

## **Working together, building confidence: Conference for the post mortem sector**

---

### **Agenda**

9.30 Registration

10.00

- Welcome and introduction – Shirley Harrison, Chair, HTA
- Summary of regulatory compliance report 2008/09 – Sandy Mather, Director of Regulation, HTA
- Post mortem examination: barriers to excellence? – Emyr Benbow, Royal College of Pathologists

11.10 Break

11.30

- Establishing a framework for consent – Ruth Musson, Nottingham Brain Bank
- Coroner reform, what will it mean for you? – Ministry of Justice
- The changing role of the Anatomical Pathology Technician – James Lowell, Association of Anatomical Pathology Technology

13.00 – 14.00 Lunch and HTA surgery

14.00 Seminar 1 and 2 chosen by delegates

15.10 Break

15.30 Seminar 3 chosen by delegates

16.10 Closing remarks – Adrian McNeil, Chief Executive, HTA

16.30 HTA Surgery

17.00 End of event

## **Seminar information**

*Delegates will be able to choose from the following seminars when registering for the conference:*

### **Decoding the DI role – Kate Rolfvondenbaumen, Regulation Manager, HTA**

Understanding the roles, responsibilities and legal obligations of the DI role is fundamental to successfully fulfilling your duties. This session aims to help DIs to understand their role in two ways.

Firstly by providing an overview of the legal framework for this role as set out in the Human Tissue Act. We will begin with a review of the qualification requirements; we will then move on to discuss the role you as DIs have in ensuring that your establishment is compliant with the standards.

The second aim is to help you develop a better understanding of the HTA site inspection process. We will review the basics of the inspection process, what we will be expecting on the day and most importantly what you can do to help your staff and your establishment prepare for an inspection.

*The HTA strongly advises that this seminar is attended by all DIs from the post mortem sector who have not completed the HTA's DI e-learning course or who participated in HTA DI training more than 12 months ago.*

### **The forensic post mortem process: controlled chaos – Jeff Adams, Forensic Science Regulation Unit, Home Office**

This seminar will review the nature of the forensic post mortem process, from the finding of the deceased to the release of all retained tissue, with particular regard to:

- The dissemination of information;
- The taking and retention of tissue samples; and
- The legal provisions applying to these processes.

This will be used as a basis for a review of the need for standards in this area and the work of the Forensic Science Regulator to establish such standards. The issues above will then be used as the basis of consideration of the role of the Designated Individual in such cases.

## **Dealing with the legacy: a collaborative approach – Mark Caswell, Alder Hey Children's NHS Foundation Trust**

Alder Hey has been at the forefront of organ retention since the revelations which came out of the Bristol Inquiry in 1999. The process that followed to address the issues raised was very complex and, at times, highly distressing for all involved. Crucial to the development of new procedures was the close involvement of many families and parents who had been affected by organ retention. They helped shape the revised consent process in the early difficult days. Latterly parents have played a central role in developing the multi-agency approach to the handling of large collections including the 10,000 plus cases kept at Alder Hey. This workshop will detail the procedures undertaken and the collaborative process that led to their development.

## **Inquests: why communication matters – Helen Shaw, INQUEST**

Making the complex relationships and communication channels between those working in the post mortem sector, the Coroner Service and bereaved families work is crucial to ensuring there is public confidence in each aspect of the processes that follow sudden and unnatural deaths. When things go wrong they can have profound impact. When communication works confidence is built in the sector, difficult questions are answered and society as a whole can benefit. The majority of post mortem examinations take place under the authority of the Coroner and of those cases that are investigated at inquests the impact on bereaved people is highly significant. In that context we will look at the role of the HTA and the importance of the principle of consent and its relevance to deaths that are investigated by the Coroner and result in an inquest. We will also look at the impact of adopting the HTA's Model Communication Pathway. The seminar will briefly highlight the possible impact on the sector of the relevant parts of the Coroners and Justice Bill 2009.

## **When things go wrong – Terry Johnson, Hull Royal Infirmary**

Since the implementation of the Human Tissue Act (and the formation of the Human Tissue Authority) I think it is fair to say that we have all done our level best to comply with its requirements. To ensure that we comply we conduct various audits and review systems and this often results in minor improvements being made. Just when you think that you are doing everything that can be done something goes drastically wrong and one is left thinking "how on earth did I miss that" or "how did that go wrong". This workshop takes

a detailed look at a genuine incident and examines what happened, what went wrong and importantly how it was put right. Without doubt some valuable lessons to be learnt.

### **Disposal or retention? It's good to talk – Ruth Hughes, Regulation Manager, HTA**

Over the last four years the HTA has increasingly found that there can be poor communication between the establishments who hold a HTA licence and the coroner's office in regard to material retained after a post mortem examination and which subsequently falls outside the coroner's authority. Communication methods fluctuate considerably throughout the UK and the HTA has taken steps to address and assist establishments in improving communication flows between themselves and the coroner's office.

The HTA has consulted with coroners, pathologists, mortuary managers and the Ministry of Justice to try and find a way forward which ensures that the establishments are not left in breach of the HT Act by retaining tissue without consent.

In conjunction with the revised codes of practice, a model communication flowchart has been developed and we hope that it assists the establishments to ensure that there is no doubt when tissue should be retained or disposed of. The HTA had to continually bear in mind, during the development of this flowchart that we do not regulate coroners, and all communication relies upon the good working practices and goodwill of all involved to meet the requirements of the HT Act.