

**Gloucestershire Coroner's Court**  
HTA licensing number 12595

Licensed under the Human Tissue Act 2004

**Licensed activities**

The table below shows the activities this establishment is licensed for and the activities currently undertaken at the establishment.

Area	Making of a post-mortem examination	Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation	Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose
<b>Gloucestershire Coroner's Court</b>	Licensed	Licensed	Licensed
<b>Mortuary</b>	<i>Carried out</i>	<i>Carried out</i>	<i>Carried out</i>

**Summary of inspection findings**

The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation.

Although the HTA found that Gloucestershire Coroner's Court ('the establishment') had met the majority of the HTA's standards, two major shortfalls were found against standards for Governance and Quality and Premises, facilities and equipment.

The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

## Compliance with HTA standards

### Major shortfalls

GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks		
g) Visiting / external staff are appropriately trained and receive an induction which includes the establishment's policies and procedures	<p>Locum staff do not complete an induction with the establishment's local policies and procedures and do not formally acknowledge they have read and understood relevant procedures specific to their role.</p> <p>In addition, the establishment did not provide training or competency assessments for Coroner's Officers who arrange viewings.</p> <p><i>The establishment addressed this shortfall prior to the publication of the final report.</i></p>	Major

  

PFE2 There are appropriate facilities for the storage of bodies and human tissue		
e) Fridge and freezer units are alarmed and the alarms are tested regularly to ensure that they trigger when temperatures go out of upper or lower set range	<p>There is no formalised testing of the temperature alarms for the fridges in the body store and specimen fridge.</p> <p><i>The establishment addressed this shortfall prior to the publication of the final report.</i></p>	Major

The HTA requires the DI to submit a completed corrective and preventative<sup>95</sup> action (CAPA) plan setting out how the shortfalls will be addressed, within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

### Advice

The HTA advises the DI to consider the following to further improve practice:

Number	Standard	Advice
1.	GQ6 (b)	The DI is advised to add training and competency as control measures in the relevant risk assessments.

### Background

The establishment has been licensed by the HTA since March 2012. This was the fourth inspection of the establishment; the most recent previous inspection took place in March 2022.

The establishment is licensed for the making of a PM examination, removal of relevant material from the deceased and storage of bodies of the deceased and relevant material for use for scheduled purposes. Since the previous inspection, there have been no significant changes to the licence arrangements, or the activities carried out under the licence.

**Description of inspection activities undertaken**

The HTA's regulatory requirements are set out in Appendix 1. The inspection team covered the following areas during the inspection:

*Standards assessed against during inspection*

All HTA licensing standards under the overarching standards for Traceability, Governance and Quality Systems and Premises, Facilities and Equipment were covered during the inspection (standards published 3 April 2017). The HTA standards relating to Consent were not applicable, as the establishment is not involved in consent seeking.

*Review of governance documentation*

A review was also carried out on: the policies and procedural documents relating to licensed activities for the mortuary; audits; risk assessments; training records for staff, meeting minutes and procedures for reporting HTA reportable incidents.

*Visual inspection*

The inspection included a visual inspection of the mortuary body store, PM room and viewing room.

### *Audit of records*

Audits were conducted for three bodies in refrigerated storage and one body in freezer storage. Body location and identification details on bodies were crosschecked against the information recorded in the mortuary register, electronic record system and relevant documentation. No discrepancies were found.

Audits were also conducted of records and tissue taken at PM examination for three cases. Relevant documentation and the electronic record system were cross referenced with location of tissue in the mortuary. No discrepancies were found.

### *Meetings with establishment staff*

Discussions with staff carrying out processes under the licence included the DI (an Anatomical Pathology Technologist), APT, Mortuary Assistant and a Pathologist.

**Report sent to DI for factual accuracy: 13 January 2025**

**Report returned from DI: 15 January 2025**

**Final report issued: 23 January 2025**

## **Appendix 1: The HTA's regulatory requirements**

Prior to the grant of a licence, the HTA must assure itself that the DI is a suitable person to supervise the activity authorised by the licence and that the premises are suitable for the activity.

The statutory duties of the DI are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

Its programme of inspections to assess compliance with HTA licensing standards is one of the assurance mechanisms used by the HTA.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. They are grouped under four headings:

- consent
- governance and quality systems
- traceability
- premises facilities and equipment.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that there has been a shortfall against a standard, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is provided.

HTA inspection reports are published on the HTA's website.

## **Appendix 2: Classification of the level of shortfall**

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor'. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue Act 2004 (HT Act) or associated Directions.

### **1. Critical shortfall:**

A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the HT Act or associated Directions

*or*

A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

A critical shortfall may result in one or more of the following:

- A notice of proposal being issued to revoke the licence
- Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
- A notice of suspension of licensable activities
- Additional conditions being proposed
- Directions being issued requiring specific action to be taken straightaway

### **2. Major shortfall:**

A non-critical shortfall that:

- poses a risk to human safety and/or dignity, or
- indicates a failure to carry out satisfactory procedures, or
- indicates a breach of the relevant Codes of Practice, the HT Act and other relevant professional and statutory guidelines, or

- has the potential to become a critical shortfall unless addressed

*or*

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

### **3. Minor shortfall:**

A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based review or at the time of the next inspection.

In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

### **Follow up actions**

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. Establishments must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine inspection.

After an assessment of the proposed action plan establishments will be notified of the follow-up approach the HTA will take.