry's investigations, seven had arrangements in place for digital autopsy with NHS, local authority and independent providers. Non-invasive PME does not have to be carried out on HTA-licensed premises, unless any human tissue or organs are removed.[270]

At one local authority, digital autopsy was provided through a subcontracting arrangement between the NHS trust with which the local authority contracted for mortuary and PME services and another NHS trust. A director at the local authority explained that quality was monitored through quarterly contract meetings and through any issues that came to the attention of the pathology service or the coroner in relation to the quality of the interpretation of the scans:

> *"So, we get assurance through the quarterly contract management activity … but also on the softer side through issues that are picked up with the pathology service and the coroner. And I would know about that through the weekly meetings that I have with the coroner."*[271]

Under this arrangement, deceased people were transported to the place where the digital imaging took place by funeral directors contracted by the NHS trust: *"So, they have their own body transportation arrangements in that respect with a different funeral director."*[272]

270 Royal College of Pathologists, *Guidelines for Post-mortem Cross-sectional Imaging in Adults for Non-forensic Deaths*, July 2021.

271 Witness transcript of A292, director, September 2024.

272 Ibid.

We spoke to a DI who told us about their experience of working with an independent digital autopsy provider. They explained that they found it difficult to understand why digital autopsy providers were not regulated by the HTA:

> *"Forgive me, I will say to you that the HTA seem to not be interested in anything that happens … If something happens in there [the scanning facility], it's as though it's a private company. It doesn't matter. I find that very difficult to comprehend … because they're still doing work for a coroner."*[273]

The DI explained that they had encountered a number of issues with the digital autopsy service. These included a door being left unlocked, collapsible trolleys and, in the early days, a deceased person being harmed after their arm was manipulated above their head by a radiographer for scanning.[274]

At two local authorities assisting the Inquiry's investigations, digital autopsy was a *"first-line intervention"*[275] in determining cause of death, meaning that, in most cases, an invasive PME would be undertaken only if the cause of death had not been established through a digital autopsy.

The digital autopsy provider used by these two local authorities also received deceased people for scanning from other local areas. The facility did not have refrigerated storage,[276] and deceased people could be held there for only a short period of time, around two hours.[277] Transportation to and from the digital autopsy facility was undertaken by the funeral directors contracted by the coroner service, or by the digital autopsy provider itself.

The Inquiry heard that transfers conducted by the digital autopsy provider were made by a single person rather than two people. We did not ascertain if there were measures in place to mitigate the risk of lone working – for example, by securely sealing body bags with a uniquely coded tag, or by using telematics in transportation vehicles. However, a local authority Mortuary Manager explained that they *"document what time the body goes out to what time the body gets down to the facility, and what time the body gets back to us"*.[278]

The Mortuary Manager also told the Inquiry that the equipment used by the digital autopsy provider was basic:

> *"[T]hey normally turn up to us about 8 o'clock in the morning, and they can take up to four cases, normally it's two to three. So, the deceased is always bagged. They've got stretchers. Not particularly well to do, the stretchers. They're very basic. Their vans are very basic."*[279]

273 Witness transcript of A430, Designated Individual, September 2024.
274 Ibid.
275 Witness transcript of A428, assistant director, September 2024.
276 Witness transcript of A541, Mortuary Manager, February 2025.
277 Witness transcript of A564, Mortuary Manager, February 2025.
278 Ibid.
279 Ibid.

The assistant director at one of these two local authorities explained that the Head of the Coroner Service attended regular meetings with the digital autopsy provider, alongside the NHS contracted provider of PME services.

The assistant director was aware of an incident that had occurred at the digital autopsy facility. This related to the trolley used to move the deceased:

> *"Yeah. There has been some unfortunate incidents … I was aware of one where unfortunately, the deceased I think may have come off the trolley during the sort of transportation arrangements to the scanning facility, or at the point when it got to the scanning facility. So, our response to that is to sort of to notify the family on the behalf of the coroner. And then we, ourselves and the head of service, the provider, the CT [computed tomography] scanning provider, and the contracted funeral director review their standard operating procedures in order to mitigate the likelihood of that happening again."*[280]

The report of this incident was provided to the Inquiry. It identifies that the deceased person fell to the floor when the trolley to which they were being transferred following their scan tipped over. The deceased person was re-scanned to ascertain if any harm had occurred, and their condition was checked on return to the mortuary.

Actions taken to prevent this happening again included changes to procedures to ensure there were two people to assist the digital autopsy staff in moving deceased people to and from the scanner. It was also decided that standardised trolleys would be used, to ensure that staff knew how equipment would behave.[281] Local authority managers, including the Coroner Service Manager, attended the digital autopsy facility to better understand working practices, and the relevant SOPs were updated in conjunction with the digital autopsy provider.[282]

The Inquiry was told that working relationships with the digital autopsy provider became closer following the incident.[283] However, it was not clear – other than through informal feedback from the funeral directors conducting transfers to the digital autopsy facility – how the local authority attained assurance that working practices were in line with the updated SOPs:

> *"[The Coroner Service Manager] and I went over to … digital autopsy, had a look at the facility so we could get a proper idea of how things worked. Also, they sent us their current SOPs and then we developed them, so it was like a three way thing, working together.*
>
> ***Q:** And do you ask [the provider] to provide you with any management information on how they're following their SOPs at all?*
>
> ***A:** I haven't had reason to ask them for a report, although we have had a number of reports going backwards and forwards."*[284]

280 Witness transcript of A428, assistant director, September 2024.
281 Incident report, incident at [place name], 17 July 2024.
282 Witness transcript of A562, local authority manager, February 2025.
283 Ibid.
284 Ibid.

The Inquiry saw one contractual agreement between a local authority and a digital autopsy provider. This includes KPIs regarding the *"skill, accuracy, timing of digital autopsy process and provision of information to the pathologist"*, and a requirement to report monthly on KPIs. In this contract, the digital autopsy provider is required to provide and maintain equipment and to notify the coroner and the local authority of *"any matters affecting property and its business"*, among a number of other obligations. The contract does not specify any obligations in relation to maintaining the security and dignity of the deceased.[285]

What we have found

- Digital autopsy providers are not regulated by the Human Tissue Authority as they do not undertake regulated activities.
- Digital autopsy providers do not typically have facilities to store deceased people, though in some places a number of deceased people are transferred for digital autopsy each day.
- In some places, transportation of the deceased is undertaken by digital autopsy providers using a single operative. The Inquiry has found limited evidence of measures put in place to reduce the risk of lone working to the security and dignity of the deceased.
- The Inquiry has heard concerns about the inadequacy of equipment used, such as trolleys to transport the deceased.
- There can be collaborative working between local authority managers and digital autopsy providers to improve working practices.
- Not all contractual agreements specify expectations in relation to the security and dignity of the deceased while they are in the care of a digital autopsy provider.

Recommendations

The Inquiry makes the following recommendations regarding local authority assurance of contracts with third-party providers.

Recommendation 57
Local authorities must review all contractual arrangements and agreements with third-party providers of services that care for and transport the deceased. This must include consideration of assurance mechanisms, such as key performance indicators, regular reporting, formal contract review meetings, site visits and stakeholder feedback.

285 CTPM contract for standard services, 29 September 2023.

Recommendation 58
There must be a contractual requirement to formally notify the contract manager and senior local authority officers of any incidents involving the deceased, as well as the outcome of inspections or other action by the Human Tissue Authority or others with an oversight role, such as the Health and Safety Executive.

Recommendation 59
Local authorities must ensure that the providers they contract or enter into agreements with have robust governance processes in place to oversee the services they provide. This should include Standard Operating Procedures that protect the security and dignity of the deceased and audits to ensure staff compliance with them, as well as the reporting of incidents.

6.7 Conclusions

The Inquiry has considered security, management and governance, and safeguarding arrangements in local authorities with mortuaries and body stores, and local authority assurance of third-party providers of these services. The Inquiry has found that these arrangements do not always adequately protect the security and dignity of the deceased. The Inquiry's findings and recommendations are set out throughout this chapter.

In fulfilling their legal obligation to provide resources to enable the coroner to carry out their judicial function, local authorities contract and enter into agreements with multiple organisations and providers involved in the storage and transportation of the deceased, and the identification of causes of death. These include digital autopsy providers and out-of-area specialist PME providers. The Inquiry has found significant variation between local authorities in the robustness of the approach they take to obtaining assurance from these third-party providers.

The HTA has identified a significant number of shortfalls against regulatory requirements in inspections of local authority mortuaries and licensed providers of post-mortem services operating on behalf of local authorities. In some cases, the HTA has found continued non-compliance from one inspection to another. It is therefore not sufficient for local authorities to rely on an HTA licence alone to assure themselves that deceased people under the legal control of the coroner are being cared for in ways that protect their security and dignity.

Based on the evidence provided to the Inquiry, the Inquiry considers that there is a need for the recommendations in this Report to be implemented as soon as possible to ensure the security and dignity of the deceased in the care of local authorities and those who provide these services on their behalf.

Chapter 7: Care homes

7.1 Introduction

Care homes provide accommodation and care for people who need substantial help and support with their personal care. People usually move into a care home when it is no longer feasible for them to live more independently, even with care provided at home. Care homes can be run by the independent sector, local authority, the NHS or the voluntary sector. There are two main categories of care home for older adults: care homes that provide in-house nursing care, which are generally known as nursing homes; and those that provide personal care, but not nursing care, generally known as residential care homes.[1]

In November 2023, there were 14,228 residential care and nursing homes in England, with an estimated population of over 370,000 people.[2]

Care homes rank third in terms of place of death in England: 20.9 per cent of all deaths, almost 114,000, occurred in care homes in England in 2023.[3]

7.2 How we did our work

Given that there are so many care homes in England, it was not feasible for the Inquiry to investigate what happens to protect the security and dignity of deceased people in every care home. Nor was it feasible to examine a meaningful sample of care homes, given the diversity of care home provision due to the diverse demographics and types of need they provide care for. In 2019, 84 per cent of care homes were owned and run by companies from the independent sector.[4]

We approached four organisations that represent care providers or care associations in England and requested statements setting out whether they provided guidance to the sector on measures to protect the security and dignity of the deceased and if they

1 Social Care Institute for Excellence, Care homes as a model for housing with care and support, SCIE website.
2 Care home facts & stats: Settings, population & workforce, Carehome.co.uk website, accessed 9 December 2024.
3 Office for National Statistics, Deaths registered for England and Wales, 2023, ONS website.
4 '84% of care home beds in England owned by private firms', *The Guardian*, 19 September 2019.

were aware of any incidents where the security or dignity of deceased people had been compromised in care homes. The four organisations the Inquiry approached were:

- National Care Association;
- Care England;
- National Care Forum; and
- The Care Provider Alliance.

All four provided the information requested to the Inquiry.

We also considered whether the Care Quality Commission (CQC), as the quality regulator for care homes in England, had any role in safeguarding the security and dignity of deceased people in care homes.

7.3 Our findings

None of the four organisations representing care providers or care associations in England that provided information to the Inquiry issues guidance to care homes on measures to protect the security and dignity of the deceased. This is not a legal requirement or required by the regulator for these settings. The partial exception to this was a protocol produced during the COVID-19 pandemic on arrangements for funeral directors to collect deceased people from care homes:

> *"The care home should seek to identify the best possible location for the funeral director's vehicle to be parked during the collection process. Whilst the nearest location is desirable, consideration should also be paid to ensuring the privacy and dignity of the deceased, so any public areas viewable from outside of the care home should be avoided."*[5]

Care England told the Inquiry that, when a death occurred in a care home, the care home did not store the body of the deceased person; it was usual practice to transfer the deceased person to a funeral director.[6] None of the organisations that provided information to the Inquiry set out details of how deceased people were kept in care homes until they were collected by funeral directors. However, each organisation confirmed that they were not aware of any incidents that had compromised the security and dignity of deceased people in care homes.

Amanda Partington-Todd, Deputy Director of Adult Social Care at the CQC, told the Inquiry that, in her experience, it was usual practice for deceased people to be left in situ in care homes until they were collected by a funeral director.[7]

5 Care Provider Alliance, Deceased Management Advisory Group, National Care Forum and National Association of Funeral Directors, 'Protocol for care homes and funeral directors during COVID-19', May 2020.

6 Written statement of Care England, November 2024.

7 Witness transcript of Ms Amanda Partington-Todd, Deputy Director of Adult Social Care, CQC, June 2024.

Ms Partington-Todd went on to confirm that the CQC's regulation and inspection of care homes did not include consideration of the security and dignity of deceased people:

> *"So, our framework at the moment only looks at the experience around when regulated activities are being provided, which implies that that person is still living because they're providing personal care or nursing care et cetera, to that person. So, our methodology doesn't look in care homes at post … after somebody has died."*[8]

What we have found

- The Inquiry has found that the care home sector is disparate. The Inquiry does not have the evidence to confirm the policies and procedures that are in place to protect the security and dignity of people who die in care homes but has found that there is no regulation that takes account of this. This is of concern, especially given that a relatively high proportion of the population die in care homes.

Recommendation

The Inquiry makes the following recommendation.

Recommendation 60
The regulatory measures recommended in Chapter 11 should apply to care homes in England. Regulation should cover both systems and professionals where staff are providing care to deceased people in care homes.

8 Ibid.

Chapter 8: Funeral sector

8.1 Introduction

This chapter describes the Inquiry's Interim Report on the funeral sector and developments since then. It includes evidence the Inquiry has received about people's interactions with funeral directors since the publication of its Interim Report on the funeral sector in October 2024, and considers how the funeral sector interacts with other settings.

Professional regulation of people working in the funeral sector is considered in Chapter 11.

8.2 Interim Report

On 15 October 2024, the Inquiry published an Interim Report on the funeral sector.[1]

The Chair expedited the Inquiry's work on this sector following reports of cases of neglect of the deceased in some funeral homes and growing calls for regulation of the sector.

The aim of publishing the Interim Report was to assist the UK government and the sector itself to take steps to assure the public that the sector is fit for purpose and does not tolerate any form of abuse or practice that compromises the security and dignity of the deceased, including where this may be caused by neglect.

The Report presented the Chair's preliminary findings on the sector and made the following recommendations (numbering here as per the Interim Report, repeated in Chapter 12, Table 31, as Recommendations 61, 62, 63, 64 and 65).

Recommendation 1

The UK government should establish an independent statutory regulatory regime for funeral directors in England as a matter of urgency in order to safeguard the security and dignity of the deceased. This regime should include a licensing scheme, mandatory standards against which funeral directors should be inspected regularly, and enforcement powers. The Inquiry would expect to be informed by the government what this statutory regulatory regime will be before publication of the Inquiry's Final Report.

1 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Interim Report – Funeral Sector*, October 2024.

Recommendation 2

These regulations and standards should be considered within the overall care and journey of the deceased rather than applying in isolation to funeral directors. This will be explored further and commented on by the Inquiry in the Final Report of Phase 2.

Recommendation 3

The standards should include details of mandatory information to be given to customers by funeral directors to provide transparency about the care of the deceased, including information on measures to protect their security and dignity, and what should be expected of funeral directors' services.

Recommendation 4

Direct cremation businesses should also be considered in this context, and mandatory standards to protect the security and dignity of the deceased should be applied to these businesses and to any emerging new models of delivery of care for the deceased.

Recommendation 5

While the introduction of a proportionate statutory regulation and inspection regime may require significant adjustment by funeral director organisations, it is the view of the Inquiry that the benefit to customers and the need for public confidence outweigh the difficulties that may be experienced by some businesses.

8.2.1 Government response to the Interim Report

On 2 April 2025, the Inquiry received a letter from the Department of Health and Social Care indicating that it would wait until the Inquiry's Final Report and recommendations were published before coordinating a government response.[2] Given this response from the Department of Health and Social Care, we urge the government to act swiftly on the recommendations in this Final Report.

8.2.2 Experiences of the funeral sector

Publication of the Interim Report prompted members of the public to contact the Inquiry, welcoming the recommendation for regulation and sharing their experiences of interacting with the sector. These included a lack of care and respect for the deceased and their relatives, and concern that there was nowhere to make complaints.

Quaker Social Action (QSA), an independent anti-poverty and social justice charity, wrote to the Inquiry welcoming the Interim Report and its recommendations. QSA has been calling for regulation of the industry for many years. It shared the findings from research[3] it had carried out, which included descriptions of the state of mind people can be in when engaging with the sector:

2 Letter from Department of Health and Social Care, April 2025.

3 QSA, *Funeral planning and vulnerability: the funeral industry's role in protecting financially vulnerable clients*, May 2023, QSA website.

> *"More than 8 in 10 respondents said that while arranging the funeral they weren't making decisions in the same way or using the same logic as they would in normal circumstances."*[4]
>
> *"Trust featured a lot in people's comments, with at least 1 in 6 indicating that they trusted their funeral director or simply felt they had to due to their own lack of knowledge or experience, or because their bereavement meant everything was such a 'blur'."*[5]

QSA also shared anonymised evidence with the Inquiry of people's experiences of the care of the deceased in this sector. Issues included a lack of information about where the deceased were being kept, being prevented from viewing the deceased, a lack of information about the embalming process, a lack of care when removing the deceased from a property, and being pressured for payment for funerals up front.

8.3 Potentially criminal behaviour

The Inquiry found that there was no organisation with specific powers to stop a funeral director from operating in the event of poor practice, misconduct or neglect that fell short of a criminal threshold.

The Inquiry is aware of active criminal investigations relating to the alleged mistreatment of the deceased in funeral homes. The Inquiry is mindful of the need to be cautious about what is said publicly while those investigations are ongoing, to avoid causing any risk of prejudice. The Inquiry also wishes to minimise any distress to the families affected and is therefore not identifying the detail of those cases in this Report.

8.4 Scotland

The Scottish Parliament recently legislated, through the Burial and Cremation (Scotland) Act 2016, to provide for an inspection and enforcement framework, a specific statutory Code of Practice and a licensing scheme for funeral directors. The Code of Practice[6] was published on 12 February 2024 and came into force on 1 March 2025. It will ensure minimum standards in the care of the deceased and will assist in providing transparency in the goods and services offered to the bereaved.

The Burial and Cremation (Inspection) (Scotland) Regulations 2025 also came into force on 1 March 2025. Under the regulations, Scottish ministers have the power to maintain an inspection register of burial authorities, cremation authorities and funeral directors. The register will include the relevant organisation's name and address, and information relating to inspection reports, enforcement notices and any complaints made to inspectors. The regulations will provide inspectors with the powers of inspection and enforcement, alongside an appeals process, to ensure compliance with the relevant legislation and codes.[7]

4 Ibid.

5 Ibid.

6 Scottish Government, Funeral Director Code of Practice, 12 February 2024, Scottish Government website.

7 Scottish Government, Funeral Industry News: Scottish Government Introduces New Regulations Under the Burial and Cremation (Scotland) Act 2016, 15 November 2024, Scottish Government website.

Although this does not apply to funeral directors in England, it has been included in this Report given its relevance.

8.5 The Competition and Markets Authority investigation into the funeral sector

In 2019, the Competition and Markets Authority (CMA) began an investigation into the arrangements at that time for oversight of activity in funeral directors' premises, as part of its funeral markets investigation. It published the final report of its investigation in December 2020; this contained a recommendation that the UK government establish an inspection and registration regime to monitor the quality of funeral director services.[8]

The Ministry of Justice's response[9] to the CMA report in March 2021 included the following points:

- It agreed in principle to a form of registration and inspection but stated that *"wholescale regulation would take considerable time to implement and may not be effective or proportionate in achieving the objective of improving customer experiences"*.[10]
- In the interim, it would work collaboratively with the sector to develop an agreed set of quality standards as part of a co-regulatory model, and committed to evaluating and reviewing the effectiveness of the co-regulation model.
- It would monitor the success of the statutory regulation regime being introduced in Scotland.

The CMA told the Inquiry that it had engaged with the new UK government on regulation of the funeral sector and stated:

> *"The CMA remains of the view that the independent, statutory regulation of funeral services is necessary to prevent the most egregious failures regarding the security and dignity of the deceased. The CMA fully supports the important work of the Inquiry in preventing anything similar to David Fuller's crimes happening again."*[11]

8.6 Interaction between the funeral sector and other settings

All the settings that the Inquiry has considered in its Phase 2 work have interactions with the funeral sector – primarily for transporting and/or storing the deceased.

Chapter 9 describes how deceased people can be left in religious buildings overnight while apparently under the care of a funeral director.

8 CMA, *Funerals Market Investigation: Final Report*, 18 December 2020, gov.uk website.
9 Ministry of Justice, *Response to the Competition and Markets Authority's Funeral Market Report*, March 2021, gov.uk website.
10 Ibid.
11 Written statement of Ms Sarah Cardell, Chief Executive, CMA, February 2025.

Chapter 10 describes how the shortage of paediatric pathologists has meant that deceased babies/children need to be transported relatively long distances for post-mortem examinations, sometimes being placed at a local funeral director's premises overnight before being transported back.

Chapter 10 also describes how a funeral director operates a body store located within an NHS hospital.

Chapter 4 describes situations where hospice staff have been concerned about funeral director operatives, but also how funeral directors have provided advice and training to hospice staff.

Chapter 4 also explains how some hospices have decommissioned their mortuaries, with the risk that this will push demand onto the funeral sector as they will receive the deceased sooner.

The Inquiry notes that a direct cremation company[12] charges relatives additional costs for collection and storage of a deceased person from a hospice, if the hospice mortuary cannot be used.

8.7 Conclusions

Anyone can be a funeral director. They do not need a licence, experience, qualifications or training, and they can use whatever facilities and equipment they choose. It is the Inquiry's view that only statutory regulation of the sector can prevent poor practice.

It is very disappointing that, over five years ago, the CMA made the recommendation that the government should establish an inspection and registration regime for the funeral industry and yet, to date, no decisive action has been taken to implement this recommendation and address the manifest weaknesses in the sector. The Inquiry understands that the government has taken some steps to progress the recommendation but that it is awaiting the Final Report of this Inquiry before taking further action. It is important that real change is implemented to ensure the security and dignity of the deceased, and that a specific government department is given responsibility for overseeing this.

Recommendations

In addition to reiterating the recommendations made in the Interim Report, as detailed in section 8.2, the Inquiry also makes one additional recommendation below.

Recommendation 66
The funeral sector in England should be considered in scope for the broader regulatory measures recommended in Chapter 11.

12 Direct Cremation, What to do when someone dies in a hospice, Direct Cremation Ltd website.

Chapter 9: Faith organisations

9.1 Introduction

This chapter considers how people of different faiths care for the deceased, and whether there is any guidance from faith organisations that focuses on maintaining the security and dignity of the deceased.

At the end of their life, many people do not wish to be separated from the communities in which they have lived, and those close to them are likely to require local support to cope with their loss. In addition, this is a time when, for some people, spiritual matters come to the fore and can be a great comfort both to the individual reaching their end of life, and their carers and loved ones.[1]

Historically, religious organisations served as networks of care, and many religious denominations have established funeral rituals, including designated prayers and readings, and attitudes towards the deceased and burial or cremation processes. Religious leaders also often offer pastoral care to bereaved families, providing support and guidance during challenging periods.

In 2021, the Office for National Statistics (ONS) Census[2] included a voluntary question on religious affiliation. The results are shown in Table 30.

Table 30: Religious affiliation in England and Wales in 2021

Religious affiliation	Percentage
Christian	46.2
Muslim	6.5
Hindu	1.7
Sikh	0.9
Jewish	0.5
Buddhist	0.5
Other	0.6
No religion	37.2
Did not answer	6

1 Public Health England, *Faith at end of life: A resource for professionals, providers and commissioners working in communities*, January 2016, gov.uk website.

2 ONS, Religion, England and Wales: Census 2021, ONS website.

9.2 How we did our work

We carried out the Inquiry's work in this area by selecting 12 faith organisations representing religions with the highest affiliation according to the ONS Census data. We requested statements from these organisations about how they supported their members to deliver high standards of care for the deceased, with a focus on their security and dignity. The organisations that the Inquiry approached were:

- Baptist Union of Great Britain;
- Board of Deputies of British Jews;
- Catholic Bishops' Conference of England and Wales;
- Church of England;
- Conference, Methodist Church;
- Evangelical Presbyterian Church in England and Wales;
- Hindu Council UK;
- Hindu Forum of Britain;
- Jewish Leadership Council;
- Muslim Council of Britain;
- Network of Buddhist Organisations; and
- Network of Sikh Organisations.

The Inquiry received responses from nine of these 12 organisations. Those that did not respond were the Network of Sikh Organisations, the Hindu Council UK and the Network of Buddhist Organisations. The Hindu Forum of Britain did respond. The Inquiry's findings therefore cannot reflect on practices relating to the security and dignity of the deceased in the Buddhist and Sikh religions.

9.3 Our findings

The Baptist Union of Great Britain told the Inquiry that, in some Baptist churches and communities, the body of the deceased might be 'laid out' at the family home for a short period so that people could come and pay their respects. It also told the Inquiry that, in some communities, it was traditional to have an open coffin at a funeral. The body would be in the care of the funeral directors while at the church or chapel, and ministers were expected to work with the family or funeral directors to ensure that the deceased person was treated with respect and dignity. Finally, it said that it would write to ministers to remind them of the outcomes from Phase 1 of the Inquiry and to emphasise the importance of following the safeguarding reporting process if they had any concerns.[3]

3 Written statement of the Baptist Union of Great Britain, October 2024.

The Board of Deputies of British Jews told the Inquiry that the bodies of deceased Jewish people would be released to a Jewish burial society and taken to its facility, where they would undergo *tahara* (cleansing of a dead body in preparation for burial). They would be looked after there by a *shomer* (guardian), who stays with the deceased from the time of death until burial. The role of the *shomer* would often be shared between family members, close friends or members of the Jewish burial society, taking turns.[4]

The Jewish Leadership Council advised that it was an umbrella organisation and it held no role in relation to caring for the deceased.[5]

The Catholic Bishops' Conference of England and Wales told the Inquiry that it was not common practice for there to be unsupervised access to a deceased person by ministers or church officials. Ministers and officials would receive the deceased into their care from funeral directors and, following the conclusion of a religious service, commit them to the ground for burial or to the crematorium officials for cremation. Where there was a Vigil of Prayer the night before a Requiem Mass, the deceased would be brought to the church in a sealed coffin for a service and left in the church overnight.[6]

The statement from the Church of England's Churches' Funerals Group explained that, when a funeral service was held in a Church of England building, the coffin containing the deceased person would be in the care of the funeral director prior to cremation or burial. The statement also explained that occasionally a coffin would be left overnight in a locked church the day before a funeral.[7]

The Conference, Methodist Church advised that its ministers had no responsibility in this area, and that the role of a Methodist minister was in working with the dying and the bereaved, and officiating funerals.[8]

The Evangelical Presbyterian Church in England and Wales explained that it was a small Presbyterian denomination, and its primary role related to conducting the funeral service and offering pastoral care to the bereaved.[9]

The Hindu Forum of Britain explained that the Hindu-Sanatan tradition did not allow a body to be left unattended and that cremation must be performed very soon after death – ideally within 12 hours and by 24 hours at the latest. It also expressed a wish for increased CCTV, access control, security clearance and alarm systems in mortuaries.[10]

4 Written statement of the Board of Deputies of British Jews, October 2024.
5 Written statement of the Jewish Leadership Council, January 2025.
6 Written statement of the Catholic Bishops' Conference of England and Wales, September 2024.
7 Written statement of the Church of England, October 2024.
8 Email response of the Conference, Methodist Church, January 2025.
9 Email response of the Evangelical Presbyterian Church in England and Wales, January 2025.
10 Email response of the Hindu Forum of Britain, January 2025.

The Muslim Council of Britain told the Inquiry that it was dedicated to ensuring the highest standards of care, security and dignity for the deceased in all settings.[11] Following the David Fuller case, it issued revised guidance[12] to member organisations, including mosques. The guidance includes restrictions on access to mortuaries,[13] CCTV monitoring and safeguarding training.

What we have found

- The Inquiry has found variations in the practice and responsibilities of the different faith organisations we engaged with regarding the security and dignity of the deceased.
- The Inquiry has heard evidence that, in some cases, the deceased may remain in a religious building overnight, although it has not been possible to investigate the security arrangements of religious buildings in detail.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 67
All faith organisations should consider how to support their members to deliver high standards of care for the deceased, with a focus on the security and dignity of the deceased – for example, by sharing guidance.

Recommendation 68
Where deceased people are in a religious building overnight, measures should be taken to ensure that the building is secure, including, for example, CCTV and secure access control for the area in which they are kept.

11 Email response of the Muslim Council of Britain, December 2024.
12 Muslim Council of Britain, MCB Recommended Guidance for Affiliates and Muslim Organisations Offering Funeral and Mortuary Services, 16 December 2024, Muslim Council of Great Britain website.
13 Note that this does not mean a mortuary licensed by the HTA.

Chapter 10: Locality visits

10.1 Introduction

In examining the arrangements in the sectors set out in this Report, the Inquiry amassed a significant amount of evidence regarding the policies, procedures, processes and governance in place in England that are intended to protect the security and dignity of people after death. In considering this evidence, to inform our findings and recommendations to the specific sectors responsible for caring for or storing deceased people, it became apparent that the settings are linked to, and very often dependent upon, each other. There are 'pathways' between these settings through which people are transported after their death.

The Chair of the Inquiry therefore decided that it would be of benefit to visit a selection of localities in England, to collect evidence on and observe the linkages and interactions between sectors in these localities. The aim was to assess how these interactions have an impact on the security and dignity of deceased people through different settings and governance systems.

10.2 How we did our work

When selecting the areas for locality visits out of all the organisations the Inquiry had examined during its investigations of the individual sectors, we considered geographical distribution across England, as well as the interactions we were already aware of from our evidence. The localities visited were all urban centres in England, where there were more interactions.

The evidence for each locality was collected through a combination of interviews with key individuals, such as Mortuary Managers, and observations made by the Inquiry team. Three individuals from the Inquiry were present at each of the locality visits. The Chair of the Inquiry was involved in each of the locality visits but did not visit every site; he attended 12 out of 15 sites.

We have not named the specific localities we visited or the individuals to whom we spoke to preserve anonymity.

10.3 Our findings

10.3.1 Locality 1

The Inquiry visited four mortuaries as follows:

- two mortuaries run by local authorities, in two cities:
  - one small facility; and
  - one large inner-city facility; and
- two NHS-run mortuaries in two cities:
  - one at an inner-city children's hospital; and
  - one at a hospital on the edge of the city.

The Inquiry had also intended to visit a standalone digital autopsy facility that provides services across the area but was not permitted to do so. Although the Inquiry received some limited information about this facility via email, the lack of full cooperation was disappointing (see Appendix 4).

All four sites relied on contracts with funeral directors to transport deceased people to and from their premises.

The smaller of the two local authority mortuaries told us that, as a result of the Inquiry's work, and an incident when a trolley being used to transfer a deceased person collapsed when they were being taken out of a vehicle at the digital autopsy facility, it had changed its working practices so that funeral directors were required to work in pairs when transporting the deceased. Funeral directors could not access the mortuary out of working hours, so would take deceased people back to their own premises if they were collected out of hours or at the weekend.

The large inner-city local authority mortuary told us that the coroner's contracted funeral director transported to the mortuary those deceased people who had died suddenly in the community, or those deceased people where a coronial post-mortem examination (PME) was required, specifically from a hospital or, more rarely, a hospice or care home. The mortuary did not receive deceased babies and children where the cause of death was related to a specialist condition and a perinatal or paediatric PME was required (see below).

The Inquiry was told that the contract for the transportation service was managed by the Coroner Service Manager. The Mortuary Manager did not know if it included any clauses pertaining to the security and dignity of deceased people. We were told that it was very rare that any other funeral director would transport deceased people to the mortuary. However, the Mortuary Manager said that this might happen in relation to deceased people of some faiths, to expedite the time they were in the mortuary. Despite being a relatively large facility, at the time of our visit during the winter period the mortuary did not have enough storage capacity for the number of deceased people in its care. We were told that this meant deceased people were, on occasion, left at a funeral director's premises prior to being transferred to the mortuary for PME.

The Mortuary Manager at the NHS hospital we visited told us that the mortuary had been approached by the inner-city local authority mortuary and other mortuaries in the locality asking if they could use its contingency capacity. The Mortuary Manager told us that the mortuary was not able to assist without sufficient notice.

The NHS hospital had a contract in place with a funeral director to transport deceased patients and to provide funeral services for deceased babies up to a certain gestation. The Mortuary Manager had regular meetings with the contracted funeral director to discuss the performance of the service against the key performance indicators in the contract. The coroner's contracted funeral director also transported deceased people to the mortuary.

The Inquiry was told that the perinatal and paediatric PME service at the children's hospital was precarious, due to a national shortage of perinatal pathologists (see Chapter 11, section 11.5.2). There are around 35 perinatal pathologists able to undertake PMEs in England, and these are based in a small number of specialist centres. This means that the post-mortem service at the children's hospital is heavily reliant on transferring babies and children to other hospitals for PME. This results in deceased babies and children frequently being transported long distances between hospitals by funeral directors. The Inquiry was told that funeral directors would often work alone when doing so and, where the distance involved was too great to travel there and back in one day, the deceased baby or child would be stored overnight at the funeral director's premises, which were not licensed or inspected by the Human Tissue Authority (HTA). The Inquiry recommended that the funeral sector should be regulated when it published its Interim Report in October 2024 (see Chapter 8, section 8.2).

The NHS hospital and local authority mortuaries in the locality rely on a single commercial provider to conduct digital autopsies, with significant numbers of deceased people being transferred to this facility.

The Inquiry was told by the inner-city local authority mortuary that it had experience of unsuitable equipment being used by the digital autopsy provider to transport deceased people, and that transfers of deceased people to and from the provider were being conducted by lone workers.

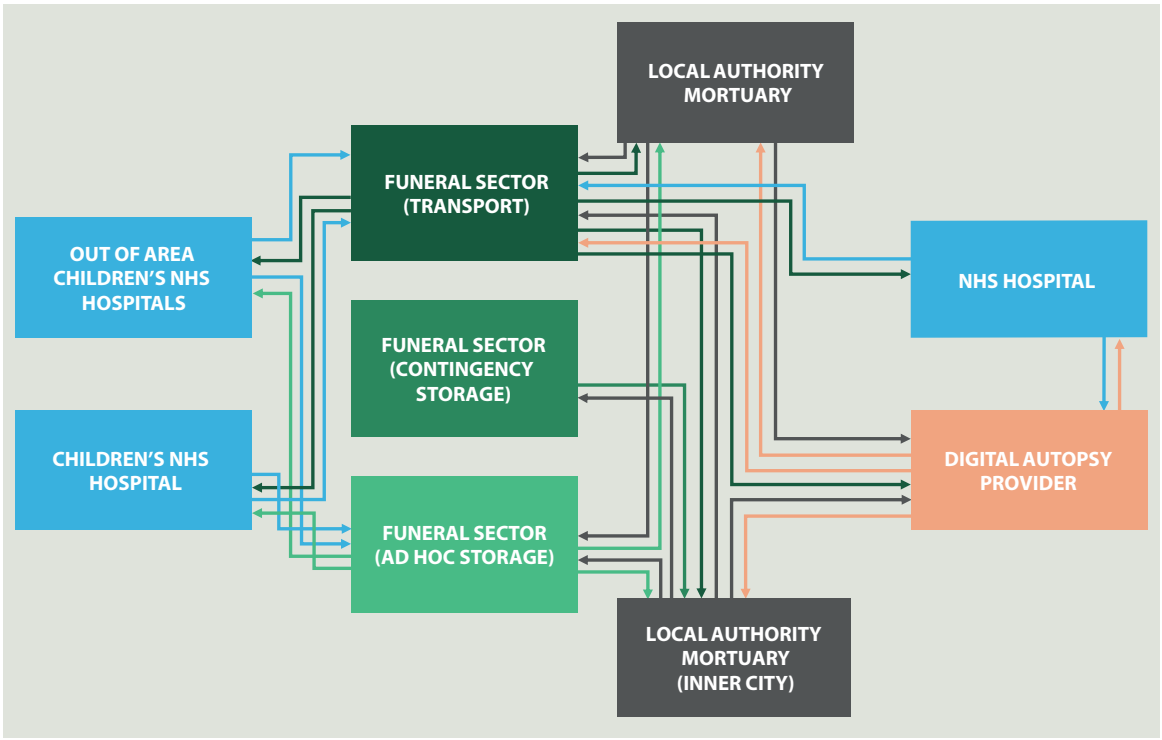
In contrast, the smaller local authority mortuary reported a good working relationship with the digital autopsy provider. The Inquiry was told of an incident where a deceased person, who had been transferred from the mortuary to the digital autopsy provider for a scan, fell to the floor as they were being lifted from the scanner onto a trolley. Managers from the mortuary were involved in investigating this incident and had visited the digital autopsy provider to understand how things worked there. The digital autopsy provider participated in the investigation, and we were told that it had amended its Standard Operating Procedures (SOPs) as a result to avoid any repetition of the incident.

The protocol for this coroner area was that all deceased patients whose death was being investigated by the coroner initially had a digital autopsy. The Mortuary Manager told the Inquiry that arrangements with the digital autopsy provider were made by the

coroner service. However, the Mortuary Manager had visited the digital autopsy provider to see what the facilities were like.

Figure 1 represents a visual illustration of the Inquiry's observations of the pathways along which deceased people are transported between sites in this locality.

***Figure 1:** Pathways of deceased people in Locality 1*



10.3.2 Locality 2

The Inquiry visited the following sites:

- a university medical school;
- the mortuary at an inner-city NHS hospital; and
- a surgical training centre based at an NHS hospital.

All three sites relied on funeral directors to transfer deceased people to and from their premises.

The medical school told the Inquiry that it had a contract in place with a funeral director to transport deceased people who had donated their bodies to the school (referred to as 'donors'). The contracted funeral director would keep donors in its cold storage facility until the administrative process to transfer them to the medical school was complete, which was usually within seven days after death but had to be within ten days. A representative of the medical school had visited the contracted funeral director to inspect the facility to check that it was suitable for storing donors. This was done on one ad hoc occasion. Visiting the funeral director's premises for assurance was not included in the contract with the funeral director, which was managed by the university procurement team, not the medical school. Alternatively, if the donor's family wished to contact a funeral director of their choice, the medical school would

recommend that they made sure the firm had cold storage at its premises. When a person has decided that, on their death, they wish their body to be donated to medical schools for research and training, the donation period usually lasts for up to three years. After this period, the medical school would contact its contracted funeral director to arrange cremation of the donor. The medical school was permitted to retain parts of the donor's body, with appropriate consent.

Deceased people admitted to the hospital mortuary for PME were transported there by either the coroner's contracted funeral director or the contracted funeral director used by the hospital from where they had come. The Mortuary Manager told the Inquiry that there was a service level agreement in place with the funeral director and an SOP for transfers into the mortuary. The NHS trust's contracted funeral director's premises had been visited by the hospital's bereavement team. The Mortuary Manager told the Inquiry that they and other relevant senior staff at the hospital met all the funeral directors who transferred deceased people to and from the mortuary to discuss any issues. The Mortuary Manager stated that it had been standard practice for deceased people who were under the legal control of one of the coroners to be taken into the coroner's contracted funeral director's premises prior to transfer to the mortuary, because of the size of the coroner area. However, following the publication of the Inquiry's Interim Report on the funeral sector, the coroner had decided that this practice must end and that all deceased people under the coroner's legal control should be taken straight to the hospital mortuary.

The NHS hospital had a contingency arrangement in place with the university medical school for the storage of deceased patients. Ten fridge spaces at the medical school were allocated for the NHS hospital to use under this arrangement, through a Memorandum of Understanding (MoU). The MoU between the two organisations included a reciprocal arrangement, although the medical school had never needed to use contingency storage at the NHS hospital. The HTA enquired about this contingency arrangement when it inspected the NHS hospital.

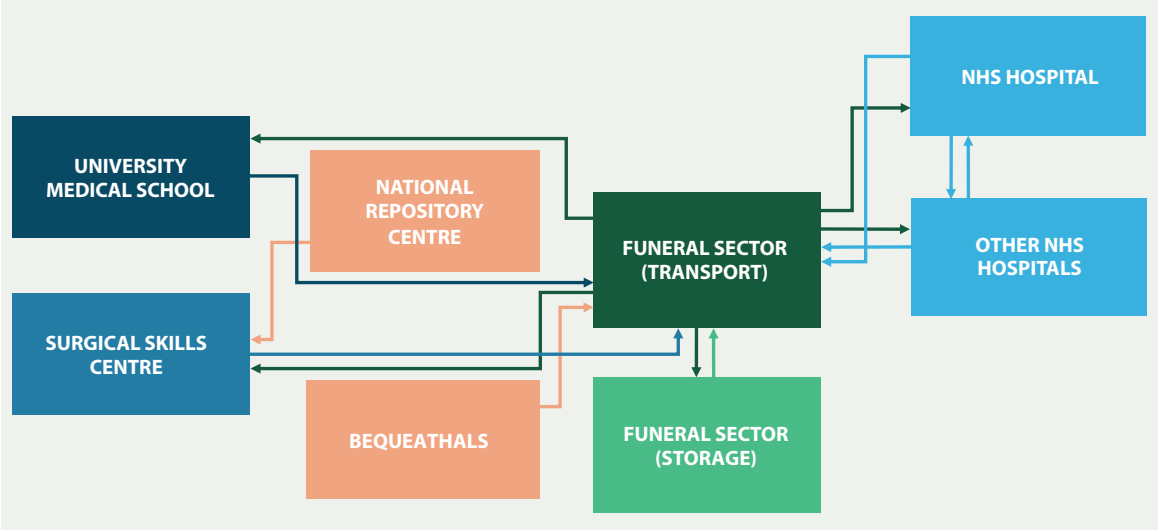
The Inquiry was told that the surgical training centre received donors from the university medical school bequeathal service and also from a donor repository for the purpose of cadaveric dissection. Donors stored at the medical school were transported to the surgical training centre by the medical school's contracted funeral director. Donors stored at the repository were transferred by the repository's contracted funeral director.

The surgical training centre is based at an NHS hospital. However, the HTA Designated Individual (DI) for the surgical training centre is based at and employed by the medical school of the university. The DI told the Inquiry that, although they did visit the surgical training centre as they taught there, they did not consider that they were able to effectively discharge their responsibilities as DI because the centre was too large to be managed remotely as a satellite of the university. The NHS trust that runs the surgical training centre told the Inquiry that it was in the process of improving the governance of the centre and of better integrating it into the governance processes of the trust's own governance arrangement. This included applying to hold the HTA licence for the centre and appointing a new DI, the Chief Nurse of the trust, who would have responsibility for the dignity of donors and regular reporting on the surgical training

centre to the trust's quality committee, a subcommittee of the trust board. The Mortuary Manager at the trust spoke to the Inquiry about working with the surgical training centre to support the team there by, for example, sharing policies and operational experience of having CCTV on site.

Figure 2 represents a visual illustration of the Inquiry's observations of the pathways along which deceased people are transported between sites in this locality.

Figure 2: *Pathways of deceased people in Locality 2*



10.3.3 Locality 3

The Inquiry visited:

- the body store of an NHS hospital;
- a small mortuary run by a local authority; and
- a large mortuary run by a local authority, with its own digital autopsy facility.

The body store at the NHS hospital is run by a local firm of funeral directors, which also holds the contract for transporting deceased patients at the hospital. The body store had previously been run by a different firm of funeral directors. The Inquiry was told that, initially, this was an informal arrangement, linked to the firm occupying the 'funeral office' at the hospital, where it offered funeral services to deceased patients' families, and it was put in place because the hospital was having difficulty staffing the body store. The Inquiry was told that the arrangements for running the body store had been regularised in recent years and there was now a contract in place between the NHS trust and the firm of funeral directors. At the time of the locality visit, the contract was in the process of being re-tendered. The Inquiry was told that a member of staff from the funeral directors operated the body store, working to the policies and SOPs of the NHS trust. This staff member worked alone, and when they were not working, another staff member from the funeral directors would work there instead. The Inquiry was told that the funeral directors owned a refrigerated body storage unit on the site, which was leased to the NHS trust. This arrangement had been made as there was not enough capacity in the hospital body store. The future of this unit was uncertain, if the

firm of funeral directors running the body store was not awarded the contract currently being re-tendered.

The Facilities Manager at the hospital was responsible for the day-to-day management of the body store. They had introduced a number of measures to improve security and governance over the previous year. These included additional CCTV cameras in the body store and on the entrances, and signing-in procedures for visitors to the body store. The Facilities Manager also described improvements in the governance of the body store that had been introduced at the NHS trust following the David Fuller case. These included conducting daily welfare checks of the mortuary staff, monthly audits of compliance with SOPs, including access control and CCTV audits, and a monthly trust-wide governance meeting. Information from the audits and monthly meetings was reported into the trust's governance processes. However, this routine governance information was not shared with the funeral directors holding the contract to run the body store, and issues were reported to them by exception.

The two local authority mortuaries visited also interact with funeral directors. The smaller of the two is part of a consortium arrangement with other local authorities within that coroner area and provides post-mortem services to the coroner. The Inquiry was told that the contract for funeral directors transporting deceased people to this mortuary, and for any transfers between mortuaries, was held by the lead authority for the coroner service. The contract stipulated that funeral directors could not work alone when transporting deceased people. The contracted funeral directors were permitted to access some of the fridges without mortuary staff being present outside of usual working hours. The Inquiry was told that, while the Mortuary Manager conducted audits to check that the contracted funeral director was accessing the mortuary appropriately out of working hours, the assurance that the service was being provided in line with the contract was a matter for the local authority that held the contract on behalf of the consortium.

For the larger mortuary, the Inquiry was told that funeral directors transported deceased people to it on behalf of coroners, but that the mortuary was not involved in the contracts for this. The contracts between the local authority (on behalf of the coroner) and the funeral directors included clauses to protect the security and dignity of the deceased – for example, the requirement for funeral directors to work in pairs while transporting deceased people. The Inquiry was told that the mortuary had established its own transport service for when it needed to transport deceased people to and from other places it provided services to (see later in this section).

The smaller public mortuary received deceased people from other mortuaries for PME under a 'mutual aid' scheme. As part of this, there was also movement of deceased people between it and other mortuaries in the locality for contingency storage. When asked about how mortuaries providing mutual aid assured themselves that others in the scheme were fit for purpose in terms of safeguarding the security and dignity of the deceased, the DI told us that assurance was taken from discussions at the consortium meeting. They went on to say that HTA reports and HTA Reportable Incidents (HTARIs) were discussed at the consortium meetings, in the presence of the coroner's Office Manager.

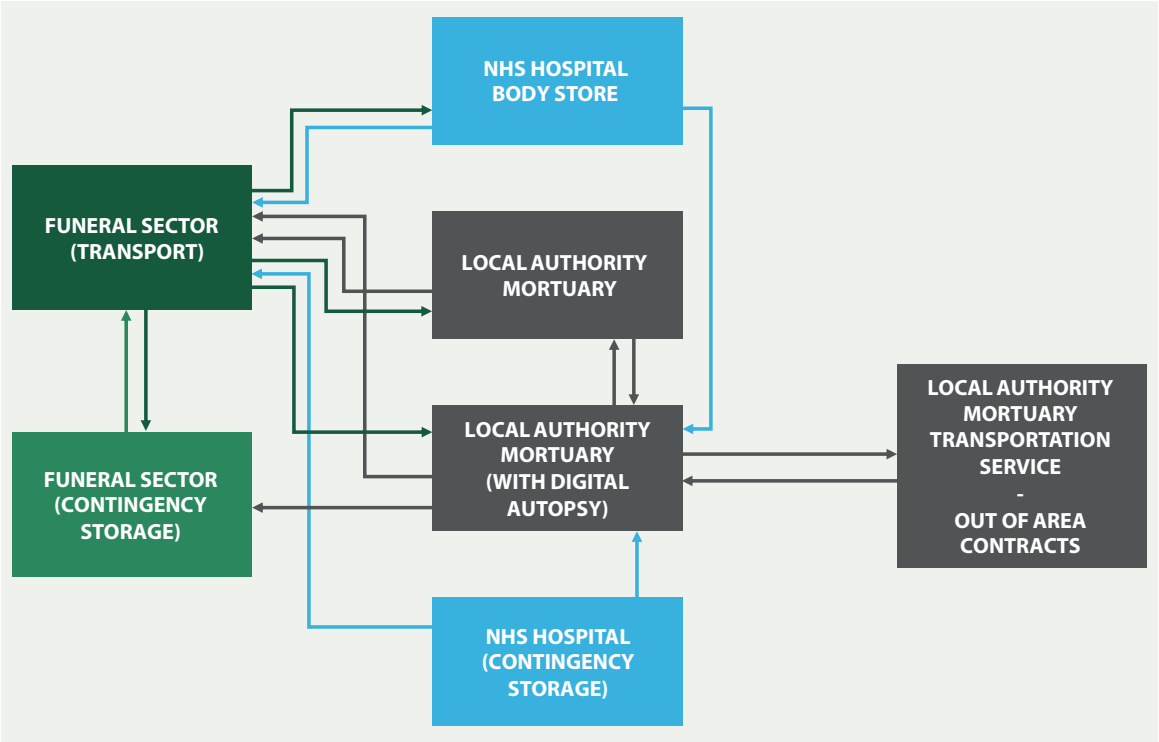
When we asked if any mutual aid scheme partners had visited the mortuary for assurance purposes, we were told that they had not, but that staff from other mortuaries had visited to assist in PMEs and would have seen the arrangements then.

The larger of the local authority mortuaries visited can undertake digital post-mortem examinations. It offers this service, alongside invasive post-mortem examinations, to other local authorities and to families of deceased people, and the service has a large catchment area. As mentioned earlier, the Inquiry was told that the mortuary had set up its own transport service to transfer deceased people to and from the mortuary for PMEs. Staff working on the transport service were required to work in pairs. The mortuary also provided training to other organisations, including a university and a public mortuary. The DI told the Inquiry that there were measures in place to protect the security and dignity of deceased people when trainees from these partner organisations were on site. This included having safeguarding policies for individuals who were not employed by the mortuary and not allowing them to have unaccompanied access to deceased people.

The larger local authority mortuary had arrangements in place for contingency storage with a firm of funeral directors and another local authority-run mortuary. There were service level agreements in place for these arrangements and the DI had visited the funeral directors and other mortuaries to satisfy themself of the quality of the contingency storage. The mortuary itself also provided contingency storage to an NHS trust in the area through a service level agreement. The NHS trust had visited the mortuary as part of setting up the service level agreement. The mortuary also generated income by offering to store deceased people.

Figure 3 represents a visual illustration of the Inquiry's observations of the pathways along which deceased people are transported between sites in this locality.

Figure 3: Pathways of deceased people in Locality 3



10.3.4 Locality 4

The Inquiry visited:

- an independent body store and transportation provider; and
- a mortuary run by a local authority.

The sites interacted with each other and other organisations, including via contracted services.

The provider of the body store held at least ten contracts with local authorities, NHS hospitals and a hospice across a wide geographical area. Services included transportation of the deceased in cases of sudden and unexpected deaths in the community, and provision of temporary or contingency storage. For example, the body store had recently provided emergency storage following equipment failure at another mortuary. It did not contract with any organisation for contingency capacity itself and stopped receiving deceased people when it was at capacity.

The Inquiry heard how the Managing Director of the body store was supported by a small management team. A wider team of senior and junior operatives supported collection and transfer activity, using a fleet of private ambulances. A probation period applied to all new staff, who were DBS checked. Assurance visits from contracting organisations were common and allowed for viewing of the cold room and separate freezer storage. Some organisations might require weekly activity reports during the contract as well, but this was not standard practice. Meetings were arranged on an ad hoc basis.

Upon collection, deceased people were transferred to the body store or to another mortuary. Contracts for transportation permitted body store operatives to access some NHS and local authority mortuaries out of hours, with keys kept securely within the vehicle(s) assigned to the contract, as well as within the main staff office. The Managing Director described how facilities managed by contracting organisations were generally secure and monitored by CCTV. Supporting contracts would detail these security arrangements, as well as the steps required to maintain the dignity of the deceased. Facial recognition technology had recently been installed in the body store in addition to existing CCTV and security measures, and the Inquiry heard that contracting organisations had welcomed this.

Operatives completed a body report for each deceased person upon arrival, and this acted as an ongoing reference point to decide whether the contracting organisation needed to be alerted to any deterioration in condition. Although the body store was unregulated, on the basis that it did not undertake any licensed activities, it applied HTA guidance requiring deceased people to be moved into freezer storage after 30 days. The Managing Director confirmed that they had previously raised concerns about the condition of deceased people being received into their care:

> *"[I]f it's from an undertaker, I will get straight onto them and say I'm really concerned about the condition of this deceased. And they all say the same thing, oh yeah, well we didn't think the family were going to see him, so we left them in the hospital for however long. And then the hospital's frozen them, and then they've got them out and they've just let them defrost, not in a fridge. They're rotten, and then they say, can you do something with them? No, no, we can't turn back time, you know … So yeah, it's that's a regular weekly thing. Yeah, especially from the big companies."*[1]

The Inquiry was told that contracting organisations permitted funeral directors to collect a deceased person from the body store when appropriate, with the body store checking back to confirm approval to release. The body store also provided an embalming service, involving regular interaction with funeral directors to collect and return the deceased person being embalmed.

The Inquiry heard that the body store had had no recent incidents other than one manual handling injury. There was no incident reporting process beyond use of the coroner's removal form. The Managing Director expressed confidence that the police, who would be present for coroner removals, would alert them to any concerns.

The local authority mortuary is provided by the lead local authority for the coroner service. The Inquiry was told that it primarily received deceased people from local hospitals, prisons, care homes and deaths occurring in the community that had been referred to the coroner. Operatives of the coroner's transportation service, provided by the independent body store and transportation provider (above), had a keypad code to facilitate out-of-hours access to the mortuary. They also escorted out-of-hours admissions for the provider of a national contract for any deaths occurring on the rail network, and provided transport to external services such as digital autopsies.

1 Witness transcript of A8, Managing Director, March 2025.

Deceased people could also be transported to the mortuary by ambulance services or by a funeral director contracted by another local authority, as set out below. Other funeral directors also interacted with the mortuary to collect deceased people released into their care. A specific entrance was used for all transfer and removal activity, which had CCTV and keypad access installed. Steps were taken to preserve the dignity of the deceased, including ensuring that staff worked in pairs. Entry data was audited at least monthly, and the interviewee was not aware of any previous incidents concerning admissions or collections.

The Inquiry was told that the mortuary sometimes needed additional capacity, particularly during seasonal peaks. It had contracts with both the independent body store and transportation provider described above and another firm of funeral directors for contingency storage. The Inquiry heard that winter contingency arrangements were planned from the preceding summer. Assurance visits were undertaken as part of awarding both contracts, and financial checks were undertaken. Meetings took place on a regular, ongoing basis but no formal reporting was required. Contracts included measures to ensure the security and dignity of deceased people.

The mortuary had recently provided storage and PME capacity for another mortuary during its refurbishment, and for another for PME capacity only. MoUs were agreed in both cases, covering the expected duration and staffing provision. One of these agreements had been extended, leading to ongoing pressure on both mortuaries. The Inquiry noted that the body store and transportation provider had similarly provided temporary storage for the same other mortuary during its refurbishment.

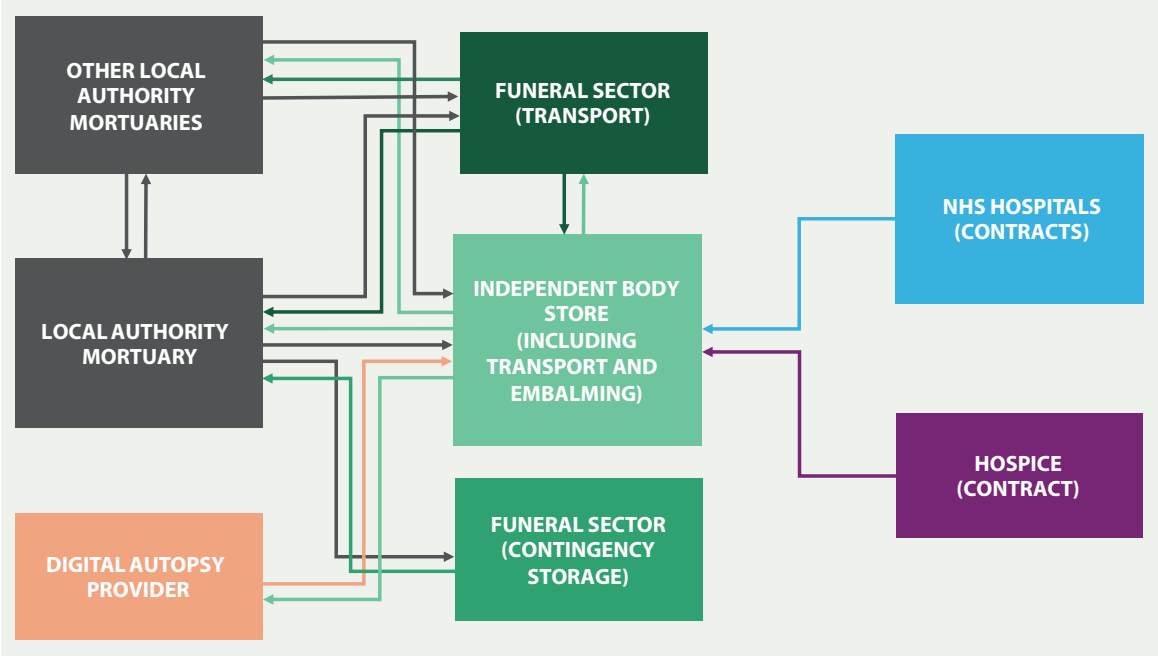
More widely, the mortuary operated within a consortium of local authorities within the same coroner area. The Inquiry heard how this consortium had an informal agreement to provide mutual PME support across the group of mortuaries, as well as other mutual aid, such as support for contingency storage. The Bereavement Services Manager of the mortuary had also worked to build connections between local Mortuary Managers and coroner's office staff across this consortium, with regular meetings to share HTA feedback, best practice and any other issues (e.g. long stays). The Inquiry heard that varying demographics could mean that some local authority mortuaries had more complex cases than others.

The Inquiry heard that the local authority providing the mortuary had a contract with another local authority to provide PME services. This local authority did not have a mortuary and separately arranged for transportation of the deceased via a firm of funeral directors which was also able to access the mortuary facilities out of hours.

The mortuary was staffed by a combination of permanent and locum anatomical pathology technologists (APTs). Pressures on the APT workforce were acknowledged and had been highlighted in a recent HTA inspection. The Inquiry heard that the mortuary had recently been able to secure approval for additional permanent staff and felt that the work of the Inquiry had helped to focus attention on mortuary management issues locally.

Figure 4 represents a visual illustration of the Inquiry's observations of the pathways along which deceased people are transported between sites in this locality.

Figure 4: *Pathways of deceased people in Locality 4*



10.3.5 Locality 5

The Inquiry visited:

- a medical school;
- a surgical skills training centre, also based in a university; and
- the mortuaries at an inner-city NHS trust.

Funeral directors transferred the deceased to and from, and between, the three sites.

The medical school anatomy department and surgical skills training centre are co-located, and both receive deceased people as 'donors' through direct bequeathal to those sites, as well as from a donor repository centre elsewhere in the country. The medical school and surgical skills training centre share a mortuary, and the Inquiry heard how deceased people could be used as donors for either purpose, with a decision made about this as soon as they arrived on the premises. Donors for the medical school were embalmed, and donors for the surgical skills training centre were placed in freezer storage.

The medical school had a contract with a firm of funeral directors to convey donors to the mortuary, with donors stored at the funeral director's premises overnight if the death occurred out of hours. This contract included a requirement for funeral directors to provide two members of staff to convey the donors, as well as requirements to ensure the dignity and respect of the donor. The contract was managed by the university procurement team, and medical school staff reported issues and periodically commented on how the contract was functioning. The medical school team had visited the funeral director's premises to confirm that the storage facilities were suitable.

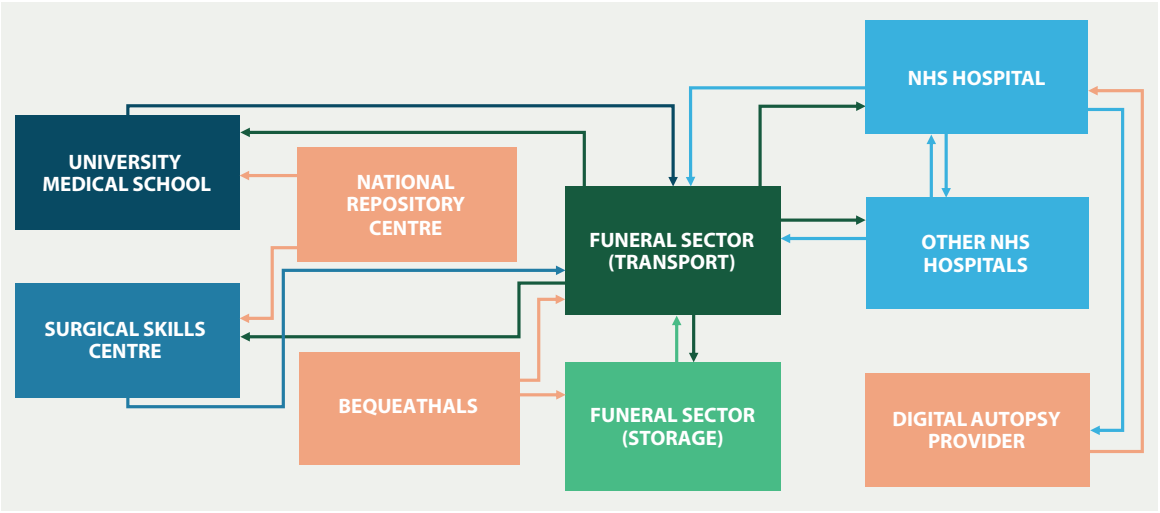
The surgical skills training centre is run by staff from the local NHS trust, although it is located in the medical school. The centre is staffed by NHS staff who are managed through the NHS trust. The NHS trust postgraduate medical education team is responsible for the management of the centre. The NHS leases the facilities and equipment for the surgical skills training centre from the university. The Inquiry heard that the local NHS trust's mortuary staff were not involved in the management or governance of the surgical skills training centre, although they did attend the steering group meetings and sometimes responded to requests for advice. NHS trust mortuary staff advised on HTA licensing and supported staff at the centre when it reopened under NHS management, including by providing manual handling training.

The HTA licence for the centre is held by the university and the DI is the same for both facilities. The licensing arrangements include the responsibility for the university to provide the DI, and the requirement for the DI to include all NHS trust staff in training and governance structures. The Inquiry heard evidence of sharing best practice and SOPs between the medical school and NHS surgical skills training centre. Any incidents at the centre were reported to the DI, as well as through the university and NHS trust reporting routes, and were taken to a steering group where all the organisations were represented.

The Inquiry also visited the adult and paediatric mortuaries at an inner-city NHS trust. The Mortuary Manager at the trust was responsible for the staffing and day-to-day running of all five of the mortuaries and body stores across different hospital sites in the trust. The trust had a service level agreement in place with another trust in the region for contingency storage, but this had never been used. The digital autopsy service contract was held by the coroner, and the trust was not involved in the management of this contract. The digital autopsy provider also arranged collection and return of the deceased through its own contracted transport provider. There was also a service level agreement with another trust, for which it undertook paediatric PMEs, reflecting the arrangements heard about on other locality visits and other evidence about the shortage of paediatric pathologists. For transfers within the trust, the trust had a member of staff who could act as a transport driver. If they were unavailable, a local firm of funeral directors was used; there was an agreement in place with the firm, including a SOP on transfer, that referred to ensuring the security and dignity of the deceased.

Figure 5 represents a visual illustration of the Inquiry's observations of the pathways along which deceased people are transported between sites in this locality.

Figure 5: *Pathways of deceased people in Locality 5*



What we have found

- Organisations that care for people after death rely heavily on the funeral sector, not only for transportation of deceased people but also for contingency storage.
- The Inquiry has found many examples of mutual aid between organisations that care for the deceased, covering contingency storage and post-mortem examination services.
- There are some good examples of governance across and between different organisations, but this is not universal.
- A common theme is that many arrangements between organisations are made and maintained through 'goodwill' and informal mutual aid agreements, rather than being formalised and underpinned by contracts or service level agreements. There is little formal monitoring of these arrangements, and the Inquiry has heard examples of where reliance on trust and personal knowledge has been used as a means of assurance.

Recommendations

The Inquiry makes the following recommendation.

Recommendation 69
Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death.

Chapter 11: Regulation and oversight

11.1 Introduction

In its Phase 1 Report, on matters relating to David Fuller's crimes at Maidstone and Tunbridge Wells NHS Trust, the Inquiry found that there were many external organisations involved in assessing the Trust's mortuaries over the years, all with different and often unclear remits. The framework of external oversight did not detect or address serious issues at the Trust's mortuaries, including lax security, non-compliance with policies and inadequate management arrangements.[1]

Despite a plethora of regulation, David Fuller was able to offend undetected for 15 years, first as an NHS staff member and then as a contractor, until his arrest in 2020 for the murders of two young women in the late 1980s. Over the years, the regulatory requirements that should have protected the deceased in the care of Maidstone and Tunbridge Wells NHS Trust were either insufficient or were not followed by those in positions of responsibility.[2]

The Inquiry stated that it would review the national regulatory framework and its effectiveness in Phase 2 of its work. Similarly, the Inquiry's Phase 1 Report set out that the regulation of mortuary staff would be considered in Phase 2.[3]

In Phase 2, the Inquiry considered the role of healthcare and other regulators to understand how they contribute to safeguarding the security and dignity of deceased people in hospital and non-hospital settings in England. For completeness, this assessment also included those that could be considered to have an oversight role rather than a statutory regulatory role.

Linked to this, we considered the impact of the current legislative framework on protecting the security and dignity of deceased people.

11.2 How we did our work

We began our work on regulation, legislation and oversight by commissioning the Inquiry's legal team to assess current arrangements. This assessment included the impact of the legal status of the deceased on regulation.

1 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023.

2 Ibid.

3 Ibid.

Following this, we invited organisations that have a regulatory or oversight function that could reasonably be considered to include mortuaries and other places where deceased people are stored to give evidence to the Inquiry through interviews and by providing statements. The organisations that provided evidence in this way were:

- Human Tissue Authority;
- NHS England;
- Care Quality Commission;
- United Kingdom Accreditation Service;
- Local Government Association;
- Association of Anatomical Pathology Technology;
- Ministry of Housing, Communities and Local Government;
- Health and Care Professions Council; and
- Professional Standards Authority for Health and Social Care.

The Inquiry also requested evidence from the Chief Coroner and each Senior Coroner in England.

The Inquiry held two seminars in November 2024 to inform its consideration of regulation and oversight. One was on the topic of regulatory, legislative and oversight measures. The second seminar was on the role of Designated Individuals (DIs) under the Human Tissue Act 2004 and was attended by DIs from a selection of NHS trusts, local authorities and medical schools.

Transcripts of both seminars are available on the Inquiry's website. The full list of participants can be found in Appendix 4 to this Report.

11.3 Current position

There are currently a number of regulators and organisations that could be reasonably considered to have a role in the quality of services that care for the deceased. These are set out in sections 11.3.1 to 11.3.7, alongside the position of coroners, who have a judicial role to investigate certain deaths and may, for that purpose, temporarily retain custody of the body of a deceased person. We consider how effective the existing regulation framework is in protecting the security and dignity of deceased people in section 11.5.2.

11.3.1 The Human Tissue Authority

The Human Tissue Authority (HTA) was created in April 2005 after the conclusion of the Retained Organs Commission. The Commission was set up following events in the 1990s that revealed a practice in some hospitals of removing and retaining human organs and tissue without consent, mainly at Alder Hey Children's Hospital in Liverpool and at Bristol Royal Infirmary. It is an executive non-departmental public body of the Department of Health and Social Care (DHSC).

The legislative basis for the HTA is the Human Tissue Act 2004. The Act clarifies that, unless authorised and done with appropriate consent, various activities involving the body of a deceased person or human tissue are unlawful. It makes provision for the regulation of authorised activities involving human tissue. The activities listed in section 1 of the Act are permitted only if they are for the purposes specified in Schedule 1 (scheduled purposes).

The scheduled purposes set out in Schedule 1 of the Act include:

- anatomical examination;
- determining the cause of death;
- establishing after a person's death the efficacy of any drug or other treatment administered to them;
- obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person);
- public display;
- research in connection with disorders, or the functioning, of the human body;
- transplantation;
- clinical audit;
- education or training relating to human health;
- performance assessment;
- public health monitoring; and
- quality assurance.

The Act applies only when specified activities for scheduled purposes take place. It therefore does not apply at locations where a deceased person might be stored or cared for but where there are no such activities – for example, hospital body stores, premises of funeral directors, care homes, hospices and nursing homes. The Act expressly did not intend to regulate all possible activities involving human tissue, bodies or body parts, and an amendment seeking to criminalise ethically undesirable uses of bodies or parts of bodies was withdrawn during the passage of the Bill.[4]

NHS trust mortuaries, local authority mortuaries and medical schools require a licence from and are then regulated by the HTA for the activities they undertake for scheduled purposes.

Organisations licensed under the Human Tissue Act 2004 for scheduled purposes in the post-mortem sector must have a Licence Holder and a DI. The Licence Holder can be an organisation or an individual. The DI is responsible for making sure that the other people to whom the licence applies are suitable to participate in the licensed activity, that suitable practices are used and that all licence conditions are complied with. The

4 UK Parliament, House of Lords, Official Report of the Grand Committee on the Human Tissue Bill, Hansard, Volume 664, Column GC 451, 15 September 2004.

role of the DI carries a personal legal responsibility to ensure that activities are carried out in compliance with the licence.

The HTA has the power to refer potential breaches of the Act (e.g. specified activities taking place without a licence) to the police. If those breaches are committed by a body corporate but it can be shown that the offence was committed with the consent or connivance, or due to the neglect, of any director or senior person in the organisation, that person is held equally responsible and can be charged as an individual. Penalties for the offence on conviction can include an unlimited fine or imprisonment for up to three years.

11.3.2 The Care Quality Commission

The Care Quality Commission (CQC) has been in operation since 1 April 2009, when it replaced the Healthcare Commission, Mental Health Act Commission and Commission for Social Care Inspection. It is the independent regulator of health and adult social care in England and is an executive non-departmental public body of the DHSC.

The CQC regulates health and social care providers under the Health and Social Care Act 2008. The Act requires those providing regulated activities to be registered, and a CQC licence then specifies the locations where regulated activities can take place.

NHS trusts, independent healthcare providers, hospices, NHS ambulance service trusts and care homes are all regulated by the CQC for some of the activities they carry out.

11.3.3 United Kingdom Accreditation Service

The United Kingdom Accreditation Service (UKAS) is the UK's national accreditation body. It assesses and accredits organisations that provide services, and includes certification, testing, inspection and calibration. It acquired the Clinical Pathology Accreditation scheme in 2009. UKAS assesses mortuaries that choose to be accredited with the service, against a standard called ISO 15189.[5] This standard is designed to assess medical laboratories. UKAS's specific role in considering a mortuary against this standard is to evaluate whether the mortuary meets the requirements of ISO 15189 from the perspective of quality and integrity of samples for scientific laboratory analysis and the prevention of cross-contamination.

The Inquiry understands that 121 mortuaries and body stores are currently accredited with UKAS.

11.3.4 NHS England

NHS England has led the NHS in England since 2013. Since April 2019, NHS England has worked together with NHS Improvement as a single organisation. NHS Improvement was formed in April 2016 through a merger between the NHS Trust Development Authority and Monitor and was responsible for overseeing NHS trusts and NHS foundation trusts. Its functions were formally transferred to NHS England in July 2022. NHS England's regional teams are responsible for the quality, financial and operational

5 International Organization for Standardization, *ISO 15189:2022: Medical laboratories – Requirements for quality and competence*, December 2022.

performance of all NHS organisations in their region. NHS England is an executive non-departmental public body of the DHSC.

11.3.5 Coroners

Coroners are independent judicial officers, funded by local authorities. Coroners are responsible for investigating violent, unnatural or sudden deaths, deaths of an unknown cause, deaths in custody or otherwise in state detention, or deaths where the deceased had not been seen by the certifying doctor during the 14 days before their death.

The bodies of the deceased are under the legal control of the coroner once the duty to investigate is triggered and the coroner is made aware that the deceased person is within the coroner area. However, the deceased are stored and cared for in NHS and local authority mortuaries through contractual arrangements with local authorities. There are 73 coronial jurisdictions in England.

11.3.6 Funeral sector

The regulation of funeral directors regarding the care of the deceased in England is entirely voluntary and based on voluntary registration with the National Association of Funeral Directors or the National Society of Allied and Independent Funeral Directors.

The Inquiry recommended statutory regulation of the funeral sector in its Interim Report, which was published in October 2024. The latest position regarding this is set out in Chapter 8 of this Report.

11.3.7 Health and Safety Executive

The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. While the HSE inspects many settings where deceased people are cared for or stored, it does so from the perspective of the safety of staff. The HSE has no statutory remit regarding the security and dignity of the deceased.

11.4 Rights of the deceased

In considering the effectiveness of regulation and oversight in protecting the security and dignity of deceased people, we were cognisant of the legal position of the deceased.[6]

There is no duty of care to a person after they have died. Other than the specific sexual offence set out in section 70 of the Sexual Offences Act 2003, safeguarding legislation does not extend to the deceased. The European Court of Human Rights has held that, as the human quality is extinguished on death,[7] the prohibition of ill treatment is not applicable to deceased people. However, there is a rule within customary international humanitarian law relating to treatment of the deceased on a battlefield. Rule 113 states: *"Each party to the conflict must take all possible measures to prevent the dead from*

6 Advice from Counsel to the Inquiry, May 2024.

7 *Akpinar and another v Turkey (App no 56760/00)* [2007] ECHR 56760/00.

being despoiled. Mutilation of dead bodies is prohibited."[8] This was first codified in the 1907 Hague Convention and is also codified in the Geneva Convention.[9]

Although there is no duty of care to a person after they have died, successful claims have been brought by relatives in their own right in cases where the relatives have suffered harm or distress owing to the treatment of a deceased person after death.[10]

While there is a lack of case law regarding the ill treatment of deceased people, a relevant factor in respect of any future cases is that mistreatment of the deceased is now a foreseeable event as a result of a number of cases, including David Fuller, Jimmy Savile, the Alder Hey organs scandal and other recent cases relating to the mistreatment of the deceased.[11]

11.5 Our findings

11.5.1 Purpose of existing regulation and oversight

There is no regulator or regulatory or oversight framework with the overriding objective of protecting the security and dignity of the deceased.

The Inquiry heard that the reason the HTA was set up was to regulate issues relating to the use of human organs and tissue rather than the security and dignity of the deceased:

> *"The Human Tissue Authority was established in 2006 under the Human Tissue Act. Its purpose is to ensure the safe and consented use and storage and handling of human tissue and organs."*[12]

The CQC regulates four of the settings considered by the Inquiry: NHS hospitals, independent hospitals, hospices and care homes. However, its remit as a regulator does not extend to the care of people after death:

> *"So the CQC has regulations on what we call regulated activity, and they cover people who use services. So it's difficult to construe, and we have taken legal advice on this, that it would apply to services to the deceased. So there's a point at which our regulation stops, and other regulators would – regulation, I suppose – would start. Where it happens, I recognise in Phase One of your report that there was a grey area but since then, we're quite clear that our regulation is not about the deceased individual, and it applies to people who are living receiving regulated services."*[13]

In Phase 1 of our work, the Inquiry found that the CQC had included the mortuary at Maidstone and Tunbridge Wells NHS Trust in its inspections, and this had contributed

8 International Humanitarian Law Databases, Rule 113, Treatment of the Dead.
9 Hague Convention (X), Article 16; Fourth Geneva Convention, Article 16, second paragraph.
10 *Brennan and others v (1) City of Bradford Metropolitan District Council (2) Leeds Teaching Hospitals NHS Trust* [2021].
11 Advice from Counsel to the Inquiry, May 2024.
12 Witness transcript of Dr Colin Sullivan, Chief Executive, HTA, October 2024.
13 Witness transcript of Ms Joyce Frederick, Director of Policy and Strategy, CQC, October 2024.

to confusion about its remit as a regulator.[14] At the time of the conclusion of the Inquiry's investigations in spring 2025, the CQC had not issued any external communications to clarify to those organisations it regulates that its remit does not extend to consideration of the care of the deceased, although the Inquiry was told that communications were planned.[15] Until this is communicated in a clear and comprehensive manner, the Inquiry believes that there remains the possibility of organisations taking false assurance regarding the care of deceased people on their premises following CQC inspections.

UKAS told the Inquiry:

> *"In the context in which the Inquiry is concerned, UKAS's role can be summarised as assessing the competence of the laboratory to perform tests and to produce reliable outcomes from examination."*[16]

UKAS went on to explain that, in its view, the ISO 15189 standard against which it accredits organisations contains requirements that support safeguarding the security and dignity of the deceased.[17] However, the Inquiry has found no requirements in the standard that specifically support such safeguarding.

The purpose of NHS England is leadership of the NHS: *"So, the macro picture for NHS England is our primary statutory duty is to promote a comprehensive health service for the people of England."*[18]

While coroners have legal control of the body of the deceased person until their coronial functions come to an end, they do not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of the deceased in their control.[19]

The Local Government Association is not a regulator and does not have a formal role in overseeing local authorities.[20]

As there is no system of regulation or oversight with the principal objective of protecting the security and dignity of the deceased, we examined how effective the current system is in achieving this.

11.5.2 Effectiveness of existing regulation and oversight

The current system of regulation and oversight is partial, piecemeal and not universally mandated in its application to the issues examined by the Inquiry. As discussed in section 11.5.1, it has been devised for particular purposes that do not expressly include protecting the security and dignity of deceased people. It covers some mortuary-related activities and locations but not others.

14 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.194.
15 Written statement of Ms Joyce Frederick, Director of Policy and Strategy, CQC, November 2024.
16 Written statement of Mr Matt Gantley, Chief Executive, UKAS, October 2024.
17 Ibid.
18 Witness transcript of Mr Steve Russell, Chief Delivery Officer, NHS England, October 2024.
19 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.198.
20 Witness transcript of Mr Mark Norris, Principal Policy Adviser, LGA, October 2024.

The Human Tissue Act 2004 provides a regulatory framework covering specific regulated activities. As set out in section 11.3.1, in locations where no such activities are undertaken, the legislation does not apply. The HTA defines human tissue as *"material that has come from a human body"*[21] and not as the body itself. The HTA has no jurisdiction over body stores, the funeral sector or other locations where deceased people are stored but where no regulated activities take place, such as hospices, independent hospitals and care homes.

The limitations of regulation under the Human Tissue Act 2004 were recognised by the HTA when the Inquiry asked which settings are in scope for inspection:

> *"So, it is mortuaries, which are attached to postmortem examination, or laboratories which are attached to postmortem examination. So, it is driven by the postmortem examination aspect rather than the location where the body is retained, which means there are a lot of things, a lot of places where bodies are retained, which are not in scope of the Human Tissue Act, which I think is a gap which probably needs to be addressed."*[22]

Where the HTA does regulate, the legal responsibility for ensuring compliance with the Human Tissue Act 2004 from a regulatory perspective falls to the DI personally rather than the organisation. In Phase 1 of the Inquiry, we set out how this contributed to individuals being reluctant to take on the role of DI at Maidstone and Tunbridge Wells NHS Trust and how it acted as a barrier to issues regarding the mortuary being reported to the Board or its subcommittees.[23]

The HTA told the Inquiry that its preference would be for the legal responsibility to reside with the organisation rather than with the DI:

> *"It would be beneficial for formal duties to be placed on the organisation and/or senior officers in the organisation holding a licence, such as placing an obligation on them to ensure there is a suitable DI in place, rather than the legal responsibilities for ensuring compliance with statutory duties being vested solely in the DI."*[24]

In Phase 1, we found that the DI's ability to influence and bring about change was limited at Maidstone and Tunbridge Wells NHS Trust.[25] In Phase 2, we found that this was still the case in some NHS trusts and local authorities the Inquiry considered.

21 HTA, Relevant material under the Human Tissue Act 2004, HTA website.

22 Witness transcript of Dr Colin Sullivan, Chief Executive, HTA, October 2024.

23 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, pp.145–7.

24 Written statement of Dr Colin Sullivan, Chief Executive, HTA, October 2024.

25 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, pp.145–7.

The HTA recognised this limitation in the role of the DI:

> *"The HTA's experience is often that DIs in the PM [post-mortem] sector want to improve the standards but at times face resourcing and other internal pressures, as well as operate in a system for managing the deceased that is itself under intense pressure, that limit their ability to effect the changes required. Placing appropriate duties on the licence holder could help address this issue."*[26]

In November 2024, the Inquiry held a seminar for DIs so that we could gain a greater understanding of the role. It was attended by eight DIs from NHS trusts, four from local authorities and two from medical schools. Attendees echoed the findings from the Inquiry's Phase 1 Report regarding the challenges of the DI role.

The lack of consistency in the governance structures supporting DIs was mentioned throughout the seminar. In some organisations, DIs are senior executives with direct access to the organisation's board; in others, they are Mortuary Managers with limited influence to make decisions on funding or security arrangements.

Some attendees explicitly stated that a lack of operational oversight and board-level accountability affected their ability to implement practices to effectively safeguard the deceased, such as enhanced or more robust security measures. Others stated that the lack of authority of the DI role or the lack of willingness among senior management to take their concerns seriously meant that they were unable to implement critical change quickly or effectively.[27]

Many representatives attending the seminar acknowledged that the legal and operational responsibilities attached to the DI role were extensive and challenging. Thirteen out of the 14 attendees said that the licence-holding organisation should have overall legal responsibility rather than the DI. The challenges of the role were further heightened by the perceived imbalance between the DI's statutory obligations under the Human Tissue Act and the organisational support they received to carry out their role effectively.[28]

A key challenge felt by the DIs who attended the seminar was that they often had to balance other, equally demanding jobs alongside the DI role. Many representatives emphasised the extensive scope of the DI role and the responsibilities attached to it, as well as how other roles they held alongside that of DI could lead to competing priorities.[29]

The DIs who attended the seminar stated that the type of training and support they received varied and was influenced by the type of organisation, the size of the mortuary and whether the individual held other roles. A number of representatives felt that there was a lack of sufficient training to help them prepare for the legal responsibility attached to the role. Representatives also felt that there was a lack of

26 Written statement of Dr Colin Sullivan, Chief Executive, HTA, October 2024.
27 Inquiry seminar for Designated Individuals, November 2024.
28 Ibid.
29 Ibid.

ongoing professional development support to assist them with the huge amount of responsibility they held on a day-to-day basis.[30]

The feedback we received during the seminar suggests that, while many DIs strive to maintain high standards, the systemic challenges they face can hinder their ability to implement changes in a timely and effective manner. However, some organisations demonstrated robust practices and proactive governance structures that mitigated these risks, indicating that the extent of compromise varies by setting.[31] We found that the DIs we interviewed as part of the Inquiry's module on medical education settings were generally better empowered to influence and bring about change than many of their counterparts in the NHS and local authorities (see Chapter 3 and Chapter 6).

The evidence collected at the seminar for DIs illustrates that the challenges we observed in Phase 1 are not specific to the role at Maidstone and Tunbridge Wells NHS Trust. It is clear that DIs are sometimes compromised by these challenges, especially in the context of their personal legal responsibility under the Human Tissue Act 2004.

UKAS accreditation for mortuaries is voluntary and is limited to settings that are managerially linked to laboratories where samples are analysed. This means that many places where deceased people are stored are excluded from UKAS accreditation:

> *"We don't accredit mortuaries in their own right, or body stores. We accredit the pathology laboratories, medical diagnostic laboratories, and where that accreditation overlaps in some examples to mortuaries or body stores, that is for the purpose of the storage and the management of samples, biological samples that were then going to be tested in that laboratory."*[32]

NHS England's remit is leadership of the NHS in England. It does not have a specific role in safeguarding the security and dignity of deceased people in NHS hospital mortuaries or body stores. However, there are some areas in which it has provided, or has sought to provide, oversight of this issue.

Since its merger with NHS Improvement in 2019, NHS England has been responsible for producing and publishing Health Building Notes (HBNs), which give guidance to the NHS on estates and facilities. Adherence to the guidance is not mandatory. There is an HBN relating to mortuaries which states: *"Mortuaries must provide a safe environment for the deceased to be handled with dignity and privacy, and to prevent unauthorised access to bodies."*[33]

30 Ibid.

31 Ibid.

32 Witness transcript of Mr Matt Gantley, Chief Executive, UKAS, November 2024.

33 NHS England, *Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services*, 2023.

NHS England provided more background relating to HBNs:

> *"So, we have a set of responsibilities in relation to mortuary services that – we publish, we have the responsibility for publishing the health building notices. That was something that transferred to NHS Improvement from the department and obviously, it's now with NHS England. Now, health building notes, they're not mandatory. So, they cover a range of different areas, maybe one for critical care, one for ED [emergency department] and so on and they cover standards that you might accept in terms of space, the facilities, resilience around backup generators, all that kind of stuff. And the one for mortuaries and actually for some other areas, like theatres, do include some provisions around security."*[34]

NHS England clarified that the HBN relating to mortuaries does not cover the operational aspects of mortuary security:

> *"While HBNs are not statutory, their aim is to ensure that facilities meet current legal, regulatory, and best practice standards. To note the HBN is a design guide and does not cover the operational aspects of a mortuary facility e.g. the requirement for Disclosure and Barring Service checks and operational security protocols. NHS England does not have oversight of policies in relation to those operational aspects."*[35]

In 2021, the Chair of the Inquiry wrote to NHS England. (At the time, he was the Independent Chair of the locally commissioned investigation into how David Fuller was able to offend undetected for so long at Maidstone and Tunbridge Wells NHS Trust.) In his letter, the Chair raised high-level themes and areas of concern that he deemed could not wait to be acted on until the police investigation had concluded and the criminal proceedings against David Fuller had been conducted. In response, NHS England wrote to NHS trusts in October 2021, asking them to take action to ensure that mortuaries and body stores were secure and to make sure that these actions were signed off by their boards. The actions required are set out in Chapter 1, section 1.1. NHS trusts were asked to confirm to NHS England that this had happened.

NHS England told us that, in June 2022, it had asked NHS trusts to reconfirm that they had assured themselves that their mortuaries were secure:

> *"We ran a further exercise to say, please reconfirm your compliance. And in that return in 2022, all providers came back and confirmed that they were at that point compliant with all of the standards. We have not done anything nationally since then. We haven't run a further assurance exercise in the sense that we've said, 'Look, boards, we're alerting you to this. You need to assure yourselves. Not reassure yourselves, but actually assure yourselves', and they confirmed back to us that, well the individual boards have, they are assured that they were compliant with that. Now, obviously, that isn't on … things happen. Things change. So, I think although we haven't run a further national assurance exercise, what we're very much expecting is that we've drawn people's attention to the standards that are required. And you would expect any issues that arise to be picked up in the normal local risk*

34 Witness transcript of Mr Steve Russell, Chief Delivery Officer, NHS England, October 2024.
35 Written statement of Mr Steve Russell, Chief Delivery Officer, NHS England, October 2024.

management issues and, you know, be flagged through the incident reporting system to the Trust."[36]

Although NHS England has no explicit role in overseeing the security and dignity of deceased people, it told the Inquiry that it would expect any concerns about mortuaries that were identified by the HTA to be considered within NHS trusts' governance arrangements:

"Where the HTA has concerns about a mortuary, NHS England expects those concerns to be appropriately escalated within the Trust's internal governance and shared with the applicable ICB [Integrated Care Board] and NHS England Regional team as appropriate. Where necessary, NHS England would have the power to investigate whether the issues identified by the HTA represented a breach of the provider licence and potentially to take more formal steps, as per NHS England's Enforcement Guidance. Crucially, this requires HTA's concerns reaching the appropriate individuals at NHS England and the matter being escalated accordingly."[37]

Despite the action taken by NHS England in 2021 and 2022 to instruct NHS trust boards to assure themselves of the security in place in mortuaries and body stores, and its expectation that concerns raised by the HTA would be escalated within NHS trusts' governance arrangements and then to NHS England's regional team, the Inquiry found that governance and assurance regarding mortuaries and body stores in some NHS trusts were inadequate (see Chapter 1). This makes it unlikely that concerns would be shared with NHS England and suggests that, despite its efforts in 2021 and 2022, NHS England's oversight in this area is not effective.

During the course of its evidence-gathering, the Inquiry found that the shortage of consultant paediatric and perinatal pathologists meant that many cases were being transferred to other hospitals for post-mortem examination. NHS England currently commissions paediatric and perinatal post-mortem services as a specialist service. NHS England told the Inquiry that there were 17 commissioned centres in England providing around 4,000 post-mortems per year, the vast majority of which were perinatal post-mortems. It said that a significant proportion of cases required transfer to another hospital for post-mortem examination due to the larger number of maternity and neonatal units than perinatal pathology units and the shortage of consultant paediatric and perinatal pathologists. NHS England told the Inquiry that the national service specification for perinatal pathology services contained the following clause relating to transport:

"Transport must be organised between the referring/receiving providers to ensure a timely, efficient and safe transportation between the referring hospitals and the designated perinatal post-mortem service provider(s)."[38]

NHS England told the Inquiry that it was considering introducing national requirements or standards for the transportation of babies for post-mortem examination. As part of this, it was scoping transport solutions, including a single

36 Witness transcript of Mr Steve Russell, Chief Delivery Officer, NHS England, October 2024.
37 Written statement of Mr Steve Russell, Chief Delivery Officer, NHS England, October 2024.
38 Written statement of NHS England, March 2025.

national transport contract.[39] It is not clear if and how this work will continue, given the announcement by the Secretary of State for Health and Social Care in March 2025 that the functions of NHS England will be subsumed by the DHSC.

In November 2021, when David Fuller's crimes at Maidstone and Tunbridge Wells NHS Trust became public knowledge, the then Department for Levelling Up, Housing and Communities wrote to local authorities in England, asking them to take action to ensure that their mortuaries were compliant with HTA guidance. The Inquiry found that only one local authority assisting the Inquiry's investigations was prompted to take action following the letter from the department (see Chapter 6).

The Local Government Association (LGA), which represents more than 300 local authorities in England, told the Inquiry that, in its view, there was no regulation or oversight in place that would prevent a recurrence of the types of crime David Fuller had committed:

> *"The unlawful and inappropriate actions carried out by David Fuller at the Maidstone and Tunbridge Wells NHS Trusts [sic] must never be allowed to happen again. However, in the LGA's view there are currently no comprehensive arrangements in place for the regulation and oversight of mortuaries and body storage facilities in England that guarantee the offences committed by David Fuller cannot happen again."*[40]

The LGA went on to say: *"In the LGA's view the best way to secure the security and dignity of the deceased is the introduction of a comprehensive regulatory regime."*[41]

The Inquiry received a letter from His Honour Judge Thomas Teague KC, then Chief Coroner, on 26 January 2022, explaining that, as they do not have their own mortuaries, coroners use those of hospitals and local authorities, and it is therefore extremely important to the coroner service that mortuaries properly safeguard the security and dignity of the deceased.[42]

Seventy-nine of the deceased women and girls whom David Fuller sexually abused were coronial cases: that is, they were legally under the control of a coroner.

In our Phase 1 Report, we noted that, while coroners have legal control of the body of the deceased person until their coronial functions come to an end, they do not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of deceased people in their control.[43]

One Senior Coroner told the Inquiry that, in March 2024, His Honour Judge Teague, in his role as Chief Coroner at the time, circulated the following information and advice:

39 Ibid.
40 Written statement of Mr Mark Norris, Principal Policy Adviser, LGA, October 2024.
41 Ibid.
42 Letter from the previous Chief Coroner to the Chair of the Inquiry, January 2022.
43 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.200.

> *"You may have seen stories in the press earlier this month about a man being charged with performing sexual acts on corpses in a hospital mortuary following an alleged break in (link: https://www.itv.com/news/calendar/2024-03-19/man-charged-with-sex-acts-on-bodies-in-hospital-mortuary). As you know, the David Fuller Inquiry is also currently investigating Mr Fuller's unlawful acts in the mortuaries at Maidstone and Tunbridge Wells NHS Trust (link: https://fuller.independent-inquiry.uk). It is obviously not a coroner's responsibility to ensure the security of mortuaries that are regulated by the Human Tissue Authority. However, in light of recent events, I would suggest that you discuss with your local authorities the importance of checking that the security arrangements agreed in their contractual arrangements with the mortuaries are satisfactory and that they are enforced."*[44]

We understand that this information was circulated to all coroners in England in a Chief Coroner's newsletter.[45] The Senior Coroner who drew the Inquiry's attention to the advice from His Honour Judge Teague had acted on it and had asked the mortuaries they used to provide information on security.[46]

Despite coroners having no obligation to ensure the proper treatment of deceased people in their control, the Inquiry considered the extent to which they oversee mortuary services provided on their behalf, either by local authorities or by NHS trusts, through a contract with a local authority.

Her Honour Judge Alexia Durran, Chief Coroner of England and Wales, told the Inquiry:

> *"I was simply going to add and make the point that what the coroner, the Senior Coroner doesn't do is make decisions as to what the mortuary provision is. So, if somebody dies in hospital and the hospital has a hospital mortuary, then the body will be moved from the ward to the hospital mortuary. If somebody dies at home and if the local authority has a public mortuary, then the arrangement will be made to move the body to a public mortuary. But what the Senior Coroner doesn't do is have any decision making in relation to the mortuary provision that is provided by the local authority."*[47]

Her Honour Judge Durran went on to say that coroners did not have the ability to direct local authorities:

> *"The coroner may raise concerns with the local authority to say, 'I am not happy that the provision is appropriate', but the Senior Coroner doesn't have the ability to make the local authority do something different."*[48]

Despite coroners having no obligation to ensure the proper treatment of the deceased in their control and not being able to formally direct local authorities in the arrangements made on their behalf, the Inquiry heard examples where coroners had influenced the provision and quality of mortuary services (see Chapter 6).

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44 Written statement of A531, Senior Coroner, November 2024.
45 Letter from the Chief Coroner to the Secretary to the Inquiry, January 2025.
46 Written statement of A531, Senior Coroner, November 2024.
47 Witness transcript of Her Honour Judge Alexia Durran, Chief Coroner, October 2024.
48 Ibid.

Mr Derek Winter, the then Deputy Chief Coroner for England and Wales, told the Inquiry that, following the Inquiry's Phase 1 Report, he had written to mortuaries that were used on his behalf to seek assurance. When the Inquiry asked what had prompted him to do this, he responded:

> *"It would have been remiss of me not to have followed that through. That was a starting point, but I wanted to have that reassurance that what I was used to was continuing and that the mortuaries themselves were looking inwards at themselves to see whether some improvements could be made."*[49]

Her Honour Judge Durran told the Inquiry that, in her view, most coroners rely on the HTA licensing of mortuaries:

> *"I'd expect most Senior Coroners to be reliant on the fact that they are using a licensed mortuary facility, but it would be unlikely that their inquiry would go beyond that, unless they received a communication to suggest that it was not appropriate."*[50]

This reliance on HTA licensing for assurance echoes what the Inquiry heard from two Senior Coroners in Kent who used the mortuary where David Fuller committed his crimes at Maidstone and Tunbridge Wells NHS Trust.[51]

In seeking to understand the extent to which coroners sought assurance about or were able to influence mortuary provision made on their behalf, the Inquiry invited the Senior Coroners for all 73 coronial areas in England to submit a statement, setting out how they assure themselves of the operational arrangements in place to safeguard the security and dignity of deceased people in their control in mortuaries. They were asked to include details of any particular difficulties they faced, and if there had been any circumstances where their ability to fulfil their duties had been compromised due to the condition of the deceased resulting from unsatisfactory storage arrangements. They were also invited to give their opinion on whether any changes to these operational arrangements were required. The Inquiry was clear that it was not expecting any coroner to comment on matters of policy or law.

In total, 21 Senior Coroners responded to the Inquiry's request; of those, 13 provided a statement or letter referring to the information requested. The reasons given for not providing a statement included: the subject matter falling outside their coronial or statutory remit; a belief that to provide a statement would breach judicial principles; and a belief that the information had already been provided by the Chief Coroner or the Coroners' Society of England & Wales. Of the 13 Senior Coroners who provided a statement or letter referring to the information requested, four told the Inquiry that 'coroners are judges and do not hold responsibility for mortuary security'.

One Senior Coroner stated that they had sought assurance that the mortuaries they used at NHS trusts had brought their practices into line with the recommendations made by the Inquiry in its Phase 1 Report.[52]

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49 Witness transcript of Mr Derek Winter, Deputy Chief Coroner, October 2024.

50 Witness transcript of Her Honour Judge Alexia Durran, Chief Coroner, October 2024.

51 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023, p.199.

52 Written statement of A537, Senior Coroner, November 2024.

Another Senior Coroner told the Inquiry that they had visited mortuaries they used with the express purpose of assuring themselves about the arrangements in place. This was the same Senior Coroner who told the Inquiry that they had acted on the advice that the previous Chief Coroner, His Honour Judge Teague KC, had included in his newsletter of March 2024:

> *"In my time as coroner, I have visited every mortuary provided for my statutory duties. I have attended to satisfy myself as to the security and to ensure that my ethos of putting the bereaved people at the centre of my work is achieved. This involves me being satisfied as to arrangements that mortal remains are treated with dignity at all times."*[53]

The Inquiry had planned to hold a seminar or round-table discussion for Senior Coroners in November 2024, to seek their views on the extent to which the current system safeguards the security and dignity of deceased people, their role in this, and any challenges they identified. This did not go ahead as only a small number confirmed that they were able to attend.

The Inquiry's Phase 1 Report explained that a significant majority of David Fuller's victims were under the legal control of the coroner when they were abused. As set out above, coroners have no obligation to ensure the proper treatment of deceased people in their control and are unable to direct local authorities in the arrangements made on their behalf. However, from the Inquiry's interactions with Senior Coroners and our examination of mortuary arrangements, it appears that some have attempted to influence the arrangements that are in place on their behalf, or to seek assurance about the arrangements, despite having no formal obligation to do so.

This is discussed in Chapter 6, which includes an example of one Senior Coroner who stopped using a hospital mortuary until the relevant NHS trust addressed the concerns the HTA had raised following an inspection. However, given the relatively low numbers of Senior Coroners who provided statements to the Inquiry, we are unable to accurately assess the extent to which coroners seek assurances about arrangements made on their behalf. In any case, this is unlikely to provide a comprehensive system of oversight, given that it is by influence rather than statute and is dependent on the appetite of the coroner to voluntarily seek assurance.

There is a clear difference in practice between coronial areas, with other Senior Coroners confirming that they relied on HTA licences for assurance or did not consider mortuary provision to be within their remit. The Inquiry considers that seeking assurance in relation to mortuary arrangements – and, where necessary, influencing these arrangements to benefit the security and dignity of the deceased – is best practice that could, and should, be followed in all coronial areas.

53 Written statement of A531, Senior Coroner, November 2024.

Recommendation

The Inquiry makes the following recommendation.

Recommendation 70
The Chief Coroner should review the difference in practice between coronial areas as soon as possible to ensure that:

- All coroners are informed of the findings of this Inquiry.
- All coroners are aware of the prevalence of offending by David Fuller against deceased people who were formally under the control of the coroner.
- All coroners understand the importance of a consistent approach to ensuring the security and dignity of deceased people who are under their control.

This is likely to require guidance from the Chief Coroner to ensure that there is a consistent approach nationally, and it should be considered an area for further training for all coroners and their staff.

In November 2024, the Inquiry held a seminar on the regulation of settings where deceased people are kept. It was attended by representatives from:

- NHS Providers;
- Royal College of Pathologists;
- Local Government Association;
- Care Quality Commission;
- Academy for Healthcare Science;
- Department of Health and Social Care;
- NHS England;
- National Society of Allied and Independent Funeral Directors;
- National Association of Funeral Directors;
- Association of Anatomical Pathology Technology;
- Human Tissue Authority;
- United Kingdom Accreditation Service; and
- Health and Care Professions Council.

There was general agreement among the attendees at the seminar that the current regulatory regime covers only some activities, locations and sectors involved in the care of deceased people. It was evident from the discussions that the regulatory framework currently in place is fragmented, has developed over time, and includes a variety of regulatory regimes covering various professions and organisations. The regimes were devised for a range of different purposes.[54]

54 Inquiry seminar on regulation, November 2024.

There were 544,054 deaths registered in England in 2023. Of these, 233,416 people died in NHS hospitals, where we found there is only partial regulation regarding the security and dignity of the deceased. In addition, 113,778 people died in care homes, 28,086 died in hospices and 257 died in non-NHS hospitals. In these places, there is no regulation in place to protect the security and dignity of the deceased. Nor is there any effective regulation for this purpose in the funeral sector, where most of the population of England is cared for after death.[55]

What we have found

- The Inquiry has found that the regulation and oversight of the care of the deceased to ensure their security and dignity are at best partial, and, for a large number of deceased people, they are entirely absent.
- The Inquiry has found there to be no system of regulation and oversight in the country that has the primary objective of protecting the security and dignity of deceased people. The current regulatory systems that do exist protect the security and dignity of the deceased only insofar as this is a byproduct of the actual regulatory purpose.

11.5.3 Changes in response to David Fuller and the Inquiry's Phase 1 Report

A number of organisations that have some role in the regulation or oversight of settings where deceased people are stored told us that they had made changes in response to the Inquiry's Phase 1 Report.

The HTA told the Inquiry that it had introduced a number of measures to improve compliance with its key standards:

> *"[T]he HTA has been robustly strengthening its approach to probing and assessing compliance with key standards relating to security, governance and quality in the PM [post-mortem] sector by developing new tools aimed at enhancing the focus on best practice and being clear with establishments what they need to do to meet Standards.*
>
> *New methods and approaches adopted in the current year [2024] have been well-received and have included: mandatory webinars for all relevant PM Designated Individuals (DIs) on security-related Standards, followed by submission of an Evidential Compliance Assessment (ECA); and the introduction of an unannounced inspection programme in the PM sector."*[56]

When the Inquiry asked about the HTA's new Evidential Compliance Assessment, the HTA responded that it was now seeking assurance by requiring evidence of practice, rather than relying on being told what was happening:

55 Office for National Statistics, Deaths registered in England and Wales, 2023, ONS website.
56 Written statement of Dr Colin Sullivan, Chief Executive, HTA, October 2024.

> *"Yes, well, this is effectively a questionnaire and a series of questions where we ask specific things. I'm sure we can get you a copy. And then we asked for the evidence to back up because again, one of your comments in the first phase was that we were passive. That's something that's burned into the back of my brain. I absolutely think that we have been much more rigorous. But not just taking it on [someone's] word, but actually seeing that it's been done, is very important."*[57]

As set out in section 11.5.1, following the Phase 1 Report, the CQC confirmed that its remit does not extend to the care of the deceased and it has adjusted its assessment framework accordingly. However, as of January 2025, this had not been widely communicated to the organisations it regulates.

In its statement to the Inquiry, UKAS outlined a number of measures it had taken to revise its accreditation processes in light of the Inquiry's Phase 1 Report:

> *"Since November 2023, taking account of the Phase 1 Report, UKAS has reviewed the processes it has in place relating to assessment and accreditation of mortuary services and body stores. The following actions have been implemented, which support consistent assessment of mortuary services including the dignity and security of the deceased:*
>
> - *Mapped the HTA Code of Practice and Standards B Post-mortem examination against ISO 15189:2022, to identify common areas between the two standards and to define key areas to include in UKAS assessments.*
> - *Engaged with the HTA to further develop the model for liaising and sharing information regarding accredited/licenced mortuary services going forward.*
> - *Delivered awareness/refresher training sessions for UKAS staff and contracted technical assessors, regarding mortuary activities and assessment of mortuaries.*
> - *Commenced work on a guidance document for mortuary assessors, to promote consistency of assessment and ensure key topics are assessed.*
> - *Distributed a questionnaire to all accredited mortuary services and audited UKAS records of those services to determine any high priority assessments required. Topics considered included: post-mortems performed on the incorrect body; details of any breaches of security; and number of incidents reported to HTA (or equivalent body).*
> - *Discussed the outcome of Phase 1 of the Inquiry and the actions taken by UKAS with the UKAS Medical Laboratory Technical Advisory Committee ('TAC'). The TAC's role is to provide expert advice on technical matters related to the development and operation of UKAS activities. All pathology specialisms are represented in the membership of the TAC, including assessors of mortuary services."*[58]

57 Witness transcript of Dr Colin Sullivan, Chief Executive, HTA, October 2024.
58 Written statement of Mr Matt Gantley, Chief Executive, UKAS, October 2024.

NHS England told the Inquiry of its plans to revise some of its documents and guidance in light of the Phase 1 Report. These plans include: referring to the HTA as a regulator in the next version of NHS England's oversight framework; plans for a requirement on providers to notify NHS England of third-party reports and inspections; and developing a new section on mortuaries and body stores in the NHS Premises Assurance Model self-assessment tool for trusts.

In 2024, NHS England established a Mortuaries Oversight Board in response to the Inquiry's work:

> *"The Mortuaries Oversight Board (MOB) is being established to improve Mortuary Oversight at NHS England through the establishment of a programme. The programme will monitor mortuary capacity and adherence of providers to regulations and codes.*
>
> *The MOB will serve as a central body to oversee the implementation of recommendations from trust data, facilitate coordination between various regulatory bodies, and ensure robust governance structures within NHS Trusts. The establishment of this Board marks a critical step in our commitment to preventing future incidents and enhancing the overall quality and safety of mortuary services."*[59]

During its Phase 1 investigation, the Inquiry discovered that the HSE had serious concerns regarding the lack of assessment of the risk of injury to staff involved in the manual transfer of the deceased in the mortuary at Kent and Sussex Hospital. The Inquiry was of the view that this indicated that there were problems with the way the mortuary was being run, and we made a finding in the Phase 1 Report that the HSE did not have a process in place to alert the HTA of its concerns.

The HSE told the Inquiry that it would *"review and ensure the profile of the HTA and their remit in communication is understood by our regulatory staff"*.[60] It also said that it would *"continue to work with other regulators as required"*.[61]

The organisations from which the Inquiry took evidence as part of this module spoke about a requirement to improve the way in which data and information about the quality of mortuaries were shared among them. They confirmed that they were taking steps to achieve this:

> *"Discussions between NHS England and the HTA to enter into an MoU [a Memorandum of Understanding] and data sharing agreement with the HTA have begun and there is a mutual commitment to ensuring this is progressed."*[62]

59 Mortuaries Oversight Board, Terms of Reference, NHS England, December 2024.
60 Letter from the HSE to the Inquiry, February 2025.
61 Ibid.
62 Written statement of Mr Steve Russell, Chief Delivery Officer, NHS England, October 2024.

What we have found

- While the actions that those with a role in regulation and oversight of organisations that store deceased people have taken in response to the crimes of David Fuller and the Inquiry's Phase 1 Report are well intentioned and welcome, they are unable to address the underlying issue that regulation and oversight are partial. They do not extend to every institution where deceased people are stored. Fundamentally, there is no regulator or system of oversight with the primary objective of protecting the security and dignity of the deceased.

11.5.4 Professional regulation

Current position

The Professional Qualifications Act 2022 sets out that a profession is regulated by law where there is a legal requirement to have certain qualifications or experience (or meet an alternative condition or requirement) in order to undertake certain professional activities or use a protected title.[63] In the healthcare sector, professional regulation assures the public that the people who provide healthcare are qualified, capable and competent.[64]

There is no system of statutory professional regulation for those who care for deceased people in mortuaries and other settings, such as funeral directors.

Healthcare professionals may sometimes provide care to deceased people and are regulated by a variety of regulators, including the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC). The Codes of Practice for the GMC, NMC and HCPC do not expressly refer to the care of deceased people. However, there are guidance documents in relation to End of Life Care, as well as broad principles (such as acting with integrity and honesty) that could be considered relevant to the care of the deceased.[65]

The Association of Anatomical Pathology Technology (AAPT) is the recognised professional body for anatomical pathology technologists (APTs). The AAPT is a small, volunteer-run professional association. It is not a regulator. APTs are able to join a voluntary register, which is held by the Academy for Healthcare Science and accredited by the Professional Standards Authority for Health and Social Care (PSA). This is not mandatory and there is no power of sanction.[66] APTs work primarily in NHS hospital and local authority mortuaries.

63 Department for Business and Trade, UK regulated professions and their regulators, updated 19 December 2024, gov.uk website.

64 DHSC, *Promoting professionalism, reforming regulation: Government response to the consultation*, July 2019.

65 Advice from Counsel to the Inquiry, May 2024.

66 Written statement of AAPT, October 2024.

Impact of the lack of professional regulation

APTs and others who work in mortuaries, including in the funeral sector, provide the most personal and intimate care to deceased people. This includes washing and dressing people after death as well as tending to leakages of bodily fluids and post-death incontinence. APTs also carry out procedures such as evisceration prior to post-mortem examination and reconstruction following a post-mortem examination. Individuals who work in the funeral sector sometimes are required to remove medical devices – for example, pacemakers – from the bodies of deceased people. They also embalm the bodies of deceased people. One might expect that all these tasks would carry standard mandatory requirements for vetting, qualifications, training and supervision. However, this is not the case.

The Inquiry heard that there are no minimum qualifications required to work as an APT in a mortuary in England, no requirement to undertake continuing professional development (CPD), and no mandated code of professional conduct in place.[67] The AAPT's Code of Conduct[68] states that it applies to all members. A failure to comply with the Code of Conduct may result in action being taken under Article 21 of the AAPT's constitution, which states:

> *"21. Expulsion of any member of the Association, or Honorary Officer, shall be the sole decision of the Council, with right to appeal at the next Council meeting at which a two-thirds majority by ballot shall be required for reinstatement. If reinstatement is refused, then no further applications or appeals will be accepted."*[69]

Around half of all APTs choose to be members of the AAPT, but this is not mandatory. The AAPT stressed that expulsion from the AAPT did not carry any professional sanctions for members, who could carry on working regardless.[70]

The AAPT told the Inquiry that, in its view, the lack of professional regulation had an impact on the security and dignity of deceased people:

> *"The regulation of mortuaries in England and Wales involves the licensing and regulation of some establishments, not individuals. Deceased patient dignity and security is vulnerable when there is a lack of control. This may be as a result of staff whose conduct falls below what is expected …"*[71]

The AAPT told the Inquiry about the lack of accountability within an unregulated workforce and the absence of checks and balances to prevent an unsuitable individual from working as an APT:

> *"The other problem we've got is when there is behaviour that is questionable, there is no accountability. And like I said earlier, you can literally be fired from a job. There are*

67 Witness transcript of Ms Lydia Judge-Kronis, Vice-Chair, AAPT, October 2024.
68 AAPT, Code of Conduct, AAPT website.
69 Ibid.
70 Written statement of AAPT, October 2024.
71 Ibid.

jobs where some APTs do not have their qualifications. They've got lost or they've got something, they don't even have copies. They're still allowed to practice, because they can work."[72]

In a written statement, the AAPT explained that, in its view, the current position where membership of a professional body was voluntary was not sustainable or safe:

"In summary, there is a massive regulatory gap in relation to Anatomical Pathology Technology, which poses a clear risk to the deceased and the wider public. The AAPT has attempted to fill this gap where possible, through their member code of conduct, disciplinary policy and defined technical standards documents. It is not sustainable for the government and the regulators to rely on a small, volunteer-run professional body who can only influence its members, through guidance, to try to uphold standards in the absence of statutory regulation."[73]

The HTA also considered the view that APTs should be regulated, on the basis that this would bring them in line with others undertaking care in a hospital setting and could also assist with the retention of staff:

"And this issue about whether APTs should be regulated or professionalised, and we obviously want to – when we make visits to postmortem mortuaries, we check that training is in place. That's one of the things that we need to be assured of. I don't have strong views as to whether or not they need to be professionalised. But when I compare it with other professions across a typical hospital Trust, it does strike me that it's probably akin with other areas, and probably therefore, it ought to be, just from a point of view of consistency, it might also help with retention, because I think that's one of the big problems and one of the reasons why I think we can come back to an establishment maybe two years later, and things haven't moved on the way we had hoped is because the staff have changed and it's not a particularly attractive job, and therefore you can imagine that there's turnover."[74]

Attendees at the Inquiry's seminar on regulation also acknowledged that APTs should be subject to professional regulation and that this should include registration, mandatory qualifications and training.[75]

The Inquiry heard that the National Association of Funeral Directors (NAFD) had introduced educational opportunities for its members in the absence of professional regulation:

"So the NAFD was formed with some fairly fundamental principles which we still exercise today. The first is to educate. There was no real education in the funeral sector, and the NAFD decided … many people call it a profession, but currently there

72 Witness transcript of Ms Lydia Judge-Kronis, Vice-Chair, AAPT, October 2024.
73 Written statement of AAPT, October 2024.
74 Witness transcript of Dr Colin Sullivan, Chief Executive, HTA, October 2024.
75 Inquiry seminar on regulation, November 2024.

is no requirement to demonstrate a level of professional knowledge or competence. Regardless of that, NAFD introduced vocational qualifications, diplomas, certificates, to help train and educate people coming into the funeral sector."[76]

The comments made by representatives of the funeral sector at the Inquiry's seminar on regulation reiterated that there is no requirement for those who work in the funeral sector to have specific qualifications or training, to be registered with a professional organisation, or to adhere to any mandatory professional standards or codes.[77]

Similar to the position with APTs, if an individual is dismissed in the funeral sector for reasons of poor conduct or lack of competence, there is no barrier to them obtaining a job with another funeral director. Attendees from the funeral sector at the Inquiry's seminar on regulation indicated that, among the public, there is a perception that the funeral profession is already regulated.[78] This is also reflected in research conducted by Dignity, the chain of funeral directors: in 2018, 92 per cent of consumers who responded to Dignity's survey indicated that they expected some form of regulation to exist in the funeral sector.[79]

Attendees at the Inquiry's seminar on regulation recognised the need for regulation within the funeral sector, including licensing of funeral directors and mandatory professional regulation of staff in terms of training and mandatory qualifications.[80]

A consequence of the lack of regulation, including professional regulation, is that those who care for people after death are not always subject to Disclosure and Barring Service (DBS) checks. DBS checks provide relevant information about a person's criminal history and can support informed recruitment decisions.[81] There are different levels of DBS checks. An enhanced DBS check is the highest level and is usually required for individuals who work in regulated activity or with vulnerable people, such as healthcare professionals, social workers and teachers.

The AAPT representative at the Inquiry's seminar on regulation noted that APTs need only a basic DBS check and it is difficult to get an enhanced check; they considered this to be an area that needed addressing.[82] As far as DBS checks are concerned, APTs differ from other staff who work in a hospital setting and provide the same types of personal and intimate care to the living as APTs provide to people after death. While passing DBS checks does not preclude future offending, the Inquiry considers them an important barrier to prevent unsuitable people from working with the deceased.

76 Witness transcript of Mr Andrew Judd, Chief Executive Officer, NAFD, March 2024.
77 Inquiry seminar on regulation, November 2024.
78 Ibid.
79 Dignity, *Time to Talk about Quality and Standards*, August 2018.
80 Inquiry seminar on regulation, November 2024.
81 DBS and Home Office, DBS checks: guidance for employers, last updated 2 December 2024, gov.uk website.
82 Inquiry seminar on regulation, November 2024.

The Inquiry heard that funeral directors were able to request DBS checks for staff on the basis that they were involved in the sale of pre-paid funeral plans but they were unable to request them on the basis of providing personal care to people after death.[83]

NAFD told the Inquiry about the difficulty in securing enhanced DBS checks for staff working in the funeral sector in the absence of this being a regulatory requirement:

> *"NAFD is not a statutory regulator, it is a trade body and, even though we set high standards for our members, there are limits to what can be achieved without the statutory underpinning of quality standards and without legislative and regulatory change. For example, as a sector we are unable to access enhanced DBS checks, which would be hugely beneficial for everyone concerned."*[84]

The PSA oversees the ten professional regulators of health and social care in the UK and also accredits organisations that hold registers of health and care practitioners that are not regulated by law.[85]

The PSA spoke about the benefits and challenges of regulating individuals who care for people after death:

> *"In terms of the benefits, I think I'd probably go back to that idea about standards and a code of practice which relates to behaviour because that, as I say, would be probably pretty universal and across the board and, you know, hold people to account, but also support them to meet those standards for looking after somebody in terms of their dignity, in terms of their compassion, in terms of dealing with families and other stakeholders and so on. So I can see merits in having standards. I think the problem we all sometimes struggle with is what is regulation, whereas really it's sort of a continuity, all the way from maybe some fairly sort of minimal standards with employer oversight, all the way through things like accredited registers and barring schemes, licences, all the way up to statutory regulation. And you would expect me to say this as a regulator, but what is important is that it's proportionate. So the challenges would be, you know, the cost of setting it up and implementing it and so on. So I think you'd have to be confident that you weren't gold plating what was needed and excessively managing the risks, but the best way to do it would be to try to assess the risks, and you've got in this case, I think, probably at least half a dozen, if not more, subgroups of people working in different settings, all of whom pose different risks. I think we could have a unifying code of conduct, but the other part of the regulation in competence would probably need to be spelt out separately from that."*[86]

83 Inquiry seminar on the funeral sector, October 2023.
84 Written statement of NAFD, September 2023.
85 PSA, What we do, PSA website.
86 Witness transcript of Mr Alan Clamp, Chief Executive, PSA, January 2025.

Despite the challenges of implementation and proportionality, the PSA told the Inquiry that, on balance, it could see the merit in a regulatory model for the care of people after death:

> *"Having said all of that, I do think, as I say, there's a lot of merit in the standards, you could set up a regulatory model which would add value to what's there and it doesn't need to be burdensome. Whether or not it fully addressed the risks or not is something to kind of keep under review, but you can actually start at that end of the scale and have the option of escalating and introducing more checks and balances as you go along."*[87]

The HCPC protects the public by regulating 15 health and care professions in the UK. It sets standards for professionals' education, training and practice, approves programmes that professionals must complete to register with the HCPC, keeps a register of professionals who meet its standards, and takes action if professionals on its register do not meet its standards.[88] The Health Professions Order 2001 was made under section 60 of the Health Act 1999 and came into force in February 2002. The Health Professions Order sets out that the overarching objective of the HCPC in exercising its functions is the protection of the public. The HCPC confirmed to the Inquiry that there is nothing in the Health Professions Order 2001 or the underpinning Health Act 1999 that would preclude the organisation from regulating staff involved in the care of the deceased.[89]

The HCPC told the Inquiry that it stopped the process for considering adding new professions to its register following the government's publication of *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers* in 2011. The HCPC made this decision on the basis that the document stated that the government would only consider regulating further groups in exceptional circumstances, where there was a compelling case and where voluntary registers were considered insufficient to manage the risk involved.[90]

When asked if deceased people could be considered 'the public', as per the Health Professions Order, the PSA told the Inquiry that, in its view, they could be:

> *"I mean, all or virtually all of the regulators that we oversee have their own legislation, but they also have an overarching duty to protect the public, and that's very broad, and that can be very helpful because it means regulators, even if they've got quite constraining legislation, can take steps to do things where they think there is a risk to the public. So yes, I mean, it's difficult within health to often think centrally about patients, but in this context, I would definitely say that would include friends and relatives of the deceased and therefore I think there is a function there. And I think in terms of the dignity of the deceased, they're exposed to a different set of harms, not usually the kind of standard health intervention, but I personally would consider them to be the public in that sense, that they need to have suitable*

87 Ibid.
88 HCPC, What we do, HCPC website.
89 Email response of the HCPC to the Inquiry, January 2025.
90 Ibid.

protections, the impact of which is going to be felt by friends and relatives. But it's actually protection for that deceased person, yes."[91]

Challenges of professional regulation

The Inquiry heard that the introduction of professional regulation for individuals who care for deceased people would bring challenges.

The AAPT spoke about the potential issue of APTs resigning if they did not want to undertake professional development:

"The problem we have is that we do have half of the workforce, and we've said very openly that the day, if it ever happens … we are regulated, we will potentially lose half of our workforce because they don't want to adhere to CPD."[92]

The AAPT also told the Inquiry that the cost of professional regulation fees could be a barrier to the APT workforce.[93]

Discussion at the Inquiry's seminar on regulation indicated that regulatory reform must take place across the board. It must ensure that those who come into contact with deceased people are appropriately qualified, have regular training and pass DBS checks. However, some attendees stated that any regulation introduced must be targeted and proportionate, and should not unfairly target low-skilled workers, who make up a high proportion of those working in the funeral sector.[94]

One of the overarching themes that emerged through the discussions at the Inquiry's seminar on regulation was that professional regulation alone was not considered sufficient to ensure the security and dignity of people after death or to prevent abuse such as that carried out by David Fuller from recurring. Organisations should also consider the benefits of other mechanisms such as supervision and ongoing performance management alongside professional regulation.[95]

From the evidence reviewed, the Inquiry's view is that the advantages of regulation, including mandatory standards relating to individuals who work with deceased people, outweigh the challenges its introduction would encounter.

91 Witness transcript of Mr Alan Clamp, Chief Executive, PSA, January 2025.
92 Witness transcript of Ms Lydia Judge-Kronis, Vice-Chair, AAPT, October 2024.
93 Ibid.
94 Inquiry seminar on regulation, November 2024.
95 Ibid.

What we have found

- Regulation and oversight of the care of people after death are partial, ineffective and, in significant areas, completely lacking. Human Tissue Authority regulation does not apply to all purposes and therefore not to all locations where a deceased person may be cared for. The Care Quality Commission's remit does not extend to the care of people after death. The professional membership available to funeral directors is entirely voluntary and does not amount to formal regulation.
- There are many organisations that provide care to people after death that are not regulated in terms of deceased people's security and dignity. We have observed the impact of the lack of regulation on the way the security and dignity of deceased people are not considered in the governance arrangements of many of the organisations we have reviewed in the Inquiry.
- There is no mandatory regulation or oversight in place with the overriding objective to protect the security and dignity of deceased people.
- Treatment of deceased people does not feature prominently or explicitly in Codes of Practice that apply to healthcare professionals. There is no mandatory professional regulation of mortuary staff wherever they work, including in the funeral sector. This represents a gap in the protection of people after death.
- In conducting the Inquiry, we have often heard witnesses speak of the need for 'proportionate regulation'. Given that the current absence of any system of regulation or oversight to protect the security and dignity of deceased people wherever they may be cared for has potential implications for every individual in England, the Inquiry considers that some form of universal regulation is both needed and proportionate.

Recommendations

The Inquiry makes the following recommendations.

Recommendation 71
The UK government should establish an independent statutory regulatory regime, headed by a Chief Inspector, for those who store and care for deceased people. The purpose of the regulatory regime should be to ensure that the security and dignity of deceased people are protected, in whichever institutions or locations they are cared for, examined or stored. The government should ensure that this role is adequately resourced to discharge its responsibilities and should provide it with powers to require information and enter premises and to take appropriate enforcement action (including against office holders in any organisation). Either the Human Tissue Authority should be required to work under the auspices of this new regime, or its remit should be formally expanded to comply with the statutory regime's requirements.

Recommendation 72
In the interim, the government should immediately appoint a Commissioner for the Dignity of the Deceased who should immediately issue universal guidance that applies to all those who store and care for deceased people. This guidance should set out expectations for the security and dignity of deceased people.

Recommendation 73
The government should amend the Human Tissue Act 2004 so that the organisation holding the licence has primary legal responsibility to ensure that:

- There is a suitable Designated Individual in place at their establishment.
- Suitable premises are provided and maintained.
- Suitable individuals are employed.
- All relevant legal and regulatory duties pertaining to the licence are met.

Recommendation 74
The Human Tissue Authority, and/or the new inspectorate, should require the organisations it licenses to ensure that any individual who provides care to deceased people is suitably qualified, experienced and supervised. The regulatory regime should set minimum standards on the qualifications likely to be considered sufficient to demonstrate 'suitability' for particular roles or levels of responsibility. Failure to ensure that suitable individuals are employed would be subject to regulatory enforcement.

The recommendations set out above are intended to work in tandem with the recommendations that are specific to specific sectors, which are set out in Chapters 1 to 10 of this Report.

Chapter 12: Chair's conclusions and recommendations

12.1 Conclusions

During the course of the Inquiry's work, my team and I received evidence from a wide range of individuals and organisations across all sectors where the deceased may be cared for. This evidence has informed the findings and recommendations in this Report.

The Inquiry was established in two phases. Phase 1 was to examine the events at Maidstone and Tunbridge Wells NHS Trust and establish how David Fuller was able to commit his appalling offences and remain undetected for so long.[1] The Phase 1 Report was published in November 2023.[2]

We expedited our work on the funeral sector following reports of cases of neglect of the deceased in some funeral homes and the growing calls for regulation of the sector. I published an Interim Report on the funeral sector in October 2024.[3]

Phase 2, the final phase of the Inquiry, has explored the wider picture of care of the deceased in England. The aim was to assess the effectiveness of systems and processes designed to ensure the security and dignity of the deceased across all sectors where they may be cared for, and thus prevent such awful crimes being committed again in the future.[4]

An investigation of this scale into the security and dignity of the deceased in England has never previously been undertaken. It is an issue of relevance to us all. No family in the future should have to experience the unbelievable distress of learning of the abuse of their deceased loved ones, as the families of David Fuller's victims have suffered.

> The obvious question is whether the current arrangements that are in place – across all sectors where the deceased are cared for – are sufficient to prevent such abuse happening again. My answer to that is: no. I am not confident that the arrangements currently in place across England are such that they satisfactorily protect the deceased from the risk of abuse.

1 Independent Inquiry into the issues raised by the David Fuller case, Inquiry website.
2 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023.
3 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Interim Report – Funeral Sector*, October 2024.
4 Independent Inquiry into the issues raised by the David Fuller case, Terms of Reference, Inquiry website.

The degree of risk and the effectiveness of protection varies by sector. The Report highlights the issues found in each sector and I make sector-specific recommendations in each chapter. These are also repeated in Table 31, the table of recommendations, below.

We have also assessed the effectiveness of the current regulation and oversight in place in England, and I make recommendations for these arrangements to be revised and significantly strengthened as a matter of priority (see Chapter 11 and Table 31).

In our work covering **NHS hospitals** (Chapter 1), my team and I have found that many of the themes identified in our Phase 1 investigation are present in NHS trusts across England. Some action had been taken by the NHS after David Fuller's crimes came to light, as well as following the publication of the Inquiry's Phase 1 Report, but the effectiveness of the specific actions taken varied. As a result, gaps and vulnerabilities still exist in the security and governance systems designed to safeguard the security and dignity of deceased people in mortuaries across NHS hospitals. Similar risks around the security and governance of NHS body stores, which are unlicensed by the Human Tissue Authority (HTA), were also identified.

In **independent hospitals** (Chapter 2), we have found a low incidence of death, and that deceased patients are kept in these facilities for relatively short periods of time. The recommendations I am making to the independent sector relate to the reliance on a nurse or other senior staff member in charge to control access to the deceased, and the vulnerabilities this may create regarding the security and dignity of deceased people.

Within the **medical education and training** sector (Chapter 3), we have explored the process of body donation, as well as the security policies and governance of those organisations providing education and training. Most notable in this sector is the culture of appreciation and respect for those who have donated their bodies to such institutions, which the Inquiry heard about from all organisations we engaged with. My recommendations for this sector aim to strengthen governance and security arrangements in these facilities.

Within the **hospice sector** (Chapter 4), we have explored arrangements and processes for maintaining the security and dignity of deceased people in their care. A culture of viewing care after death as an ongoing and valued part of a patient's care at the hospice is evident. Many hospices had taken steps to improve the security and governance around areas where they care for deceased people, largely in response to the findings of Phase 1 of this Inquiry. However, a lack of standards around ensuring security and dignity for care of the deceased in the sector means that there is considerable variation in practice. We have also found that the Care Quality Commission's role in inspecting areas where deceased people are cared for in hospices can be unclear. This has the potential to give false assurance. My recommendations for this sector aim to strengthen governance and security arrangements for care of deceased patients in hospices.

The Inquiry also took evidence from **NHS ambulance services** in England (Chapter 5). We have found that there is a lack of data on the conveyance of the deceased in NHS ambulances, and a variation between different organisations in terms of the policies

and procedures in place to safeguard the security and dignity of the deceased while they are being transported in ambulances.

In relation to **local authorities** (Chapter 6) providing HTA-licensed mortuaries, we have found substantial variation in their ability to ensure the security and dignity of the deceased. Some local authorities have struggled to identify the measures necessary to strengthen security, with almost all requiring action by the regulator before they took these steps. Local authorities do not have the sort of governance structures that underpin the delivery of clinical services within the NHS, and managers are overly reliant on technical staff working in the mortuaries. We have found incidences of substantial, and in some cases longstanding, non-compliance with regulatory requirements. In some local authorities, there is limited scrutiny of the mortuary, as well as a lack of routine reporting at a senior level.

Some local authorities are operating body stores in response to pressures on capacity locally. This means that deceased people are being held in non-regulated facilities, sometimes prior to post-mortem examination. There is a lack of standardisation in the policies and practices in place to protect the security and dignity of the deceased, as well as a lack of guidance available to local authorities.

Some local authorities do not have effective mechanisms to ensure that they are notified of regulatory action or serious incidents in relation to their contracted providers of mortuary and post-mortem services. The reporting of incidents that occur while the deceased are in the care of unregulated providers relies on the integrity of those working for those providers.

My team and I did not gather evidence from **care and nursing homes** across England, but we did receive statements from four organisations representing the sector (Chapter 7). Nevertheless, I feel that it is important to consider this sector and include it within my overarching recommendations, due to the large proportion of people who die in care homes.

With regard to the **funeral sector** (Chapter 8), I have already published an Interim Report in October 2024. This was prompted by concerns about this sector, following a number of reports of cases of neglect of the deceased in funeral homes.

We have found that anyone can be a funeral director. They do not need a licence, experience, qualifications or training, and they can use whatever facilities and equipment they choose. It is my view that only statutory regulation of the sector can prevent poor practice. This situation has been brought into even sharper focus during our work in Phase 2 of the Inquiry, where we have found that there are interactions with the funeral sector across all sectors and in all settings – primarily for transporting and/or storing the deceased.

More than five years ago, the Competition and Markets Authority recommended that the government should establish an inspection and registration regime for the funeral industry. It is very disappointing that, to date, no action has been taken to implement this recommendation and address the manifest weaknesses in the sector.

For **faith organisations** (Chapter 9), we have found variations in practices and responsibilities held across the organisations we engaged with, in relation to the security and dignity of the deceased.

In the **locality visits** my team and I conducted (Chapter 10), we have seen a reliance on funeral directors for transportation and contingency storage of the deceased. There are multiple examples of 'mutual aid' between organisations for contingency storage and post-mortem services. These arrangements are, in some cases, created and maintained through informal and 'goodwill' agreements rather than formal contracts or service level agreements, and there is often little formal monitoring of the arrangements in practice. We have found evidence of good governance across and between different organisations, but the variation in standards and care seen in all the sectors making up the individual modules of this Inquiry was also replicated in the evidence gathered during the locality visits.

We have found that **regulation and oversight** (Chapter 11) of the care of people after death are partial and ineffective, and, in some significant areas, completely lacking. Many organisations that provide care to people after death are not regulated in terms of the care they provide or in relation to safeguarding the security and dignity of the deceased. We have observed that the lack of regulation has a negative impact on the way in which the security and dignity of people after death are considered in the governance arrangements for many organisations we reviewed in the Inquiry.

There is no mandatory regulation or oversight in place that has an overriding objective to protect the security and dignity of deceased people.

There is no mandatory professional regulation of mortuary staff wherever they work, including in the funeral sector. This represents a significant gap in the protection of people after death.

In Phase 1, we heard evidence of unclear governance systems, a lack of clear accountability for services, and a cultural reluctance to accept that something like David Fuller's crimes might be taking place.[5] My team and I have seen evidence of these themes throughout our Phase 2 work, and they are reflected in the findings of this Report.

Implementing the recommendations in this Report, as well as those from our Interim Report on the funeral sector,[6] is essential to effectively safeguard the security and dignity of the deceased across England. I have concluded that, while some sectors face a greater risk of this type of offence taking place than others, it is possible that abuse of the deceased could happen in any of the sectors we have explored. I am mindful of the need for any increase in regulation to be necessary and proportionate, but I believe that the recommendations in this Report are the least that should be acceptable.

5 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report*, November 2023.

6 Sir Jonathan Michael, *Independent Inquiry into the issues raised by the David Fuller case: Phase 2 Interim Report – Funeral Sector*, October 2024.

Following the publication of this Report, the Inquiry will cease to operate. It will then be for the UK government to respond to this Report and my recommendations.

The Inquiry welcomes the government's response to the House of Lords Statutory Inquiries Committee's recommendations on monitoring the implementation of the recommendations from public inquiries.[7] Therefore, I make the following **final recommendation**.

Recommendation 75
The government should take responsibility for the implementation of all the recommendations we make in this Report, regardless of the primary organisation they are directed at, and make arrangements to monitor the progress of their implementation.

I urge the government to act as soon as possible, noting again that the opportunity for harm to occur to the deceased, either deliberately or through neglect, exists in all of the sectors covered in this Report.

12.2 Recommendations

Table 31 below lists all the recommendations from the Report as a whole. Most recommendations are for the UK government to address.

Where recommendations are allocated to NHS England, the Inquiry expects that whichever organisation or body takes over the relevant activities that are currently the responsibility of NHS England should become responsible for the recommendations, at the point from which responsibility is transferred from NHS England.

7 Cabinet Office, Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust, 10 February 2025, gov.uk website.

Table 31: Table of recommendations from the Phase 2 Report of the Independent Inquiry into the issues raised by the David Fuller case		
Rec. number	**Recommendation**	**Organisation/ body**
Chapter 1: NHS hospitals		
1	All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: • the systems in place to identify any unauthorised access to the facility; • the strength and effectiveness of barriers to prevent unauthorised access to the facilities; • the systems in place to identify any access to deceased people for unauthorised purposes; and • how CCTV is used, including its monitoring and any audits undertaken.	NHS trusts
2	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.	NHS trusts
3	All NHS trusts should routinely audit the access data of all facilities used to store deceased people.	NHS trusts
4	The practice of using shared electronic swipe cards for specific staff groups should cease immediately.	NHS trusts
5	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.	NHS trusts

Rec. number	Recommendation	Organisation/ body
6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	NHS trusts
7	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.	NHS England and the body that subsumes its functions
8	All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	NHS trusts
9	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	NHS trusts
10	NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	NHS trusts
11	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	NHS trusts
12	NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	NHS trusts
13	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.	NHS trusts

Rec. number	Recommendation	Organisation/ body
14	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	NHS trusts
15	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: • staffing matters; • security incidents; • all serious incidents; • Human Tissue Authority reports (where applicable); and • all security audits, including audits of access and any access breaches.	NHS trusts
16	Trust boards should assure themselves that the recommendations in this Report have been implemented	NHS trusts
17	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people.	NHS trusts
18	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.	NHS trusts
19	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	NHS trusts
20	The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.	NHS trusts

Rec. number	Recommendation	Organisation/ body
21	NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.	NHS England or the body that subsumes its functions
Chapter 2: Independent hospitals		
22	Independent sector healthcare providers should ensure that there are Standard Operating Procedures and policies in place to protect the security and dignity of any patients that die under their care. Wherever possible, deceased patients' rooms should be kept locked. Providers should also ensure that staff are aware of the need to protect the security and dignity of deceased patients and are able to assess and mitigate risks to this.	Independent sector hospitals
23	Independent sector healthcare providers should ensure that only people who have a legitimate reason to access a room that contains a deceased patient do so, even if they are staff members, and that they are always accompanied.	Independent sector hospitals
Chapter 3: Medical education and training		
24	All organisations providing anatomical education and training using donors should make sure that policies and procedures are in place to ensure the security and dignity of donors. These should include: • security and access policies and the auditing of security and access measures such as swipe card access, CCTV and access to the locations where donors are kept; • governance arrangements to ensure effective oversight of and accountability for the security and dignity of donors; • a review of contracts or agreements with external organisations for the transfer of donors to or between facilities; and • policies and processes on incident reporting, both within the organisation and to the Human Tissue Authority, that are clear and accessible to all students and staff.	Medical and other clinical faculties of universities and medical postgraduate training providers

Rec. number	Recommendation	Organisation/ body
25	Postgraduate training providers using donors should ensure clarity in their governance and information-sharing, in particular where the providers are linked to both university and NHS settings. This clarity should include formal agreements, where relevant, including management, governance and Human Tissue Authority licensing arrangements for the organisations involved.	Medical postgraduate training providers
26	The Human Tissue Authority should change its guidance to require that relevant adverse incidents in the anatomy sector are formally reported as Human Tissue Authority Reportable Incidents (HTARIs).	Human Tissue Authority
Chapter 4: Hospices		
27	Hospices that care for deceased people on their premises should: • introduce auditable access control of the area where deceased people are kept; • have Standard Operating Procedures regarding the care of deceased people, including security of and access to the areas where deceased people are kept; and • minimise unaccompanied access to areas where deceased people are cared for, wherever possible.	Hospices
28	To avoid confusion over its remit, the Care Quality Commission should issue clear guidance to inspectors (and others) that hospice inspections should not include areas where deceased people are kept, other than to focus on the needs of bereaved relatives.	Care Quality Commission
29	Hospices should be considered in scope for the regulatory measures recommended in Chapter 11.	UK government

Rec. number	Recommendation	Organisation/ body
Chapter 5: Ambulance services		
30	Data on how often deceased patients are conveyed in ambulances, and the reasons for this, should be routinely collected and reported to NHS England, and monitored to assess risk.	NHS ambulance service trusts, NHS England or the body that subsumes its functions
31	Every NHS ambulance service should have a policy setting out where ambulance crew members should sit when conveying deceased patients. This should include reference to the risk of abuse of deceased patients, as well as training requirements.	NHS ambulance service trusts
32	NHS ambulance services should also have policies regarding the security and dignity of the deceased, including when the deceased should be covered and/or secured. NHS England should monitor that such policies are in place.	NHS ambulance service trusts, NHS England or the body that subsumes its functions
33	Every NHS ambulance service must put policies in place regarding taking photographs of deceased patients, including any circumstances in which this may be required, and ensure that ambulance staff are aware of these and comply with them.	NHS ambulance service trusts
34	The Inquiry has focused its investigations into ambulance services on NHS ambulance services. However, the Inquiry considers that these recommendations could also be applied to independent ambulance services, including private ambulances.	Ambulance service providers
Chapter 6: Local authorities		
35	There should be a process to routinely review who is permitted to access the mortuary unsupervised.	Local authorities with an HTA-licensed mortuary

Rec. number	Recommendation	Organisation/ body
36	Where unsupervised access is permitted for a legitimate and unavoidable purpose, there should be individualised electronic access controls to enter the mortuary and restrict access to specific areas of the mortuary, such as the post-mortem room. There should be a requirement to 'swipe to exit' to ensure that all activity is auditable. There should be no shared electronic access controls.	Local authorities with an HTA-licensed mortuary
37	Where people other than mortuary staff are visiting the mortuary during working hours, for example contractors, cleaners and other visitors: • Access must be limited to specific areas required for the purposes of their work or visit. • They must be supervised when working in areas where there is access to deceased people, for example in the fridge or post-mortem rooms. • Their attendance must be recorded and audited.	Local authorities with an HTA-licensed mortuary
38	Where mortuary staff are permitted to work alone in the mortuary, there should be a review of lone working policies, including consideration of activities involving direct handling of the deceased, alongside mitigations that can be put in place to safeguard the security and dignity of the deceased, such as CCTV.	Local authorities with an HTA-licensed mortuary
39	Routine and regular audits of security must be conducted, encompassing both access to and exit from the mortuary and movement within it, including the post-mortem room. Access data must be reconciled against CCTV footage. Audits must be reported to the Designated Individual and head of service or equivalent.	Local authorities with an HTA-licensed mortuary

Rec. number	Recommendation	Organisation/ body
40	Immediate steps must be taken to commission a specialist strategic review of the systems in place to protect the deceased, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: • the systems in place to identify unauthorised access to the facility; • the strength and effectiveness of barriers to prevent unauthorised access to the facility; • the systems in place to identify any inappropriate access to the deceased; and • how CCTV is used, including its monitoring and any audits undertaken.	Local authorities with an HTA-licensed mortuary
41	There must be no reliance on keys and keypad codes alone to secure access to the mortuary.	Local authorities with an HTA-licensed mortuary
42	Fridges and freezers containing deceased people must be locked at all times, with appropriate key security in place.	Local authorities with an HTA-licensed mortuary
43	CCTV must be installed inside the mortuary facing all doors and access points, the reception area and the doors of all fridges containing deceased people, including where these are accessible from within the post-mortem room. Local authorities must put appropriate safeguards in place to maintain the security and dignity of the deceased in relation to the monitoring of CCTV. CCTV footage should be regularly reviewed. This should be done by mortuary staff where it is of a sensitive nature.	Local authorities with an HTA-licensed mortuary
44	Arrangements for responding to incidents of unauthorised access must be reviewed and incorporated into Standard Operating Procedures.	Local authorities with an HTA-licensed mortuary

Rec. number	Recommendation	Organisation/ body
45	All policies and procedures in relation to the security of the mortuary must be accurately and comprehensively reflected in a single security Standard Operating Procedure.	Local authorities with an HTA-licensed mortuary
46	There must be a process to ensure that, where there is a requirement for funding to strengthen mortuary security, it is expedited and considered at the highest levels within the local authority.	Local authorities with an HTA-licensed mortuary
47	There must be an investigation into the root cause of each security breach. Each incident, the investigation and action plan must be reported to director level within the local authority as a minimum. Serious security breaches must also be reported to the relevant cabinet member and/or committee of elected members.	Local authorities with an HTA-licensed mortuary
48	There must be audits of the mortuary Standard Operating Procedures and compliance with Human Tissue Authority requirements, undertaken annually as a minimum, with a clear record of authorisation by the Designated Individual, head of service or equivalent. Audits of staff compliance with the Standard Operating Procedures must be undertaken at least annually, with the results of the audits reported to the Designated Individual and head of service or equivalent.	Local authorities with an HTA-licensed mortuary

Rec. number	Recommendation	Organisation/ body
49	There must be a review of the management and oversight arrangements for the mortuary service, taking into consideration who is appointed as the Designated Individual, their direct contact with the mortuary, level of influence within the local authority, and attendance at governance forums. In particular: • Local authorities must ensure that the Designated Individual has enough time and resource to fulfil their statutory responsibilities, including time for learning and development. • The Designated Individual must have access to director-level officers in the local authority. The Designated Individual must also be able to directly raise issues in relation to the mortuary at the highest level within the local authority if they deem it is necessary. • Where the Designated Individual is non-technically trained, a senior anatomical pathology technologist must fulfil the Mortuary Manager role to ensure that there is sufficient technical experience within the mortuary. • The Designated Individual must attend regular, documented meetings at mortuary level. The Designated Individual must also attend governance forums where the mortuary is discussed and scrutinised. • In line with Human Tissue Authority guidance, the named Licence Holder must be at a more senior level than the Designated Individual (e.g. director level or higher) and have a clear understanding of the Human Tissue Authority's statutory requirements and the role of the Designated Individual.	Local authorities with an HTA-licensed mortuary

Rec. number	Recommendation	Organisation/ body
50	The mortuary service must be treated in the same way as other regulatory services within local authority reporting structures: • The mortuary must be visible to scrutiny at the relevant statutory committee, with regular reporting. • Key performance indicators must be identified and must include the results of audits of compliance with Human Tissue Authority requirements. • Inspections by the Human Tissue Authority and Human Tissue Authority Reportable Incidents (HTARIs) must be reported to the relevant statutory committee, and actions to achieve compliance monitored.	Local authorities with an HTA-licensed mortuary
51	The mortuary service must be reviewed by professional auditors at least biennially, with the results of the audit reported to a formal committee regardless of the level of assurance. Local authorities must arrange a peer review of the mortuary service at least every three years.	Local authorities with an HTA-licensed mortuary
52	All relevant reports and incidents concerning the mortuary must be made known to the lead local authority manager for the coroner service (and the Senior Coroner if they wish to see these reports). Local authorities that are not the lead authority for the coroner service must also share these reports and incidents with the coroner service lead in that coroner area.	Local authorities with an HTA-licensed mortuary
53	The implementation of these recommendations must be reported to the relevant statutory committee.	Local authorities with an HTA-licensed mortuary
54	Local authorities providing a coroner service must review plans for the provision and operation of contingent body storage, in collaboration with local organisations providing mortuary services.	Local authorities providing a coroner service

Rec. number	Recommendation	Organisation/ body
55	Local authorities providing an unlicensed body store must be prepared to comply with the Human Tissue Authority's standards and guidance where applicable, in the event that a Human Tissue Authority licence is required to enable activities outside Human Tissue Authority licensing exemptions.	Local authorities providing an unlicensed body store
56	Where local authorities provide an unlicensed body store, they should do so in line with this Report's recommendations to local authority providers of licensed mortuaries.	Local authorities providing an unlicensed body store
57	Local authorities must review all contractual arrangements and agreements with third-party providers of services that care for and transport the deceased. This must include consideration of assurance mechanisms, such as key performance indicators, regular reporting, formal contract review meetings, site visits and stakeholder feedback.	Local authorities who contract with third-party providers in relation to the deceased
58	There must be a contractual requirement to formally notify the contract manager and senior local authority officers of any incidents involving the deceased, as well as the outcome of inspections or other action by the Human Tissue Authority or others with an oversight role, such as the Health and Safety Executive.	Local authorities who contract with third-party providers in relation to the deceased
59	Local authorities must ensure that the providers they contract or enter into agreements with have robust governance processes in place to oversee the services they provide. This should include Standard Operating Procedures that protect the security and dignity of the deceased and audits to ensure staff compliance with them, as well as the reporting of incidents.	Local authorities who contract with third-party providers in relation to the deceased
Chapter 7: Care homes		
60	The regulatory measures recommended in Chapter 11 should apply to care homes in England. Regulation should cover both systems and professionals where staff are providing care to deceased people in care homes.	UK government

Rec. number	Recommendation	Organisation/ body
Chapter 8: Funeral sector		
61	The UK government should establish an independent statutory regulatory regime for funeral directors in England as a matter of urgency in order to safeguard the security and dignity of the deceased. This regime should include a licensing scheme, mandatory standards against which funeral directors should be inspected regularly, and enforcement powers.	UK government
62	These regulations and standards should be considered within the overall care and journey of the deceased rather than applying in isolation to funeral directors.	UK government
63	The standards should include details of mandatory information to be given to customers by funeral directors to provide transparency about the care of the deceased, including information on measures to protect their security and dignity, and what should be expected of funeral directors' services.	UK government
64	Direct cremation businesses should also be considered in this context, and mandatory standards to protect the security and dignity of the deceased should be applied to these businesses and to any emerging new models of delivery of care for the deceased.	UK government
65	While the introduction of a proportionate statutory regulation and inspection regime may require significant adjustment by funeral director organisations, it is the view of the Inquiry that the benefit to customers and the need for public confidence outweigh the difficulties that may be experienced by some businesses.	UK government
66	The funeral sector in England should be considered in scope for the broader regulatory measures recommended in Chapter 11.	UK government

Rec. number	Recommendation	Organisation/ body
Chapter 9: Faith organisations		
67	All faith organisations should consider how to support their members to deliver high standards of care for the deceased, with a focus on the security and dignity of the deceased – for example, by sharing guidance.	Faith organisations
68	Where deceased people are in a religious building overnight, measures should be taken to ensure that the building is secure, including, for example, CCTV and secure access control for the area in which they are kept.	Faith organisations
Chapter 10: Locality visits		
69	Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death.	NHS trusts, local authorities, medical education providers, funeral sector

Rec. number	Recommendation	Organisation/ body
Chapter 11: Regulation and oversight		
70	The Chief Coroner should review the difference in practice between coronial areas as soon as possible to ensure that: • All coroners are informed of the findings of this Inquiry. • All coroners are aware of the prevalence of offending by David Fuller against deceased people who were formally under the control of the coroner. • All coroners understand the importance of a consistent approach to ensuring the security and dignity of deceased people who are under their control. This is likely to require guidance from the Chief Coroner to ensure that there is a consistent approach nationally, and it should be considered an area for further training for all coroners and their staff.	Chief Coroner of England and Wales
71	The UK government should establish an independent statutory regulatory regime, headed by a Chief Inspector, for those who store and care for deceased people. The purpose of the regulatory regime should be to ensure that the security and dignity of deceased people are protected, in whichever institutions or locations they are cared for, examined or stored. The government should ensure that this role is adequately resourced to discharge its responsibilities and should provide it with powers to require information and enter premises and to take appropriate enforcement action (including against office holders in any organisation). Either the Human Tissue Authority should be required to work under the auspices of this new regime, or its remit should be formally expanded to comply with the statutory regime's requirements.	UK government

Rec. number	Recommendation	Organisation/ body
72	In the interim, the government should immediately appoint a Commissioner for the Dignity of the Deceased who should immediately issue universal guidance that applies to all those who store and care for deceased people. This guidance should set out expectations for the security and dignity of deceased people.	UK government
73	The government should amend the Human Tissue Act 2004 so that the organisation holding the licence has primary legal responsibility to ensure that: • There is a suitable Designated Individual in place at their establishment. • Suitable premises are provided and maintained. • Suitable individuals are employed. • All relevant legal and regulatory duties pertaining to the licence are met.	Department of Health and Social Care
74	The Human Tissue Authority, and/or the new Inspectorate, should require the organisations it licenses to ensure that any individual who provides care to deceased people is suitably qualified, experienced and supervised. The regulatory regime should set minimum standards on the qualifications likely to be considered sufficient to demonstrate 'suitability' for particular roles or levels of responsibility. Failure to ensure that suitable individuals are employed would be subject to regulatory enforcement.	UK government
Chapter 12: Chair's conclusions and recommendations		
75	The government should take responsibility for the implementation of all the recommendations we make in this Report, regardless of the primary organisation they are directed at, and make arrangements to monitor the progress of their implementation.	UK government

Appendix 1: How we did our work

The Inquiry's Phase 1 Report describes how the Inquiry was set up, how the Terms of Reference (see Appendix 2) were finalised, and how we carried out our work in Phase 1. This appendix describes how we carried out our work in Phase 2.

Phase 2 work

Unlike Phase 1 of the Inquiry's work, which focused on the specific matters relating to Maidstone and Tunbridge Wells NHS Trust and its system partners, Phase 2 considered the practices and procedures in place to safeguard the security and dignity of the deceased in other settings across England.

We also reviewed the adequacy and effectiveness of the regulatory arrangements for the care of deceased people. The Inquiry was not investigating – and cannot formally investigate – these organisations, but we sought to understand their current policies and practices relating to the security and dignity of the deceased.

The Inquiry divided Phase 2 into modules, covering each of the sectors it examined, to be able to systematically assess the arrangements to protect the security and dignity of deceased people sector by sector. The Inquiry used a range of methods in carrying out its work, including questionnaires, interviewing or obtaining statements from those responsible for caring for people after death and those with an oversight or regulatory role, reviewing documents and visiting a sample of sites where deceased people are cared for or stored.

The specific methods used in each of the different modules are set out in the individual chapters of this Report.

The relatives of David Fuller's victims

The relatives of the victims of David Fuller are at the heart of this Inquiry. The Inquiry has kept those relatives who gave their consent for the Inquiry to contact them informed at key points during the work of Phase 2.

Witnesses

The Inquiry identified individuals with relevant roles from the organisations with which we wanted to engage, so that they could provide evidence to assist the Inquiry to fulfil its Terms of Reference.

Interviews with witnesses were recorded and a transcript was subsequently made available to them, which they were asked to check for factual accuracy. The interviews were held in private. The Inquiry undertook 223 interviews during Phase 2. These evidence sessions were attended by at least two, usually three, members of the Inquiry team. Witnesses were asked questions in line with the Inquiry's Terms of Reference and Protocol. Some witnesses were also invited to send documentary evidence to the Inquiry.

The organisations that gave evidence to the Inquiry are listed in Appendix 4. Not all organisations and individuals have been named in specific chapters, and some have instead been assigned a cypher. Some individuals have been named where they hold positions of authority in national organisations.

The Inquiry had no powers to compel people to give evidence, but the overwhelming majority of those we invited did so. A very small number of organisations did not respond to the Inquiry or did not cooperate fully, and these are listed in Appendix 4.

Documentary evidence

The Inquiry reviewed over 2,300 pieces of documentary material in its investigations. The Inquiry put information-sharing agreements in place with key organisations to ensure that relevant information was shared with the Inquiry securely.

Fairness Process

This Report contains criticisms of six organisations. The Inquiry conducted a Fairness Process, which involved writing to the organisations the Chair was minded to criticise in the Report, to provide them with an opportunity to respond to summaries of the criticisms about them. The Chair carefully considered these responses and any information provided, before making the final decision on the text of the Report.

In writing this Report and in making the findings within it, including the criticisms of organisations, the Inquiry has been careful to ensure that the findings it has made are based on the information and evidence that were available at the time.

The Inquiry cannot and does not make any findings that relate to civil and criminal liability, as this is not our role. The Inquiry has adopted the same standard of proof as has been adopted by many other inquiries, which is a variable and flexible approach to determining factual issues.

Where the Inquiry found, during the course of its evidence-gathering, something of concern or a potential safety issue that it felt required immediate action, it informed the relevant organisation and/or oversight authority.

Recommendations

All the evidence we gathered was analysed against the Inquiry's Terms of Reference. Advice was sought from the Inquiry's Independent Advisers where necessary. The Inquiry's findings and recommendations are based on the analysis of the evidence we received. The Chair of the Inquiry has made recommendations to the Secretary of State and a number of other organisations, the aim of which is to safeguard the security and dignity of deceased people and to prevent a recurrence of David Fuller's appalling offences.

Risks

We identified risks to the Inquiry throughout the course of our work. These were discussed by the Inquiry team at fortnightly meetings and mitigating actions were agreed. In its investigations, the Inquiry also identified some risks for other organisations, which were compromising the safety of the deceased. These were escalated to the relevant organisation as soon as they were identified, in line with clause 10 of the Inquiry's Terms of Reference.

Appendix 2: Terms of Reference

Background

1. David Fuller, an electrical maintenance supervisor firstly at Kent and Sussex Hospital and then later at Tunbridge Wells Hospital, was arrested in December 2020 for the murders of two women in 1987. When police searched his house, they found images and videos of him committing sexual offences on the bodies of at least 100 women and children at the Maidstone and Tunbridge Wells NHS Trust mortuary since 2008.

2. In January 2021, David Fuller pleaded not guilty to the murders. He was later charged with the mortuary offences. In October 2021, he pleaded guilty to the mortuary offences. In November 2021, he pleaded guilty to the murders.

3. Maidstone and Tunbridge Wells NHS Trust began an investigation into the activities of David Fuller overseen by an independent Chair, Sir Jonathan Michael. On 8 November 2021, the Right Honourable Sajid Javid MP, Secretary of State for Health and Social Care announced that this was to be replaced with an independent inquiry given the scale and nature of the offences. The Inquiry has not been set up under the Inquiries Act 2005 and will be adopting a non-judicial approach to its work.

Terms of Reference

4. The Inquiry will be split into two phases:

- an initial report, on matters relating to Maidstone and Tunbridge Wells NHS Trust, reporting by the middle of 2022, and
- a final report, looking at the broader national picture and the wider lessons for the NHS and for other settings, reporting by the middle of 2023.

5. The Inquiry will review David Fuller's unlawful actions, how he was able to carry these out, why his actions went apparently unnoticed, and will make recommendations with the aim of preventing anything similar happening again.

6. An important part of the Inquiry is to afford the families who have been affected by David Fuller's offending an opportunity to be heard and for the Inquiry to be informed by this. The Inquiry will preserve the anonymity of families throughout the course of its work. Staff of the Trust and of David Fuller's private sector employers who have been affected by David Fuller's actions will also

have an opportunity to share their experiences with the Inquiry. The Inquiry will make sure that families and others affected by the actions of David Fuller can share their experiences and information with it in ways that are supportive and sensitive.

7. The Inquiry will also consider evidence and information from other interested parties, including, for example, Maidstone and Tunbridge Wells NHS Trust and its predecessors ('the Trust'), relevant regulatory bodies and subject matter experts. All interested parties are required and expected to cooperate with the inquiry as is normal, professional practice. Findings and recommendations from previous relevant reports will also be considered in the work of the Inquiry.

8. The Inquiry will treat all information and personal data received in accordance with all relevant legal and regulatory requirements, including the UK General Data Protection Regulation (GDPR).

9. The Inquiry will ensure that the families of victims are kept informed of progress. The Inquiry team will remain accessible throughout.

The issues the Inquiry will consider in each phase, but is not limited to, are as follows.

Phase 1

- To consider the process by which David Fuller was recruited and employed by the NHS and by private sector facilities maintenance service providers during the period 1989 to 2020 and whether appropriate and adequate checks were carried out prior to and during his employment, whether the current checks are appropriate for individuals with access to mortuary facilities, and whether risks associated with those checks were managed.
- To determine what access David Fuller was given to the mortuary and other areas of the Trust, and whether this was subject to usual or appropriate supervision, oversight and assurance, including analysis of swipe card activity and CCTV.
- To identify any evidence of other inappropriate or unlawful activities by David Fuller elsewhere on Trust premises.
- To review any evidence of complaints, concerns or incidents concerning David Fuller's behaviour at the Trust, and how they were addressed by the Trust and his private sector employers.
- To consider whether the Trust's arrangements for management of the mortuary, including security and access, to safeguard the bodies of the deceased, were in accordance with Human Tissue Authority (HTA) standards, any relevant guidance or regulatory requirements and any relevant recommendations from other inquiries.
- To consider whether arrangements for post-mortem examinations were satisfactory.
- To examine inspection reports of the mortuary by the HTA and any other regulator, and the associated assurance processes.

- To consider whether the Trust's Board received sufficient assurance on the issues raised by the case of David Fuller.
- To examine arrangements for transfer of the deceased between the Trust and other organisations, for example local funeral directors and to identify whether concerns were or should have been raised.

Phase 2

- To consider whether procedures and practices in hospital settings, including in the private sector, where bodies of the deceased are kept, safeguard the security and dignity of the deceased, and would prevent a recurrence of matters raised by the case of David Fuller.
- To consider whether procedures and practices (including the use of locum Anatomical Pathology Technologists) in non-hospital settings, including local authority mortuaries, funeral directors, the NHS ambulance service, medical schools, temporary mortuaries, direct funeral companies and hospices, where bodies of the deceased are kept, safeguard the security and dignity of the deceased and would prevent a recurrence of matters raised by the case of David Fuller.
- To consider the role of regulators and their use of regulatory measures in assuring that mortuary practices safeguarded the security and dignity of the deceased in all settings, and hence consider the effectiveness of the national regulatory regime.
- To consider any other issues that arose during Phase 1 of the Inquiry.

General

10. The Inquiry will:

- Produce a Phase 1 report on its findings and recommendations on issues arising from its consideration of events at Maidstone and Tunbridge Wells NHS Trust and identify areas of concern for the wider NHS to be aware.
- Produce a final report which will provide an overview of the information it has reviewed, and which will set out the Inquiry's findings and its recommendations.
- Publish anonymised accounts, setting out the experiences of the families affected by David Fuller's offending and inappropriate behaviour, and the impact this has had on them.
- Escalate any matters it comes across that require immediate attention to the relevant authorities.

- Report any instances of apparent collusion or other conduct of concern (including conduct that indicates the potential commission of criminal or disciplinary offences, or breach of professional codes of conduct) to the relevant employer(s), professional or quality regulator(s), and/or the police for their consideration. The Inquiry does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability.

11. The Inquiry will aim to make its initial report to the Secretary of State for Health and Social Care by the middle of 2022 and its final report with its findings and recommendations by the middle of 2023. The Secretary of State for Health and Social Care will make arrangements for their presentation to Parliament.

12. Although the Inquiry will be restricted to matters concerning mortuary practices in England, its findings and recommendations may have relevance across the United Kingdom.

Addendum May 2023

This is an addendum to the Terms of Reference that were published by the Inquiry on 23 February 2022. The addendum relates to points 4 and 11 of the Terms of Reference. New information has been provided to the Inquiry. The Inquiry will investigate this new information in line with its Terms of Reference which include assessment of the management of the mortuary, including the arrangements for security and access necessary to safeguard the bodies of the deceased.

This further investigation means that the Inquiry will now be unable to publish its initial report on matters relating to Maidstone and Tunbridge Wells NHS Trust before the Autumn 2023. A final report, looking at the broader national picture and the wider lessons for the NHS and for other settings is planned for publication in 2024. The Inquiry will present the findings of both reports to the Secretary of State for Health and Social Care, who will make arrangements for their presentation to Parliament.

Addendum November 2024

The final report, looking at the broader national picture and the wider lessons for the NHS and other settings is now planned for publication in 2025.

Appendix 3: Team members

Members of the Inquiry team

Sir Jonathan Michael, Chair of the Inquiry (from November 2021)

Rebecca Chaloner, Secretary to the Inquiry (from November 2021)

Jane Campbell, Deputy Secretary to the Inquiry (from November 2021)

Kathryn Whitehill, Head of Investigations (from September 2022 to December 2024)

Fiona Pearson, Head of Investigations (from January 2025)

Claire Gillespie, Inquiry Team Leader (from January 2024)

Yvonne Waring, Business and Investigations Manager (from January 2022)

Henny Goddard, Inquiry Policy Officer (from July 2022 to February 2025)

Libby Crowther, Inquiry Support Officer (from March 2024)

Legal representatives

Tim Suter, Partner, Public Regulatory, Fieldfisher

Laura Penny, Senior Associate, Fieldfisher

Alice Boydell, Senior Associate, Fieldfisher

Liah Roberts, Associate, Fieldfisher

Emily Devaney, Associate, Fieldfisher

Jonathan Landau, Counsel to the Inquiry

Independent Advisers

Professor Michael Osborn, MRCS FRCPath, Consultant Histopathologist and former President, Royal College of Pathologists

John Pitchers, MSc, FAAPT, FRSPH, MIBMS, Chair, Association of Anatomical Pathology Technology, Service Manager, Mortuary and Coroner Support, Legal and Democratic Services, Bristol City Council

Communications

Simon Whale, Executive Chair, Luther Pendragon

Jennifer Evans, Associate Director, Luther Pendragon

William Gray, Associate Director, Luther Pendragon

Tabitha Adams, Associate Director, Luther Pendragon

Adrian Dias, Head of Luther Studio, Luther Pendragon

Harriet Reeve, Consultant, Luther Pendragon

Appendix 4: Witnesses and participants

The Inquiry gathered evidence via a variety of different methods, including interviews, seminars, questionnaires and written statements. Some witnesses and participants provided evidence in more than one format. The Inquiry heard from individuals and organisations. Most of the interviews were held online, although some were in person.

In total, 314 individuals and 897 organisations participated in the Inquiry. They provided evidence in the following ways:

- 223 interviews;
- 90 witness statements or other written evidence;
- four seminars involving 51 individuals;
- 855 questionnaire responses via seven different questionnaires;
- over 2,300 documents submitted; and
- five locality visits involving 15 individual sites.

Participants were from the organisations listed in the sections that follow overleaf.

NHS trusts[1]

- Airedale NHS Foundation Trust
- Alder Hey Children's NHS Foundation Trust
- Ashford and St Peter's Hospitals NHS Foundation Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Barnsley Hospital NHS Foundation Trust
- Barts Health NHS Trust
- Bedfordshire Hospitals NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Birmingham Community Healthcare NHS Foundation Trust
- Birmingham Women's and Children's NHS Foundation Trust
- Black Country Healthcare NHS Foundation Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Bolton NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Camden and Islington NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- Central London Community Healthcare NHS Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Cornwall Partnership NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- Coventry and Warwickshire Partnership NHS Trust
- Croydon Health Services NHS Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Dartford and Gravesham NHS Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Devon Partnership NHS Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

1 In some places, a Community Interest Company responded as a provider of NHS-funded services, instead of an NHS trust

- Dorset County Hospital NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- Dudley Integrated Health and Care NHS Trust
- East and North Hertfordshire NHS Trust
- East Cheshire NHS Trust
- East Coast Community Healthcare Community Interest Company
- East Kent Hospitals University NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- East Suffolk and North Essex NHS Foundation Trust
- East Sussex Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Essex Partnership University NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- George Eliot Hospital NHS Trust
- Gloucestershire Health and Care NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Hampshire Hospitals NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Hertfordshire Community NHS Trust
- Homerton Healthcare NHS Foundation Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- Hull University Teaching Hospitals NHS Trust
- Humber Teaching NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Isle of Wight NHS Trust
- James Paget University Hospitals NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Kingston Hospital NHS Foundation Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Leeds and York NHS Partnership Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Leicestershire Partnership NHS Trust
- Lewisham and Greenwich NHS Trust

- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- Livewell Southwest Community Interest Company
- London North West University Healthcare NHS Trust
- Manchester University NHS Foundation Trust
- Medway NHS Foundation Trust
- Mersey and West Lancashire Teaching Hospitals NHS Trust
- Mersey Care NHS Foundation Trust
- Mid and South Essex NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Mid Yorkshire Teaching NHS Trust
- Midlands Partnership University NHS Foundation Trust
- Milton Keynes University Hospital NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- North Bristol NHS Trust
- North Cumbria Integrated Care NHS Foundation Trust
- North East London NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- North Staffordshire Combined Healthcare NHS Trust
- North Tees and Hartlepool NHS Foundation Trust
- North West Anglia Foundation Trust
- Northampton General Hospital NHS Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Northern Care Alliance NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Portsmouth Hospitals University NHS Trust
- Queen Victoria Hospital NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Devon University Healthcare NHS Foundation Trust
- Royal Free London NHS Foundation Trust

- Royal National Orthopaedic Hospital NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- Royal Surrey NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Sandwell and West Birmingham NHS Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Sirona Care and Health Community Interest Company
- Solent NHS Trust
- Somerset NHS Foundation Trust
- South London and the Maudsley NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust
- South Warwickshire University NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Southern Health NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust
- Stockport NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- Sussex Partnership NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- The Christie NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- The Dudley Group NHS Foundation Trust
- The Hillingdon Hospitals NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust
- The Royal Wolverhampton NHS Trust

- The Tavistock and Portman NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- United Lincolnshire Teaching Hospitals NHS Trust
- University College London Hospitals NHS Foundation Trust
- University Hospital of North Midlands NHS Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- University Hospitals Dorset NHS Foundation Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospitals Plymouth NHS Trust
- University Hospitals Sussex NHS Foundation Trust
- Walsall Healthcare NHS Trust
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- West Hertfordshire Teaching Hospitals NHS Trust
- West London NHS Trust
- West Suffolk NHS Foundation Trust
- Whittington Health NHS Trust
- Wirral Community Health and Care NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- Worcestershire Acute NHS Trust
- Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
- Wye Valley NHS Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

Independent hospitals

- Circle Health Group
- Cygnet Health Care Ltd
- HCA Healthcare UK
- Nuffield Health
- Priory
- Ramsay Health Care UK
- Spire Healthcare
- St Andrew's Healthcare

Medical education

- Anglia Ruskin University (School of Medicine)
- Aston University (Aston Medical School)
- Brunel University London (Brunel Medical School)
- Canterbury Christ Church University (Kent and Medway Medical School)
- Edge Hill University (Medical School)
- Imperial College London (Faculty of Medicine)

- Keele University (School of Medicine)
- King's College London (Faculty of Life Sciences and Medicine)
- Newcastle University (School of Medicine)
- Queen Mary University of London (Faculty of Medicine and Dentistry)
- The University of Manchester (School of Medical Sciences)
- University College London (Medical School)
- University of Birmingham (Birmingham Medical School)
- University of Brighton and University of Sussex (Brighton and Sussex Medical School)
- University of Bristol (School of Anatomy)
- University of Buckingham (Medical School)
- University of Cambridge (Human Anatomy Centre)
- University of Chester (Chester Medical School)
- University of East Anglia (Norwich Medical School)
- University of Exeter (Medical School)
- University of Hull and University of York (Hull York Medical School)
- University of Leeds (Leeds School of Medicine)
- University of Leicester (Leicester Medical School)
- University of Lincoln and University of Nottingham (Lincoln Medical School)
- University of Liverpool (School of Medicine)
- University of London (St George's Medical School)
- University of Nottingham (Medical School)
- University of Oxford (School of Medicine and Biomedical Sciences)
- University of Plymouth (Peninsula Medical School)
- University of Sheffield (Medical School)
- University of Southampton (School of Medicine)
- University of Sunderland (School of Medicine)
- University of Surrey (School of Medicine)
- University of Warwick (Warwick Medical School)
- University of Worcester (Three Counties Medical School)

Hospices

- Acorns Children's Hospice
- Alexander Devine Children's Hospice Service
- Alice House Hospice
- Arthur Rank Hospice Charity
- Ashgate Hospice
- Barnsley Hospice
- Beaumond House Hospice Care
- Birmingham Hospice (Erdington)
- Birmingham Hospice (Selly Park)
- Bluebell Wood Children's Hospice
- Blythe House Hospice
- Bolton Hospice
- Bury Hospice
- Butterwick Hospice

- Campden Home Nursing CIO[2]
- Children's Hospice South West
- Claire House Children's Hospice
- Compton Care
- Cornwall Hospice Care
- Cransley Hospice Trust
- Cynthia Spencer Hospice
- Demelza Hospice Care for Children
- Derian House Children's Hospice
- Derwentside Hospice Care Foundation
- Dorothy House Hospice
- Douglas Macmillan Hospice
- Dove Cottage Day Hospice
- Dove House Hospice
- Dr Kershaw's Hospice
- East Anglia's Children's Hospices
- East Cheshire Hospice
- East Lancashire Hospice
- Eden Valley Hospice and Jigsaw, Cumbria's Children's Hospice[3]
- Ellenor
- Farleigh Hospice
- Florence Nightingale Hospice
- Forest Holme Hospice Charity
- Forget Me Not Children's Hospice
- Francis House Family Trust
- Garden House Hospice Care
- Great Oaks Hospice
- Greenwich and Bexley Community Hospice
- Halton Haven Hospice
- Harlington Hospice
- Haven House Children's Hospice
- Havens Hospices
- Heart of Kent Hospice
- Helen and Douglas House
- Hope House Children's Hospices
- Hospice at Home Carlisle and North Lakeland
- Hospice at Home West Cumbria
- Hospice in the Weald
- Hospice Isle of Man and Rebecca House Children's Hospice[4]
- Hospice of St Francis
- Hospice of the Good Shepherd
- HospiceCare North Northumberland
- Hospiscare
- Isabel Hospice
- James Hopkins Trust
- Jessie May Children's Hospice at Home
- John Eastwood Hospice
- Julia's House
- Kate's Home Nursing
- Katharine House Hospice (Banbury) and Sobell House Hospice[5]
- Katharine House Hospice (Stafford)
- Keech Hospice Care
- KEMP Hospice
- Kirkwood Hospice
- Lakelands Day Care Hospice
- Lewis-Manning Hospice Care

2 Charitable Incorporated Organisation.
3 One service provider covering multiple sites.
4 One service provider covering multiple sites.
5 One service provider covering multiple sites.

- Lindsey Lodge Hospice
- Longfield Community Hospice
- Macmillan Caring Locally
- Marie Curie (Bradford)
- Marie Curie (Hampstead)
- Marie Curie (Liverpool)
- Marie Curie (Newcastle)
- Marie Curie (Solihull)
- Martin House Children's Hospice
- Martlets Hospice
- Mary Ann Evans Hospice
- Mountbatten Hospice Group
- Myton Hospice
- Naomi House and Jacksplace
- Noah's Ark Children's Hospice
- North Devon Hospice
- North London Hospice
- North Yorkshire Hospice Care
- Nottinghamshire Hospice
- Oakhaven Hospice
- Overgate Hospice
- Pendleside Hospice
- Phyllis Tuckwell Hospice
- Pilgrims Hospices in East Kent
- Primrose Hospice and Family Support Centre
- Princess Alice Hospice
- Prospect Hospice
- Queenscourt Hospice
- Rainbows Hospice for Children and Young People
- Rennie Grove Peace Hospice Care
- Richard House Children's Hospice
- Rossendale Hospice
- Rotherham Hospice
- Rowans Hospice
- Rowcroft Hospice
- Royal Trinity Hospice
- Saint Catherine's Hospice
- Saint Francis Hospice
- Salisbury Hospice
- Seaton and District Hospital League of Friends
- Severn Hospice
- Shipston Home Nursing
- Shooting Star Children's Hospices
- Sidmouth Hospice at Home
- South Bucks Hospice
- Springhill Hospice
- St Andrew's Hospice
- St Ann's Hospice (Heald Green)
- St Ann's Hospice (Little Hulton)
- St Barnabas Hospice (Lincolnshire)
- St Barnabas Hospices (Chestnut Tree House Children's Hospice)
- St Benedict's Hospice
- St Catherine's Hospice (Crawley)
- St Catherine's Hospice (Preston)
- St Christopher's Hospice
- St Clare Hospice
- St Cuthbert's Hospice
- St Elizabeth Hospice
- St Gemma's Hospice
- St Giles Hospice
- St Helena Hospice
- St John's Hospice (Lancashire)
- St John's Hospice (London)
- St Joseph's Hospice (London)
- St Joseph's Hospice Association
- St Leonard's Hospice

- St Luke's Hospice (Basildon)
- St Luke's Hospice (Cheshire)
- St Luke's Hospice (Harrow and Brent)
- St Luke's Hospice (Plymouth)
- St Luke's Hospice (Sheffield)
- St Margaret's Hospice
- St Mary's Hospice
- St Michael's Hospice (Hastings and Rother)
- St Michael's Hospice (Hereford)
- St Michael's Hospice (North Hampshire)
- St Nicholas Hospice Care
- St Oswald's Hospice
- St Peter and St James Hospice
- St Peter's Hospice
- St Raphael's Hospice
- St Richard's Hospice
- St Rocco's Hospice
- St Teresa's Hospice
- St Wilfrid's Hospice (Chichester)
- St Wilfrid's Hospice (Eastbourne)
- Sue Ryder (Duchess of Kent Hospice)
- Sue Ryder (Leckhampton Court Hospice)
- Sue Ryder (Manorlands Hospice)
- Sue Ryder (Palliative Care Hub South Oxfordshire)
- Sue Ryder (St John's Hospice)
- Sue Ryder (Thorpe Hall Hospice)
- Sue Ryder (Wheatfields Hospice)
- Tameside and Glossop Hospice Ltd (Willow Wood Hospice)
- Teesside Hospice
- Thames Hospice
- The Butterfly Hospice Trust
- The Leicestershire and Rutland Hospice
- The Mary Stevens Hospice
- The Norfolk Hospice (Tapping House)
- The Prince of Wales Hospice
- The Rosemary Foundation Hospice at Home
- The Shakespeare Hospice
- Treetops Hospice
- Trinity Hospice and Palliative Care Services
- Tynedale Hospice
- Wakefield Hospice
- Weldmar Hospicecare
- Weston Hospicecare
- Wigan and Leigh Hospice
- Willen Hospice
- Willowbrook Hospice
- Wirral Hospice St John's
- Wisdom Hospice
- Woking and Sam Beare Hospice and Wellbeing Care
- Woodlands Hospice
- Zoe's Place Hospice

Ambulance service trusts

- East Midlands Ambulance Service NHS Trust
- East of England Ambulance Service NHS Trust
- Isle of Wight Ambulance Service[6]

6 Part of Isle of Wight NHS Trust.

- London Ambulance Service NHS Trust
- North East Ambulance Service NHS Foundation Trust
- North West Ambulance Service NHS Trust
- South Central Ambulance Service NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- West Midlands Ambulance Service University NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

Local authorities

- Adur Council
- Amber Valley Borough Council
- Arun District Council
- Ashfield District Council
- Ashford Borough Council
- Babergh District Council
- Barnsley Metropolitan Borough Council
- Basildon Borough Council
- Basingstoke and Deane Borough Council
- Bassetlaw District Council
- Bath and North East Somerset Council
- Bedford Borough Council
- Birmingham City Council
- Blaby District Council
- Blackburn with Darwen Borough Council
- Blackpool Council
- Bolsover District Council
- Bolton Metropolitan Borough Council
- Borough Council of King's Lynn and West Norfolk
- Borough of Broxbourne Council
- Boston Borough Council
- Bournemouth, Christchurch and Poole Council
- Bracknell Forest Council
- Braintree District Council
- Brighton and Hove City Council
- Bristol City Council
- Broadland District Council
- Bromsgrove District Council
- Broxtowe Borough Council
- Buckinghamshire Council
- Burnley Borough Council
- Bury Council
- Calderdale Council
- Cambridge City Council
- Cambridgeshire County Council
- Canterbury City Council
- Castle Point Borough Council
- Central Bedfordshire Council
- Charnwood Borough Council
- Chelmsford City Council
- Cheltenham Borough Council
- Cheshire East Council
- Cheshire West and Chester Council
- Chesterfield Borough Council
- Chichester District Council
- Chorley Council

- City of Bradford Metropolitan District Council
- City of Doncaster Council
- City of Lincoln Council
- City of London Corporation
- City of Wolverhampton Council
- City of York Council
- Colchester City Council
- Cornwall Council
- Cotswold District Council
- Coventry City Council
- Crawley Borough Council
- Cumberland Council
- Dacorum Borough Council
- Darlington Borough Council
- Dartford Borough Council
- Derby City Council
- Derbyshire County Council
- Derbyshire Dales District Council
- Devon County Council
- Dorset Council
- Dover District Council
- Dudley Metropolitan Borough Council
- Durham County Council
- Ealing Council
- East Cambridgeshire District Council
- East Hampshire District Council
- East Hertfordshire District Council
- East Lindsey District Council
- East Riding of Yorkshire Council
- East Staffordshire Borough Council
- East Suffolk Council
- East Sussex County Council
- Eastbourne Borough Council
- Eastleigh Borough Council
- Elmbridge Borough Council
- Epping Forest District Council
- Epsom and Ewell Borough Council
- Erewash Borough Council
- Essex County Council
- Exeter City Council
- Fareham Borough Council
- Fenland District Council
- Folkestone and Hythe District Council
- Forest of Dean District Council
- Fylde Council
- Gateshead Council
- Gedling Borough Council
- Gloucester City Council
- Gloucestershire County Council
- Gosport Borough Council
- Gravesham Borough Council
- Guildford Borough Council
- Halton Borough Council
- Hampshire County Council
- Harborough District Council
- Haringey Council
- Hart District Council
- Hartlepool Borough Council
- Hastings Borough Council
- Havant Borough Council
- Herefordshire Council
- Hertfordshire County Council
- High Peak Borough Council
- Hinckley and Bosworth Borough Council
- Horsham District Council
- Hull City Council

- Huntingdonshire District Council
- Hyndburn Borough Council
- Ipswich Borough Council
- Isle of Wight Council
- Isles of Scilly Council
- Kent County Council
- Kirklees Council
- Knowsley Metropolitan Borough Council
- Lancashire County Council
- Leeds City Council
- Leicester City Council
- Leicestershire County Council
- Lewes District Council
- Lincolnshire County Council
- Liverpool City Council
- London Borough of Barking and Dagenham
- London Borough of Barnet
- London Borough of Bexley
- London Borough of Brent
- London Borough of Bromley
- London Borough of Camden
- London Borough of Croydon
- London Borough of Enfield
- London Borough of Hackney
- London Borough of Hammersmith and Fulham
- London Borough of Harrow
- London Borough of Havering
- London Borough of Hillingdon
- London Borough of Hounslow
- London Borough of Islington
- London Borough of Lambeth
- London Borough of Lewisham
- London Borough of Merton
- London Borough of Newham
- London Borough of Redbridge
- London Borough of Richmond upon Thames
- London Borough of Southwark
- London Borough of Sutton
- London Borough of Tower Hamlets
- London Borough of Waltham Forest
- London Borough of Wandsworth
- Luton Borough Council
- Maidstone Borough Council
- Maldon District Council
- Malvern Hills District Council
- Manchester City Council
- Mansfield District Council
- Medway Council
- Melton Borough Council
- Mid Devon District Council
- Mid Suffolk District Council
- Mid Sussex District Council
- Middlesbrough Council
- Milton Keynes City Council
- Mole Valley District Council
- New Forest District Council
- Newark and Sherwood District Council
- Newcastle City Council
- Newcastle-under-Lyme Borough Council
- Norfolk County Council
- North Devon District Council
- North East Derbyshire District Council

- North East Lincolnshire Council
- North Hertfordshire District Council
- North Kesteven District Council
- North Lincolnshire Council
- North Northamptonshire Council
- North Somerset Council
- North Tyneside Council
- North Warwickshire Borough Council
- North West Leicestershire District Council
- North Yorkshire Council
- Northumberland County Council
- Nottingham City Council
- Nottinghamshire County Council
- Nuneaton and Bedworth Borough Council
- Oadby and Wigston Borough Council
- Oldham Council
- Oxford City Council
- Oxfordshire County Council
- Pendle Borough Council
- Peterborough City Council
- Plymouth City Council
- Portsmouth City Council
- Preston City Council
- Reading Borough Council
- Redcar and Cleveland Borough Council
- Redditch Borough Council
- Ribble Valley Borough Council
- Rochdale Borough Council
- Rossendale Borough Council
- Rother District Council
- Rotherham Metropolitan Borough Council
- Royal Borough of Greenwich
- Royal Borough of Kensington and Chelsea
- Royal Borough of Kingston upon Thames
- Royal Borough of Windsor and Maidenhead
- Rugby Borough Council
- Runnymede Borough Council
- Rushcliffe Borough Council
- Rutland County Council
- Salford City Council
- Sandwell Metropolitan Borough Council
- Sefton Metropolitan Borough Council
- Sevenoaks District Council
- Sheffield City Council
- Shropshire Council
- Slough Borough Council
- Solihull Metropolitan Borough Council
- Somerset Council
- South Cambridgeshire District Council
- South Gloucestershire Council
- South Hams District Council
- South Holland District Council
- South Norfolk Council
- South Oxfordshire District Council
- South Ribble Borough Council
- South Staffordshire Council
- South Tyneside Council
- Southampton City Council

- Southend-on-Sea City Council
- Spelthorne Borough Council
- St Albans City and District Council
- St Helens Borough Council
- Staffordshire County Council
- Staffordshire Moorlands District Council
- Stevenage Borough Council
- Stockport Metropolitan Borough Council
- Stockton-on-Tees Borough Council
- Stoke-on-Trent City Council
- Stratford-on-Avon District Council
- Stroud District Council
- Suffolk County Council
- Sunderland City Council
- Surrey County Council
- Surrey Heath Borough Council
- Swale Borough Council
- Swindon Borough Council
- Tameside Metropolitan Borough Council
- Tamworth Borough Council
- Tandridge District Council
- Telford and Wrekin Council
- Tendring District Council
- Test Valley Borough Council
- Tewkesbury Borough Council
- Thanet District Council
- Three Rivers District Council
- Thurrock Council
- Torbay Council
- Trafford Metropolitan Borough Council
- Tunbridge Wells Borough Council
- Uttlesford District Council
- Vale of White Horse District Council
- Wakefield Metropolitan Borough Council
- Walsall Metropolitan Borough Council
- Warrington Borough Council
- Warwick District Council
- Warwickshire County Council
- Watford Borough Council
- Waverley Borough Council
- Wealden District Council
- Welwyn Hatfield Borough Council
- West Berkshire Council
- West Devon Borough Council
- West Lancashire Borough Council
- West Lindsey District Council
- West Northamptonshire Council
- West Oxfordshire District Council
- West Suffolk Council
- West Sussex County Council
- Westminster City Council
- Westmorland and Furness Council
- Wigan Council
- Wiltshire Council
- Winchester City Council
- Wirral Council
- Woking Borough Council
- Wokingham Borough Council
- Worcester City Council
- Worcestershire County Council
- Worthing Council
- Wychavon District Council
- Wyre Council
- Wyre Forest District Council

Funeral sector

- A.B. Taylor Funeral Services Ltd
- A.B. Walker
- Abbey Funeral Services Ltd
- A.H. Cheater Ltd
- A.J. Wakely and Sons
- A.L. and G. Abbott
- Alex Jones Funeral Directors
- A Natural Undertaking Ltd
- Andrew Johnson Funeral Services
- Anstey and District Funeral Services
- Arthur C. Towner Ltd (Towners)
- Arthur E. Davey and Sons Ltd
- Arthur Jary and Sons Ltd
- Ash Brook Independent Funeral Directors Ltd
- Austin's Funeral Directors
- A.W. Lymn The Family Funeral Service
- Barrington's Funeral Services
- Blackburn's Funeral Directors
- Bowley and Sons Funeral Directors
- Brodies Funeral Services Ltd
- Calo's Funeral Directors Ltd
- Cathedral Funeral Services (Hereford) Ltd
- Christopher's Family Funerals
- C.L. Rescorla and Son Funeral Directors
- Cloud 9 Funerals Ltd
- Cornwall Funeral Services Ltd
- Cotton and Son Funeral Directors
- Countryside Funerals
- C.P.J. Field and Co. Ltd
- Crescent Funeral Services Ltd
- Deborah Ingham Funeral Service (Huddersfield Funeral Service Ltd)
- Devonport Funeral Services
- Dignity Funerals (Gloucestershire)
- Dillistone Funeral Service
- D.J. Hall Funeral Directors
- Dolby Funeral Services Ltd
- E.C. Alderwick and Son Ltd
- E.C. Gilbert Ltd (A.J. Adkinson and Son)
- Eric Eyre Funeral Services
- Fakenham and District Funeral Services Ltd
- F.C. Douch and Son (Funerals) Ltd (Douch Family Funeral Directors)
- F.P. Gaunts and Sons Funeral Directors
- Francis Chappell and Sons
- Full Circle Funerals
- Funeral Partners Ltd
- Gordon and Watson Funeral Directors
- Gowards Funeral Services
- Grassby and Sons Ltd
- G. Saville and Son Ltd
- G. Seller
- Haseldine Funeral Services Ltd
- Hathaway Funeral Directors
- Hawden and Burgess Family Funeral Directors
- H.D. Tribe Ltd
- Henry Dorricott Funeral Directors
- H.G. King Funeral Services
- Hickling's Funeral Service
- Hortons Funeral Directors Ltd
- H. Porter and Sons

- H.R. Palmer
- Hugh F. Chamberlin Funeral Directors
- Hunnaball Family Funeral Group Ltd
- Ian Hazel Funerals Ltd
- Jacksons Hub Ltd
- J. Barlow and Family Funeral Service
- Jerry March Funeral Services
- John Burrows and Sons
- J. Pidgeon and Son Ltd
- J. Stamp and Sons
- Keith Penrose Funeral Services
- Kirsty Sailes Funeral Directors
- Lamberts Funeral Service
- LeRoy Funerals
- Leverton and Sons Ltd
- Lincolnshire Co-operative Ltd (Funeral Services)
- Lodge Brothers (Funerals) Ltd
- Mashford Funeral Service
- McNulty Funeral Service
- M.K. Ginder and Sons Funeral Directors
- M. Lucking and Sons Ltd
- Murrell Cork Funerals
- Native Woodland Ltd (Leedam Natural Heritage)
- Near and Near Undertakers Ltd
- Neville Funeral Service Ltd
- Paul Hilton Funeral Services Ltd
- Paul Pender and Son Ltd
- Pearson Funeral Service
- Penrose Funeral Services
- Peter Haigh and Sons Funeral Directors
- Poppy's Funerals Ltd
- Pure Cremation Ltd
- R.A. Brooks and Son
- R. Davies and Son Funeral Directors (Roy Preddy Funeral Directors)
- Regent Funeral Services
- Richard Gegg and Sons
- Roberts Funerals Ltd (G. Roberts Independent Family Funeral Director)
- Rosedale Funeral Home
- Rowland Brothers Funeral Group
- Sears Funeral Directors
- Sher Azam Funeral Directors Ltd
- Southern Co-operative Funerals Ltd
- S. Stibbards and Sons
- Susan Whymark Funeral Service
- T. Cribb and Sons
- Trevor E.W. Hickton Ltd (Hickton Family Funeral Directors)
- Village Undertakers
- W.E. Pinder and Son Ltd
- Will Case and Partners Independent Funeral Directors
- Yeowart, Gill and Rudd Funeral Services

Faith organisations

- Baptist Union of Great Britain
- Board of Deputies of British Jews
- Catholic Bishops' Conference of England and Wales
- Church of England
- Conference, Methodist Church
- Evangelical Presbyterian Church in England and Wales

- Hindu Forum of Britain
- Jewish Leadership Council
- Muslim Council of Britain

Other organisations that participated

- Academy for Healthcare Science
- Academy of Medical Royal Colleges
- Association of Ambulance Chief Executives
- Association of Anatomical Pathology Technology
- Blake Emergency Services
- British Institute of Funeral Directors
- Care England
- Care Quality Commission
- Chief Coroner of England and Wales
- College of Paramedics
- Competition and Markets Authority
- Department of Health and Social Care
- Health and Care Professions Council
- Health and Safety Executive
- Home Office
- Hospice UK
- Human Tissue Authority
- Independent Funeral Standards Organisation
- Independent Healthcare Providers Network
- Institute of Cemetery and Crematorium Management
- Kenyon International Emergency Services
- Local Government Association
- London Anatomy Office
- Losberger De Boer UK
- Medical Schools Council
- Ministry of Housing, Communities and Local Government[7]
- Ministry of Justice
- National Association of Funeral Directors
- National Care Association
- National Care Forum
- National Repository Centre
- National Society of Allied and Independent Funeral Directors
- NHS England and its regional teams
- NHS Providers
- Professional Standards Authority for Health and Social Care
- Quaker Social Action
- Royal College of Pathologists
- Royal College of Physicians
- Royal College of Surgeons of England
- Scottish Government
- The Care Provider Alliance
- Together for Short Lives
- United Kingdom Accreditation Service

7 Previously the Department for Levelling Up, Housing and Communities.

Seminar attendees

Participants at the Inquiry's seminar on the funeral sector in Manchester, held in October 2023:

- Claire Barrington, Barrington's Funeral Services
- David Barrington, Barrington's Funeral Services
- David Coulson, Regent Funeral Services
- Ross Hickton, Trevor E.W. Hickton Ltd
- Paul Hilton, Paul Hilton Funeral Services
- Sarah Jones, Full Circle Funerals
- Nigel Lymn-Rose, A.W. Lymn The Family Funeral Service
- Natalya McLackland, Regent Funeral Services
- Clive Pearson, Pearson Funeral Service
- Debbie Torrie, Deborah Ingham Funeral Service
- Carrie Weekes, A Natural Undertaking Ltd
- David Wright, Eric Eyre Funeral Services

Participants at the Inquiry's seminar on the funeral sector in London, held in December 2023:

- Maria Davies, H. Porter and Sons
- Jeremy Field, C.P.J. Field and Co. Ltd
- Saul Hunnaball, Hunnaball Family Funeral Group Ltd
- Wendy Jackson, Jacksons Hub Ltd
- Andrew Leverton, Leverton and Sons Ltd
- David McLaren, Pure Cremation Ltd
- Clare Montagu, Poppy's Funerals Ltd
- Jo Parker, Abbey Funeral Services Ltd
- Lee Pedley, Neville Funeral Service Ltd
- Maria Stibbards, S. Stibbards and Sons
- Nathan Van Der Pant, Penrose Funeral Services
- Richard Van Nes, Funeral Partners Ltd

Participants at the Inquiry's seminar on regulation in London, held in November 2024:

- Isabelle Brown, NHS Providers
- Brendon Edmonds, Health and Care Professions Council
- Joyce Frederick, Care Quality Commission
- Matt Gantley, United Kingdom Accreditation Service
- Andrew Judd, National Association of Funeral Directors
- Lydia Judge-Kronis, Association of Anatomical Pathology Technology
- Gavin Larner, Department of Health and Social Care
- Declan Maguire, National Society of Allied and Independent Funeral Directors
- Janet Monkman, Academy for Healthcare Science
- Mark Norris, Local Government Association
- Steve Russell, NHS England
- Dr Colin Sullivan, Human Tissue Authority
- Dr Esther Youd, Royal College of Pathologists

Participants at the Inquiry's seminar for Designated Individuals in London, held in November 2024:

- Mudher Al-Adnani, Guy's and St Thomas' NHS Foundation Trust
- Jahran Allen-Thompson, London Borough of Tower Hamlets and London Borough of Waltham Forest
- Mark Croxford, Birmingham City Council
- Dr Kaushik Dasgupta, North Tees and Hartlepool NHS Foundation Trust
- Stephen Davison, Royal Cornwall Hospitals NHS Trust
- Louise Fox, Hampshire Hospitals NHS Foundation Trust
- Clive Graham, North Cumbria Integrated Care NHS Foundation Trust
- Dr Catherine Hennessy, Brighton and Sussex Medical School
- Christina Houghton, London Borough of Hammersmith and Fulham
- Mark Lankester, Norfolk and Norwich University Hospitals NHS Foundation Trust
- Karen Mizzi, Surrey County Council
- Mark Pietroni, Gloucestershire Hospitals NHS Foundation Trust
- Daniel Shingleton, Manchester University NHS Foundation Trust
- Rachael Waddington, Imperial College London Faculty of Medicine

Witnesses who did not respond or cooperate fully

Almost all the witnesses invited to give evidence to the Inquiry did so. Those listed below were invited to provide evidence to the Inquiry, and could have provided useful insights, but did not respond:

- Hindu Council UK;
- Network of Buddhist Organisations; and
- Network of Sikh Organisations.

The Inquiry asked another organisation, Digital Autopsy UK (an independent company specialising in digital autopsies), to provide a witness statement regarding its processes to safeguard the security and dignity of deceased people and to facilitate a visit to one of its sites. Digital Autopsy UK did not provide a full witness statement (some limited information was provided via email) and did not allow the Inquiry to visit a site. While the Inquiry was grateful for the information Digital Autopsy UK did provide and acknowledges that it could not be compelled to facilitate a visit or provide a statement, the lack of full cooperation was disappointing.

The Inquiry notes that there are references to digital autopsy providers in this Report more generally. A number of organisations provide this service and a reference to a digital autopsy provider in this Report should not be interpreted as a reference to Digital Autopsy UK unless the Inquiry has explicitly referred to the provider by that name.

Appendix 5: Glossary of terms

Definitions of terms used within this Report.

Sources for the following definitions are: Association of Anatomical Pathology Technology (AAPT); Courts and Tribunals Judiciary; gov.uk website (including legislation); Health and Safety Executive (HSE); Parliament UK; Human Tissue Authority (HTA); International Organization for Standardization (ISO); nhs.uk website (including NHS Health Careers and NHS England); Royal College of Pathologists; United Kingdom Accreditation Service (UKAS).

1907 Hague Convention – Convention respecting the laws and customs of war on land.

Adverse incident – Any event or circumstances that led or could have led to unintended harm, loss or damage.

Ambulance – A medically equipped emergency vehicle normally used to transport patients to treatment facilities, such as hospitals. Ambulances may sometimes transport deceased people to mortuaries for deaths occurring in the community.

Anatomical – Relating to bodily structure or the study of anatomy.

Anatomical pathology technologist (APT) – Carries out a range of tasks related to different aspects of mortuary work, including assisting pathologists during a post-mortem examination to determine cause of death.

Anatomy Act 1832 – An Act regulating schools of anatomy.

Anatomy Act 1984 – An Act to make provisions about the use of bodies of deceased people, and parts of such bodies, for anatomical examination and about the possession and disposal of bodies of deceased people, and parts of such bodies, authorised to be used for anatomical examination, and for connected purposes.

Association of Anatomical Pathology Technology (AAPT) – The professional body for anatomical pathology technologists (APTs) employed in hospital and public mortuaries.

Bariatric – Extremely obese or overweight.

Befriending – A social support service that matches a volunteer (befriender) with an individual who is experiencing isolation and loneliness.

Bequeathal – The act of giving or leaving property (in relation to deceased people becoming body donors).

Bereavement – The loss of someone special, including the grief and mourning experienced.

Biomedical scientists – People who conduct scientific tests in laboratories to support the diagnosis and treatment of disease.

Blood and transport team – A team that supports the donation of organs and tissue from deceased people to help someone else in need. Also referred to as a **retrieval team**.

Board – The senior decision-making structure of an organisation.

Board committee / subcommittee – Subgroups of a board that focus on specific areas.

Body donor – Someone who donates their body after death for the purposes of medical research or training (*see also Cadaver*).

Body store – A place that is used for the storage of deceased people, usually refrigerated. This is not a facility licensed by the HTA.

Burial and Cremation (Scotland) Act 2016 – An Act of Scottish Parliament to restate and amend the law relating to burial and cremation; to make provision about exhumation of human remains; to make provision in relation to the inspection and regulation of burial authorities, cremation authorities and funeral directors; to enable provision to be made for the licensing of funeral directors; and for connected purposes.

Cadaver – A dead body intended for dissection. Cadavers are used by medical students and other scientists to study anatomy.

Cadaveric dissection – A way of teaching anatomy where students dissect cadavers.

Care Act 2014 – An Act to make provision about care and support for adults and carers, including safeguarding adults from abuse or neglect.

Care home / nursing home – A communal setting where nursing and personal care are provided together with accommodation.

Care Quality Commission (CQC) – The independent regulator of health and adult social care in England.

Charitable Incorporated Organisation – An incorporated structure designed for charities.

Chief Coroner – The judicial head of the coroner system, providing national leadership for coroners in England and Wales.

Chief Executive / Chief Executive Officer – The most senior employee in an organisation's structure.

Chief Medical Officer *see Medical Director.*

Chief Nurse – The most senior nursing professional in a health system or organisation, often as a member of the board.

Chief Operating Officer – A very senior employee who is responsible for the day-to-day operations of an organisation, reporting to the Chief Executive.

Children Act 2004 – An Act that includes provisions for the establishment of a Children's Commissioner and for services provided to and for children and young people by local authorities and other persons.

Civil Contingencies Act 2004 – An Act that includes provisions about civil contingencies and emergency preparedness in the UK.

Code of Practice – A set of standards which explain how people working in a particular profession should behave.

Cold room – A room in which a low temperature is maintained to preserve the condition of a deceased person.

Community Interest Company – A limited company which operates to provide a benefit to the community it serves.

Competition and Markets Authority (CMA) – A non-ministerial government department in the UK, responsible for strengthening business competition and preventing and reducing anti-competitive activities.

Computer Aided Dispatch system (CAD) – The system that helps dispatchers, crews and call handlers respond to an incident.

Consortium – More than one local authority funding a specific coronial jurisdiction.

Consultant pathologist *see Pathologist*.

Contingency capacity / contingency storage – Provision or arrangement made for additional or **temporary storage** that might be needed.

Continuing professional development (CPD) – Opportunities to continue to learn and develop during a career. Roles that require registration with a regulatory body in order to practise usually require ongoing CPD to maintain registration.

Contracted funeral director – A company that is contracted by a local authority or another organisation to provide transportation and sometimes storage of deceased people whose death is under the investigation of the coroner.

Cooling blankets – Specialist equipment that cools a deceased person to preserve their appearance, condition and dignity.

Coroner – Independent judicial office holder, with the legal authority to investigate any death if: there is a reason to suspect that the death was violent or unnatural; the cause of death is unknown; or the deceased died while in state detention.

Coroners and Justice Act 2009 – An Act relating to coroners and the investigation, certification and registration of deaths.

Coronial cases – Deceased people whose death is under investigation by the coroner.

Coronial jurisdiction – The geographical district in which a coroner operates (subject to provisions made in the Coroners and Justice Act 2009).

Coronial post-mortem examination – A post-mortem examination to determine the cause of death instructed to take place by the coroner investigating the death.

Corrective and Preventative Action (CAPA) Plan – Corrective action plan following HTA inspection.

Cremation – The act of burning a deceased person, or the part of a funeral ceremony in which this is done.

Crematorium – A building where the deceased are cremated, usually as part of a funeral ceremony.

Crown Prosecution Service – An independent body that prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales.

Cypher – A code.

Deaneries – Teams responsible for postgraduate medical education and training within a region. Following the merger of Health Education England (HEE) and NHS England (NHSE) in 2023, deaneries are also known as **regional Workforce, Training and Education teams**.

Department of Health and Social Care (DHSC) – The UK government department responsible for government policy on health and adult social care.

Department for Levelling Up, Housing and Communities (DLUHC) *see Ministry of Housing, Communities and Local Government.*

Designated Individual (DI) – A person with a legal duty to ensure that the statutory and regulatory requirements of the Human Tissue Act are met. They are responsible for supervising licensed activities and ensuring that suitable practices are taking place.

Digital autopsy – A non-invasive post-mortem examination in which digital imaging technology is used to develop cross-sectional images for a virtual exploration of a human body. Also referred to as a **digital post-mortem examination**.

Digital keypad / lock *see Keypad.*

Digital post-mortem examination *see Digital autopsy.*

Direct cremation – A cremation without a ceremony or funeral service.

Disclosure and Barring Service (DBS) – An executive non-departmental public body, sponsored by the Home Office, which processes and issues DBS checks.

Elective surgery – Surgery that is scheduled in advance.

Electronic patient record – A digital platform for patient information, comprising individual patient records as part of a wider database.

Embalming – The practice of introducing specialist embalming solutions into the body to delay the natural effects of death.

End of Life Care (EoLC) – The care of a person as they approach the end of their life. This is a service that can form part of a CQC inspection.

European Court of Human Rights – A judicial court established in 1959 which rules on violations of civil or political rights as set out in the European Convention on Human Rights.[1]

Evisceration – The process of removing one or all of the organs from the inside of a body, usually as part of a post-mortem examination.

Executive non-departmental public body – A body that has a role in the processes of national government.

Fobs – A security system that uses a small electronic device as a lock, typically in place of a key.

Funeral director – A person or company whose business consists of, or includes, the arrangement and conducting of funerals and the subsequent burial or cremation of the deceased, for and on behalf of customers. Also known as an **undertaker**.

Funeral home – A place where a deceased person is prepared to be buried or cremated, and where relatives and friends can see the body.

General Medical Council (GMC) – The independent regulator for doctors, physician associates and anaesthesia associates in the UK.

Geneva Convention – International law establishing legal standards for humanitarian treatment in war.

Health and Care Professions Council (HCPC) – Statutory regulator of 15 health and care professions in the UK, including biomedical scientists.

Health and Safety Executive (HSE) – Statutory regulator of workplace health and safety.

Health and Social Care Act 2008 – An Act to establish and make provision in connection with a Care Quality Commission (among other provisions).

Health Building Note (HBN) – Gives best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

Histology / histopathology – The study of tissues and organs under a microscope to identify diseases.

Histopathologist – A medical doctor who studies organs, tissues, cells and genetics to help provide a diagnosis.

Hospice – An organisation providing care for people from the point at which their illness is diagnosed as terminal to the end of their life, however long that may be. Care may be provided at home, as a day patient or as an inpatient at the hospice itself.

1 Council of Europe.

Hospice at home – The provision of specialist hospice care within the home.

Human tissue – Relevant material from a human body as defined in the Human Tissue Act 2004, section 53, as *"relevant material, other than gametes, which consists of or includes human cells"*, with the exception of embryos outside the human body and hair and nail from the body of a living person.

Human Tissue Act 2004 – An Act to make provision about activities involving human tissue; to make provision about the transfer of human remains from certain museum collections; and for connected purposes.

Human Tissue Authority (HTA) – The regulator of human tissue and organs. A non-departmental public body of the Department of Health and Social Care.

HTA Designated Individual *see Designated Individual.*

HTA Evidential Compliance Assessment (ECA) – An exercise conducted by the HTA to assess evidence of compliance against standards.

HTA licence – The HTA licenses a number of activities relating to human tissue, including storage for the purposes of post-mortem examination.

HTA licence conditions – Actions which must be achieved (sometimes within a prescribed timescale) to reach the required standards. Conditions are statutory, standard or additional. Statutory conditions are set out in the Human Tissue Act 2004 and the Human Tissue (Quality and Safety for Human Application) Regulations 2007. Standard conditions are applied to all licences (or a subset of them) by the HTA. Additional conditions are specific to a licence.

HTA Licence Holder – A Licence Holder can be an individual or a corporate body. The role of Licence Holder does not impose the duties that are expected of the Designated Individual but does have the right to apply to the HTA to vary the licence.

HTA licensed activity – Activities as set out in Schedule 1 of the Human Tissue Act 2004, 'Scheduled purposes'.

HTA Reportable Incident (HTARI) – A serious incident or near-miss incident. Establishments licensed in the post-mortem sector are required to notify the HTA of serious incidents and near-miss incidents that may affect the dignity of the deceased and damage public confidence.

HTA standards – A set of specifications to be complied with by licensed organisations.

Incident reporting – The process of capturing and documenting information about adverse events to support the assessment of cause and identify learning and improvements in practice.

Independent healthcare / independent hospitals – Healthcare funded by individual patients, either by paying an independent healthcare provider directly or through private healthcare insurance.

Inpatient – A patient who needs to stay in a healthcare facility overnight while receiving treatment.

Integrated Care Board (ICB) – A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the integrated care system area. Replaced clinical commissioning groups (CCGs) from 2022.

Internal audit – Review of systems and processes within an organisation, which is reported to its audit committee and/or directors. Provides assurance on the effectiveness of services provided and on risk management policies.

International Organization for Standardization (ISO) – Develops and publishes international standards.

ISO 15189 – Specifies requirements for quality and competence in medical laboratories and can be used by medical laboratories to develop their quality management systems.

Key performance indicators (KPIs) – Measurable values that organisations use to evaluate and track their progress towards achieving specific objectives or goals.

Key safe – A secure box or cabinet in which keys are kept.

Keypad – Security feature using a code to access a building/location. This may use a button press or digital system.

Lead local authority – A local authority that takes the lead responsibility for providing a coroner service on behalf of other local authorities within that coroner area, usually under a formal agreement.

Ligature – A thread or wire to tie off blood vessels or other structures.

Local authority – A local government organisation responsible for a range of vital services for people and businesses in defined areas.

Local Government Association (LGA) – The representative body for local government.

Lone working – People who work without direct or close supervision, or without being accompanied.

Magnetic lock – A locking device that uses magnets (*see also Fobs or Swipe card).*

Manual handling – The transporting or supporting of a load by hand or bodily force.

Medic – A medical practitioner or student.

Medical Director – A doctor who provides leadership on medical matters within an organisation, usually as an executive member of the board. Can also be referred to as **Chief Medical Officer** (although note that this is distinct from the national Chief Medical Officer role, based in the Department of Health and Social Care).

Medical education setting / medical school – Generally a department within a university that teaches medicine, often with close working relationships with NHS teaching hospitals.

Medical examiner – A senior medical doctor who is contracted to provide independent scrutiny of the causes of deaths not investigated by coroners, outside their usual clinical duties.

Medical Schools Council – The representative body for UK medical schools.

Memorandum of Understanding (MoU) – Written agreement between two or more parties setting out mutually agreed ways of working or understanding.

Ministry of Housing, Communities and Local Government (MHCLG) – UK government department, formerly called Department for Levelling Up, Housing and Communities (DLUHC).

Morbidity – Refers to having a disease or a symptom of disease, or to the amount of disease within a population.

Mortality – The state of being mortal (destined to die), often expressed as a rate, or the number of deaths in a certain group of people in a certain period of time.

Mortuary – A place where deceased people are placed. A mortuary can provide storage only, or conduct activities as set out in the Human Tissue Act 2004, such as post-mortem examination, where licensed by the HTA to do so.

Mortuary Manager – An employee responsible for day-to-day operation of an HTA-licensed mortuary.

Next of kin – A person's closest living relative. For children under 18 years, this is someone who has the legal authority to make decisions on their behalf, such as a parent or legal guardian.

NHS acute hospital – A type of NHS hospital that primarily provides secondary care services.

NHS ambulance service trust – A type of NHS trust that provides ambulance services.

NHS England (NHSE) – The organisation that provides national leadership for the NHS in England. It is an executive non-departmental public body of the Department of Health and Social Care, established in 2013. The Secretary of State for Health and Social Care announced in March 2025 that NHS England would be merged with the Department of Health and Social Care.

NHSE postgraduate deans / postgraduate regional deans – Clinical leaders who are responsible for postgraduate medical education and training within a region.

NHSE region – One of seven regional teams of NHS England who support local systems to provide more joined-up care.

NHSE Safeguarding Accountability and Assurance Framework (SAAF) – A framework published by NHS England (last updated in 2022) that sets out the safeguarding roles and responsibilities of all individuals in providers of NHS-funded settings and NHS commissioning organisations.

NHS hospital mortuary / NHS mortuary / NHS trust mortuary – A mortuary managed by an NHS trust.

NHS Patient Safety Incident Response Framework – A framework published by NHS England which sets out the approach of the NHS to responding to patient safety incidents for the purpose of learning and improving patient safety.

NHS trusts – A legal entity responsible for providing NHS services under the NHS Act 2006. A single trust may have multiple hospital sites.

Non-licensed facility – A body storage facility that is not licensed by the HTA. May also be described as **unlicensed**.

Nursing home *see Care home.*

Paediatric – Relating to the branch of medicine that focuses on the medical care of infants, children and adolescents.

Palliative care – Symptomatic rather than curative treatment for a terminal condition (*see also End of Life Care).*

Paramedic – A registered healthcare professional who attends both emergency and non-emergency situations.

Paraphernalia – Miscellaneous articles.

Pathologist – A medical doctor or clinical scientist who works in a hospital or laboratory to establish the diagnosis, cause and effects of disease, usually examining body tissues or fluids. Senior pathologists are called **consultant pathologists**.

Pathology – The study of disease in organs, tissues and cells, providing advice on the nature, cause and seriousness of a patient's illness.

Perinatal – The time between conceiving a baby and the end of the first postnatal year.

Personal access control – A type of access control that restricts access to an authorised individual.

Persons Designated – Persons Designated assist Designated Individuals in ensuring compliance with HTA standards. Persons Designated can assist with developing procedures, as well as reporting incidents.

PFE1 – A standard of the HTA providing that premises, facilities and equipment are fit for purpose.

Porter – An employee who moves equipment or patients.

Postgraduate deans – *see NHSE postgraduate deans / postgraduate regional deans.*

Post-mortem examination (PME) – Examination of a body after death to determine the cause of death.

Professional Qualifications Act 2022 – An Act to make provision relating to entitlement to practise certain professions, occupations and trades; and for connected purposes.

Professional Standards Authority for Health and Social Care (PSA) – An independent regulatory oversight body working to improve the regulation and registration of health and care practitioners in the UK.

Private ambulance – A medical transportation vehicle operated by a private company. These ambulances are distinct from their public counterparts, which are typically operated by government or public organisations like the NHS.

Private Finance Initiative (PFI) – A type of public–private partnership used to fund major capital investments.

Professional regulation *see Regulator / Regulation.*

Public health funeral – A funeral provided by a local authority for deceased people who have no next of kin, or whose next of kin, relatives or friends are unable or unwilling to make the necessary arrangements for a funeral.

Regulator / regulation – The controlling of an activity or process, usually by means of rules. Regulation can relate to systems or whole professions (known as **professional regulation**). It is overseen by a regulator. When underpinned by legislation, it is known as statutory regulation.

Retrieval team *see Blood and transport team.*

Safeguarding – Protecting those whose needs mean that they are more vulnerable to abuse and neglect.

Satellite sites / satellite body stores – Other locations covered by an HTA licence, often in a 'hub and spoke' model, with different premises carrying out different licensable activities.

Senior Coroner – Independent judicial office holder who leads a coroner area.

Service level agreement (SLA) – Agreement between two organisations to identify the expected level of service one provides to the other.

Sexual Offences Act 2003 – An Act to make provision about sexual offences, their prevention and the protection of children from harm.

Standard Operating Procedures (SOPs) – Instructions for performing a specific task.

Statutory – Relating to a rule written down in law.

Swipe card – A plastic card with magnetically encoded information to allow access to premises for authorised individuals.

Teaching hospital – An NHS hospital that trains health professionals.

Telematics – Technology that transmits data in real time for vehicle tracking.

Temporary storage *see Contingency capacity or storage.*

Trade association – A not-for-profit organisation comprising a collection of companies that work in the same industry and are funded by their members through subscription fees.

Trustee – A person who is appointed to have independent control over, and legal responsibility for, a charity's management and administration.

Undertaker – *see Funeral director.*

United Kingdom Accreditation Service (UKAS) – National accreditation body for the UK that assesses and accredits organisations that provide services, including certification, testing, inspection and calibration.

Unlicensed body store *see Non-licensed facility.*

Urgent and emergency care – Care which involves any life-threatening illness or injury.

Voluntary sector – Relating to organisations which are not for profit and non-governmental (in contrast to the private sector and public sector).

Appendix 6: Questionnaires

NHS questionnaire response form

February 2024

Questionnaire seeking understanding of the policies and procedures in place in NHS Trusts in England that store deceased people

Questionnaire for NHS Trusts This questionnaire is to support the Inquiry's work understanding the policies and procedures in place in NHS hospitals that store deceased people. If your Trust does not have either a mortuary or a body store please select no at question 5. This will complete the questionnaire for you and ask you to submit it. Thank you for your assistance with this important work.
General details about mortuary/body store provision
Please tell us the name of your Trust below
Who is the person completing this questionnaire and what is their role?
Are we able to contact you to discuss this work further? Yes ☐ No ☐
If yes please complete your contact details below
Does your Trust have either a mortuary or a body store that contains deceased persons? Yes ☐ No ☐
Does your Trust have a mortuary that is licensed by the Human Tissue Authority (HTA) for post-mortems? Yes ☐ No ☐ Other ☐
If yes, please list by name all HTA licensed facilities within the Trust

Does your Trust have a facility to store deceased people that is not licensed by the HTA? Yes ☐ No ☐ Other ☐
If yes, please list all facilities to store deceased people that are not licensed by the HTA
On average how long do the deceased remain in the mortuary/body store at your Trust? 24 hours or less ☐ 7 days or less ☐ More than 7 days ☐ Not applicable ☐ Other ☐
Does the Trust have any teaching or research partnerships with other organisations, such as universities and associated spin-out companies or other private sector organisations, for the use of deceased people for purposes such as dissection or demonstration for clinical training or for research? Yes ☐ No ☐ Other ☐
Does the Trust send deceased people to an off-site body storage facility? By off-site facility we mean a facility that is not located on Trust premises Yes ☐ No ☐ Other ☐
If so, please list the off-site facility used by the Trust
On average, how long do the deceased remain in the off-site facilities arranged by your Trust? 24 hours or less ☐ More than 24 hours but less than 7 days ☐ More than 7 days ☐
Do you have temporary arrangements to manage surge in capacity? Yes ☐ No ☐ Other ☐
What are the temporary arrangements to deal with capacity surge? Temporary on-site body storage ☐ Off-site body storage ☐ Not applicable ☐ Other ☐
Management accountability
Which Executive Director has accountability for the mortuary/body store service? Chief Operating Officer ☐ Chief Nurse ☐ Medical Director ☐ Other ☐

Has the Trust Board ever received a report such as an HTA report, an internal report or a peer review report about the mortuary since 2014? Yes ☐ No ☐ Not applicable ☐ Other ☐
If so when did the Trust Board receive this report? Within the past 6 months ☐ Within the past 12 months ☐ More than 12 months ago ☐ Not applicable ☐
Has the Phase 1 Report of the Independent Inquiry into the issues raised by the David Fuller case been discussed at Trust Board? Yes ☐ No ☐ Don't know ☐
If so when was this discussed?
If not is this planned for a future meeting? Yes ☐ No ☐ Other ☐
What action has the Trust taken following the NHS England assurance exercise in relation to mortuary security, undertaken in 2021?
Regulation and the mortuary/body store
When was the last HTA inspection of the Trust's mortuary service? In the last 12 months ☐ More than 12 months ago ☐ Not applicable ☐
How are HTA reports shared within the Trust?
Which Trust governance forums receive HTA inspection reports? Trust Board ☐ Quality Committee (sub-committee of the Trust Board) ☐ Not applicable ☐ Other ☐
Does the Trust share HTA inspection reports with any of the following organisations? CQC ☐ NHSE ☐ None ☐ Not applicable ☐ Other ☐
Has the CQC inspected the Trust's mortuaries/body stores? Yes ☐ No ☐ Other ☐
Please tell us which facility CQC has visited

Information about the Designated Individual
How long has the Designated Individual been in post? Less than 12 months ☐ More than 12 months ☐ Not applicable ☐ Other ☐
What is their professional background? Anatomical Pathology Technician ☐ Biomedical scientist ☐ Consultant Pathologist ☐ Not applicable ☐ Other ☐
Has the Designated Individual undertaken any training in relation to their role? Yes ☐ No ☐ Not applicable ☐ Other ☐
Please list the training courses that the Designated Individual has attended in relation to their role, in the past three years.
Has the Designated Individual been asked to present to Trust Board in relation to their role in the past 12 months? Yes ☐ No ☐ Not applicable ☐ Other ☐
How often does the Designated individual meet with the CEO to discuss their responsibilities as DI? Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ As required but no fixed interval ☐ Never ☐ Not applicable ☐
Does the Designated Individual attend any governance forums specifically in relation to their role as DI? Yes ☐ No ☐ Not applicable ☐ Other ☐
Which Trust governance forums does the Designated Individual attend, specifically in relation to their role as DI? Trust Board ☐ Quality Committee (sub-committee of the Trust Board) ☐ Not applicable ☐ Other ☐
Mortuary service and management
Do you have a mortuary that is managed by a mortuary manager? Yes ☐ No, we have a body store only ☐
Does the mortuary manager hold an Anatomical Pathology Technician qualification? Yes ☐ No ☐ Not applicable ☐ Other ☐
If no, what is their professional background? Biomedical scientist ☐ Other ☐
Does the mortuary manager only have the mortuary in their management portfolio? Yes ☐ No ☐ Not applicable ☐ Other ☐

If no, what other management responsibilities are in their portfolio?
Is the mortuary manager located on the same hospital site as the main mortuary? Yes ☐ No ☐ Other ☐
Has the mortuary manager undertaken any professional training, in relation to their role, in the past 12 months? Yes ☐ No ☐ Other ☐
If so, please list relevant training courses
During what hours is the mortuary/body store staffed?
Are there any staff working alone during this period? Yes ☐ No ☐
Are there standard operating procedures supporting the daily work of the mortuary/ body store? Yes ☐ No ☐ Other ☐
Has there been an audit to assess compliance with these standard operating procedures in the past 12 months? Yes ☐ No ☐
Who undertakes these audits?
Does the mortuary have a governance meeting? Yes ☐ No ☐ Other ☐

Mortuary staffing If you do not have a mortuary, please go to section 7.
How many staff work in the mortuary undertaking mortuary tasks?
How many of these staff hold APT qualifications?
How many of the mortuary staff do not hold an APT qualification?
Have the APTs undertaken continuing professional development courses in the last 12 months? Yes ☐ No ☐
Please list the different CPD courses undertaken by APTs in the past 12 months. We do not require this list for individual staff, only the different courses taken overall.
Are all of the APTs registered with the Academy for Healthcare Science or Science Council? Yes ☐ No ☐
Please state how many staff are registered with the Academy for Healthcare Science or Science Council

Access to the mortuary and body stores
Is the mortuary/body store classed as a restricted area? Yes ☐ No ☐
How is each facility controlled, e.g. by key, digital lock, electronic magnetic lock?
How do mortuary/body store staff access each individual facility? Electronic swipe card ☐ Key ☐ Digital lock ☐ Other ☐
Please identify the staff groups, other than mortuary/body store staff, that require access to mortuaries and body stores at your Trust. Porters ☐ Maintenance staff ☐ Domestics ☐ Bereavement officers ☐ Other ☐
Please give details of other staff groups that access the mortuary/body store facilities.
Are any of these staff groups allowed unsupervised access, e.g. allowed to be in the mortuary on their own? Porters ☐ Maintenance staff ☐ Bereavement officers ☐ Domestic staff ☐ Other ☐
If you have ticked other, please give details of other staff groups
Do any staff groups access mortuaries and body stores out of office hours? Porters ☐ Maintenance staff ☐ Domestic staff ☐ Bereavement staff ☐ Other ☐
How do non-mortuary staff access the mortuary/body store out of hours? Individual electronic swipe card ☐ Their own key ☐ A shared electronic swipe card ☐ A shared key ☐ Digital lock ☐ Other ☐
Are audits of access to the mortuary and body store ever carried out? Yes ☐ No ☐ Don't know ☐
Is there CCTV covering all mortuary entrances? Yes ☐ No ☐ Other ☐
If not please list mortuary/body stores that do not have CCTV covering an entrance.
Is there CCTV inside the mortuary? Yes ☐ No ☐
Is there CCTV covering mortuary/bodystore fridge doors? Yes ☐ No ☐
Is there CCTV in the post-mortem room? Yes ☐ No ☐
Is the CCTV covering the mortuary monitored? Yes ☐ No ☐

Who monitors the CCTV? Trust security ☐ Mortuary staff ☐ Other ☐
Do you audit CCTV recording of who is accessing the mortuary/body store? Do you audit CCTV recording of who is accessing the mortuary/body store? Yes ☐ No ☐ Don't know ☐
Serious incidents in the mortuary
Are you aware of any current or historical serious incidents which have taken place in the Trust mortuary/body store? Yes ☐ No ☐
Have you reported any incidents to the HTA that have not been classified as a HTARI? Yes ☐ No ☐ Not applicable ☐
Have any serious incidents been reported to the Coroner or anyone else, apart from the HTA? Yes ☐ No ☐ Not applicable ☐
Have any HTARIs or incidents been reported to the Board or one of its sub-committees? Yes ☐ No ☐ Not applicable ☐
Relationship with the Local Authority and Coroner
Does the Trust meet with the Coroner or the Coroner's staff to discuss arrangements for mortuary services? Yes ☐ No ☐ Not applicable ☐
If so, how regular are these meetings? Monthly ☐ Quarterly ☐ Yearly ☐

NHS Mortuary Managers questionnaire response form

January 2025

Questionnaire seeking understanding of the role and responsibilities of Mortuary Managers within the NHS

Questionnaire for Mortuary Managers This questionnaire is to support the Inquiry's work understanding your role and responsibilities as a Mortuary Manager at an NHS Trust. This questionnaire is not expected to take you longer than 15 minutes and should be completed by the manager(s) responsible for the mortuary/mortuaries at your Trust. Thank you for your assistance with this important work.
Individual details
Please list the mortuaries and/or body stores that you are responsible for and the name of your Trust.
Please provide your name, job title and email address, should we wish to contact you to discuss your responses.
How long have you held this post? More than 12 months ☐ Less than 12 months ☐
Roles and responsibilities
How and to whom are you required to present/report to within the Trust on mortuary matters?
How often do you present or report to these individuals (or groups) on mortuary matters?

Please outline the areas covered in your whole portfolio of roles and responsibilities (including areas outside of the mortuary).
Please list any changes to your whole portfolio of roles and responsibilities (including areas outside of the mortuary) in the past 12 months.
Please describe the support in place to help you in your role as mortuary manager.
Thank you for your responses. The questionnaire is now complete. Please click 'submit'.

Medical school questionnaire response form

February 2024

Questionnaire seeking understanding of the arrangements in place at medical schools in England in relation to deceased people

Medical School Questionnaire This questionnaire is being shared with the Dean of the medical school, with the intention that it will be shared with the Designated Individual of the facility or the member of staff best able to provide this information. This questionnaire is not to be shared with students and not to be disseminated widely with staff in the medical school. Please fill in the questionnaire as accurately as possible, if there is more information you wish to provide to the Inquiry please respond to the email address you received this questionnaire from.
Name of organisation
What is your role in the organisation?
Does your medical school offer cadaveric dissection? Yes ☐ No ☐ Other ☐
Is your medical school based in a facility licensed by the Human Tissue Authority? Yes – for anatomical examination ☐ Yes – for research ☐ Yes – for both ☐ No ☐ Other ☐
Does your medical school offer cadaveric dissection at any other sites? Yes ☐ No ☐ Other ☐
If yes, list these below and note if they are HTA licensed.
Does your medical school use any other facility to store the deceased outside of the sites listed in the previous answer? Yes ☐ No ☐ Other ☐
Is this facility licensed with the Human Tissue Authority? Yes ☐ No ☐ Don't know ☐
Does your medical school intend to continue offering cadaveric dissection for anatomy or research purposes in the next five years? Yes ☐ No ☐ Other ☐

NHS postgraduate deans questionnaire response form

September 2024

Questionnaire seeking understanding of the arrangements in place at NHS postgraduate deaneries in England in relation to deceased people

NHS Postgraduate Deans Questionnaire This questionnaire is being shared with the Dean of the NHS region, with the intention that it will be shared with the individual best able to provide the relevant information. This questionnaire is not to be shared with students and not to be disseminated widely with staff in the region. Please fill in the questionnaire as accurately as possible, if there is more information you wish to provide to the Inquiry please email contact@fuller.independent-inquiry.uk or call 020 7972 1444
Name of organisation
Role in organisation
Can we contact you for further information following this questionnaire response? Yes ☐ No ☐
If yes, please provide your contact details below
Does your deanery offer postgraduate medical training using cadavers? Yes ☐ No ☐ Other ☐
If yes, please list the sites used for the postgraduate medical training using cadavers and note if they are licensed by the Human Tissue Authority for anatomical examination.
Does your deanery use any other facility to store the deceased for postgraduate training outside of the sites listed in the previous answer? If yes, please list below.

Hospice questionnaire response form

March 2024

Questionnaire seeking understanding of whether the deceased are kept on hospice premises, and of the security measures in place to safeguard their security and dignity

Questionnaire for hospices in England This questionnaire is being shared with the Chief Executives of hospices with the intention that it is shared with members of staff best able to provide information on the facilities of the hospice. We would be grateful if the questionnaire is shared only with necessary staff members. If you do not keep deceased people on your premises please answer 'no' to question three and you will be taken to the end of the survey. Please complete the questionnaire as accurately as possible by Thursday 4th April 2024. If there is more information you wish to provide to the Inquiry, or have any queries, please email Contact@fuller.independent-inquiry.uk or call 020 7972 1444
Please answer the following questions in relation to the site(s) you are responsible for.
Name of organisation and contact details for respondent:
Are you an adult or children's hospice? Adult ☐ Children's ☐ Other ☐
Areas where deceased people are kept?
Are deceased people kept on your premises? Yes ☐ No ☐ Other ☐
Where are deceased people kept? Cold room ☐ Mortuary ☐ Other ☐
How many people can be kept in this area?
How long on average are deceased people kept in this area? < 24 hours ☐ 1-2 days ☐ 3-7 days ☐ >7 days ☐ Other ☐
How do you control access to deceased people? Please select all that apply and list any not mentioned in 'other'. Swipe card ☐ Key ☐ Digilock ☐ Other ☐

Do you have CCTV coverage of the areas where deceased people are kept? Yes ☐ No ☐ Other ☐
Do any staff/contractors have unaccompanied access to areas where deceased people are kept? Please do not include personal information. Yes ☐ No ☐ Other ☐
Are any surgical procedures carried out on deceased people on your premises, for example cornea removal? Yes ☐ No ☐ Other ☐
Please explain which procedures are carried out on deceased people on the premises.
Do you keep any deceased people on your premises that have died elsewhere? Yes ☐ No ☐ Other ☐
Please provide details.
Training and raising concerns
Have you had any coronial cases in the last 5 years? Yes ☐ No ☐ Other ☐
Has anybody raised any concerns about security of deceased people on your premises in the last 5 years? Yes ☐ No ☐ Other ☐
Inspections
Are you inspected by the CQC? Yes ☐ No ☐ Other ☐
Do the CQC inspect areas where deceased people are kept? Yes ☐ No ☐ Other ☐
Do any other external organisations inspect the area where deceased people are kept? Yes ☐ No ☐ Other ☐
Which other external organisations inspect the areas where deceased people are kept?

Closing questions
Have you made any changes to how you work following the David Fuller case? Yes ☐ No ☐
Please provide details of any changes.
Please share any other information that you feel would be relevant to the Inquiry.

Local authority questionnaire response form

March 2024

Questionnaire seeking understanding of the full scope of mortuaries and body storage facilities that are overseen by local authorities in England

Questionnaire for local authorities in England
This questionnaire is being shared with the Chief Executive of the local authority with the intention that it is shared with the member of staff best able to provide information on the local authority's mortuary facilities. The purpose of this questionnaire is to ascertain the full scope of mortuaries and body storage facilities that are overseen by local authorities in England. This includes both permanent and temporary facilities; and facilities that are licensed by the Human Tissue Authority, and those that are not (because they do not undertake activities that require a licence). The Inquiry is also interested to know the extent to which local authorities contract with external organisations to provide mortuary and body storage facilities. Please fill in the questionnaire as accurately as possible and submit your response by 22 March 2024. If there is more information you wish to provide to the Inquiry, or have any queries, please email the Inquiry at contact@fuller.independent-inquiry.uk.
The local authority
What is the name of the local authority?
Please provide the name, email address and role of the most appropriate person the Inquiry can contact if there are any follow up questions.

Facilities

This section seeks information on mortuary and bodystore facilities that the local authority has responsibility for. Please provide the name, address and point of contact (email) for each facility. Together with an indication of the activities undertaken there; its size; whether it is temporary or permanent; licensed with the Human Tissue Authority; and if it is currently operational.

There is space in the questionnaire to provide details for 4 facilities. If there are more than 4 facilities, please email the Inquiry with the full information at contact@fuller.independent-inquiry.uk. However, please continue to complete as much of the questionnaire as you can and submit.

If the local authority does not have responsibility for any mortuary or bodystore facilities, please answer no and proceed to Q21.

Does the local authority have responsibility for a mortuary, body storage facility or similar? This includes permanent and temporary facilities (operational or dormant).

Yes ☐ No ☐

If so, please provide the name of facility 1, its address and point of contact (email).

Facility 1, please indicate the activities undertaken there:

Post-mortem examinations ☐ Bodystore ☐ Other ☐

Facility 1, please indicate how many deceased people the facility can accommodate:

50 and under ☐ Between 50 and 100 ☐ Between 100 and 150 ☐

More than 150 ☐

Facility 1, please indicate if the facility is temporary or permanent, whether it is licensed with the Human Tissue Authority, and whether it is currently operational:

Temporary ☐ Permanent ☐ Licensed with HTA ☐ Operational ☐ Dormant ☐

Facility 2, please provide the name of facility 2, its address and point of contact (email).

Facility 2, please indicate the activities undertaken there:

Post-mortem examinations ☐ Bodystore ☐ Other ☐

Facility 2, please indicate how many deceased people the facility can accommodate:

50 and under ☐ Between 50 and 100 ☐ Between 100 and 150 ☐
More than 150 ☐

Facility 2, please indicate if the facility is temporary or permanent, whether it is licensed with the Human Tissue Authority, and whether it is currently operational:

Temporary ☐ Permanent ☐ Licensed with HTA ☐ Operational ☐ Dormant ☐

Facility 3, please provide the name of facility 3, its address and point of contact (email).
Facility 3, please indicate the activities undertaken there: Post-mortem examinations ☐ Bodystore ☐ Other ☐
Facility 3, please indicate how many deceased people the facility can accommodate: 50 and under ☐ Between 50 and 100 ☐ Between 100 and 150 ☐ More than 150 ☐
Facility 3, please indicate if the facility is temporary or permanent, whether it is licensed with the Human Tissue Authority, and whether it is currently operational: Temporary ☐ Permanent ☐ Licensed with HTA ☐ Operational ☐ Dormant ☐
Facility 4, please provide the name of facility 4, its address and point of contact (email).
Facility 4, please indicate the activities undertaken there: Post-mortem examinations ☐ Bodystore ☐ Other ☐
Facility 4, please indicate how many deceased people the facility can accommodate: 50 and under ☐ Between 50 and 100 ☐ Between 100 and 150 ☐ More than 150 ☐
Facility 4, please indicate if the facility is temporary or permanent, whether it is licensed with the Human Tissue Authority, and whether it is currently operational: Temporary ☐ Permanent ☐ Licensed with HTA ☐ Operational ☐ Dormant ☐
Please include here any further information in relation to facilities for which the local authority is responsible.

Contracts and agreements

The Inquiry is interested to know the extent to which local authorities contract with external organisations to provide mortuary and body storage facilities.

There is space in the questionnaire to provide details for 4 contracts/agreements/ arrangements. If there are more than 4, please email the Inquiry with the full information at contact@fuller.independent-inquiry.uk. However, please continue to complete as much of the questionnaire as you can and submit.

If the local authority does not have any contracts/agreements/arrangements to provide mortuary or body storage facilities, please answer no to Q21 and then proceed to Q35**.**

Does the local authority contract or have agreements or arrangements in place with external organisations to provide mortuary or body storage facilities?

Yes ☐ No ☐

Contract/agreement/arrangement 1: Please give the name of the provider:

Please indicate the nature of contract/agreement/arrangement 1:

Post-mortem examination and body storage ☐ Body storage ☐
Contingency body storage ☐ Emergency/temporary mortuary service ☐ Other ☐

Please give any further information about contract/agreement/arrangement 1 you feel would be helpful:

Contract/agreement/arrangement 2: Please give the name of the provider:

Please indicate the nature of contract/agreement/arrangement 2:

Post-mortem examination and body storage ☐ Body storage ☐
Contingency body storage ☐ Emergency/temporary mortuary service ☐ Other ☐

Please give any further information about contract/agreement/arrangement 2 you feel would be helpful:

Contract/agreement/arrangement 3: Please give the name of the provider:
Please indicate the nature of contract/agreement/arrangement 3: Post-mortem examination and body storage ☐ Body storage ☐ Contingency body storage ☐ Emergency/temporary mortuary service ☐ Other ☐
Please give any further information about contract/agreement/arrangement 3 you feel would be helpful:
Contract/agreement/arrangement 4: Please give the name of the provider:
Please indicate the nature of contract/agreement/arrangement 4: Post-mortem examination and body storage ☐ Body storage ☐ Contingency body storage ☐ Emergency/temporary mortuary service ☐ Other ☐
Please give any further information about contract/agreement/arrangement 4 you feel would be helpful:
Please include here any further information in relation to contracts, agreements and arrangements the local authority has in place.
End of questionnaire
In addition to the information provided under sections 1 and 2, is there any further information you would like to tell the Inquiry that would assist its investigation?

Funeral director questionnaire response form

July 2023

Questionnaire seeking understanding on arrangements for safeguarding the privacy, security and dignity of the deceased in the funeral care sector.

Name and address of organisation. Name, position/role and contact details of person submitting response. Type of organisation (e.g., family-run, large scale).
Services provided: Funeral ☐ Private Mortuary ☐ Private Ambulance ☐
How does your organisation ensure that the privacy and dignity of the deceased is preserved?
What security measures do you have in place at your premises, e.g., CCTV?
Who is permitted access to the deceased and for what reasons?
What processes do you have in place to control and monitor access to the deceased?
What employment checks do you carry out on your staff?

What induction and training are staff given in relation to safeguarding the dignity of the deceased?
What supervision of staff and visitors is in place?
Do you have a lone worker policy?
Do you have safeguarding training in place?
Do you have a process for raising concerns about any incidents regarding the privacy, security and dignity of the deceased?
Are you a member of a trade association? If so, which is that and what does membership involve? Do they give advice on matters relating to the privacy, security and dignity of the deceased?
Are you subject to management/oversight by another organisation? If so, please provide details.

Have you made any changes to how you work following the news of David Fuller's mortuary crimes?
Do you think anything needs to change in how people in this sector should work to prevent David Fuller's crimes happening in this setting?
Are you aware of any incidents that have compromised the privacy, security and dignity of the deceased in the same setting as your organisation? If so, please provide details. This will help the Inquiry understand issues that have arisen and how they might be addressed.
Please share any other information that you feel would be relevant to the Inquiry.
Signed by Date

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