HTA Board meeting, 18 September 2025

Agenda item	**3.1 – Dignity of the Deceased: Making Improvements**
For information or decision?	Information
Decision making to date?	N/A
Recommendation	The HTA Board is asked to note and comment on the approach outlined
Which strategic risks are relevant?	Risk 1: Operational
Strategic objective	Approach to Regulation
Core operations / Change activity	Core operations
Business Plan item	Regulation – fulfilling our licensing, inspection, incident management and approvals functions, providing technical advice and superintending compliance across the sector, including responding to the Fuller Independent inquiry and engaging with a review of our implementation of the Duty to Report regulations
Committee oversight?	N/A
Finance and resource implications	N/A
Timescales	2025/26
Communication(s) (internal/external stakeholders)	N/A
Identified legislative implications	N/A

Dignity of the Deceased: Making Improvements

Background and Context

1. Since the establishment of Sir Jonathan Michael's Independent Inquiry, on the conviction of Fuller in November 2021[1], the HTA has fully supported his Inquiry by providing evidence and a variety of inputs, including data, explanations, analyses and submissions concerning the regulatory framework under which the HTA operates and the much broader context in which that sits, including across the landscape for managing the deceased.

2. The HTA welcomes the completion of the Inquiry's work. Sir Jonathan Michael's final Phase 2 report was published on 15th July 2025[2], which built on the Phase 1 report, published on 28th November 2023[3], on how Fuller came to undertake his offending at Maidstone and Tunbridge Wells NHS Trust for so long, apparently undetected, and the interim report into Funeral Directors, published on 15th October 2024[4].

3. This paper provides the Board with a summary of the findings from the Inquiry's Phase 2 report and updates the Board on the HTA's work and next steps.

Ask

4. The Board is asked to note the report and the ongoing work by the HTA in this important aspect of our operational activity.

Progress

5. The appalling offending by Fuller in a hospital mortuary highlighted the

1 Oral statement on David Fuller by the Secretary of State for Health and Social Care in the House of Commons on an independent inquiry into the crimes committed by David Fuller; 8th November 2021; Available at: <Oral statement on David Fuller - GOV.UK>. [Link accessed 29th August 2025]

2 Independent Inquiry into the issues raised by the David Fuller case Phase 2 Report Sir Jonathan Michael, Chair of the Inquiry; 15th July 2025; Available at: <https://fuller.independent-inquiry.uk/wp-content/uploads/2025/07/1417-HH-E03283051_Fuller-Inquiry_Phase-2_ELAY-1.pdf>. [Link accessed 29th August 2025]

3 Independent Inquiry into the issues raised by the David Fuller case Phase 1 Report Sir Jonathan Michael, Chair of the Inquiry; 28th November 2023; Available at : <https://fullerinquiry.wpenginepowered.com/wp-content/uploads/2023/11/Fuller-Inquiry-Phase-1-Report-1.pdf>. [Link accessed 29th August 2025]

4 Independent Inquiry into the issues raised by the David Fuller case Phase 2 Interim Report – Funeral Sector Sir Jonathan Michael, Chair of the Inquiry; 15th October 2024; Available at: <https://fuller.independent-inquiry.uk/wp-content/uploads/2024/10/fuller-inquiry-phase-2-interim-report-hc-260-accessible-with-correction-slip.pdf>. [Link accessed 29th August 2025]

particular additional risks to the security and dignity of the deceased from determined criminal behaviour. The HTA implemented a series of actions and activities, as set out below, to address the additional risks highlighted by this offending, whilst also updating our approach with wider changes:

a) We have significantly increased our inspection coverage rate, with a notable increase in in the PM sector, with the total number of inspections (on existing licences) increased from 140 in 2021/22 to 210 in 2022/23, 222 for 2023/24, 223 in 2024/25 and a target of 222 for 2025/26. As a result, by May 2022 we had inspected all PM establishments under the 2017 Standards and since then have inspected all PM establishments at least once.

b) We amended our guidance to certain Licensing Standards relating to security and governance and quality assurance for the Post Mortem (PM) and Anatomy sectors within our 'Codes and Guidance' documents. These were implemented in September 2022 and January 2023 respectively, following consultation with relevant stakeholders, with the revisions reinforcing the importance of having effective systems and procedures to limit, control and monitor access to the deceased.

c) Anatomy establishments have been working to the revised guidance since January 2023 and we have also stepped-up inspection activity in the Anatomy sector, with all inspections continuing to include a site visit. Since January 2023, we have inspected around three-quarters of the Anatomy sector, as part of an ongoing and rolling programme of scrutiny.

d) In Quarter 4 of 2023/24 and Quarter 1 of 2024/25, we implemented a series of mandatory webinars on security and related topics for DIs (Designated Individuals) in the PM sector to reinforce the revised guidance and help DIs prepare for the forthcoming Evidential Compliance Assessments (ECAs), that would target these Standards. Then, in Quarter 2 of 2024/25, we undertook a programme of ECAs across the whole PM sector, requiring establishments to submit evidence of compliance with relevant Standards and guidance relating to security and assurance checks, with targeted follow-up for establishments whose responses indicated concerns about their understanding of how to meet their obligations or where there were indications of non-compliance.

e) Having prepared the sector for this change, including advising them as to the standard set of policies and Standard Operating Procedures we would expect to be in place, we introduced routine use of unannounced inspections in the PM sector from Autumn 2024, initially on a trial basis. This strengthened our ability to assess compliance with Standards for practice as actually undertaken. Having been found to be beneficial in

terms of the HTA's obligations to superintend compliance with the Human Tissue Act (*'the Act'*) and having been widely welcomed by establishments as reducing the burden of inspection preparation for them, this approach was adopted as standard from 2025/26.

f) Building on previous 'Compliance Updates' (undertaken by the HTA across all licensed establishments every two years up to 2019) and the revised Data Collection Exercise (DCE) undertaken in 2023/24, we undertook a further DCE across all Act sectors plus ODT licences and a more focused exercise in Human Application in Quarter 1 of 2025/26. For the PM and Anatomy sectors, this included a focus on security arrangements and assurance activities against those requirements. This exercise was very successful, resulting in a 100% completion rate within the anticipated deadline and with the data being utilised internally to provide sector and establishment insight and inform our regulatory risk assessment process.

Phase 2 Report

6. In addition to the changes, outlined above, that we have progressed within the HTA, there are the recommendations flowing from the Phase 2 Report of the Inquiry to be considered.

7. Overall, there were 75 recommendations contained within the Phase 2 Report (see **Annex A**). The HTA notes that many of the recommendations were directed at specific types of organisation or sector, with a relatively small number of higher-level recommendations being addressed to 'Government'.

8. Members will note that of the 75 recommendations, only one has been directed at the Authority, which is that (Recommendation 26)[5] the HTA should amend its guidance concerning the reporting of incidents in the Anatomy sector (which is already happening informally in many cases).

9. There is also one recommendation for Government (Recommendation 73)[6] concerning a proposed change to the Human Tissue Act (2004) to provide for specific and primary legal responsibilities to be applied to the organisation

5 Phase 2 Report 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).'* [See Annex A for full list of recommendations from Phase 2 Final Report.]

6 Phase 2 Report 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.'*

[See Annex A for full list of all recommendations.]

holding a HTA licence. The HTA was also mentioned in connection with a number of other more general recommendations concerning proposals for regulation of those involved in managing the deceased.

10. The Executive considers the HTA's actions over the period since Fuller's offending came to light, in particular to strengthen and be more explicit about our expectations relating to actions to protect the security and dignity of the deceased and a significantly increased operational focus on this topic, has resulted in the Phase 2 Report reflecting well on the HTA

Next Steps

11. Whilst the Inquiry has now concluded its work, the HTA is continuing to engage and provide support where relevant to activities by officials at DHSC and wider Government supporting Ministers in their decision-making in response to the final Phase 2 report.

12. On the day, the Final Report was published, Ministers replied with a Written Ministerial Statement (WMS), which noted that 'Government recognises the urgency of the concerns raised by the Inquiry's recommendations' and would respond at pace, including through 'an interim update on progress this year and a final response by Summer 2026.[7]

13. The HTA is conscious of the importance of not pre-empting Ministers decisions about the Government response to the Inquiry whilst being content to talk about the Inquiry with external stakeholders.

14. We are attending meetings led by DHSC officials which will arrive at advice for Ministers to consider.

15. The HTA has powers under the Human Tissue Act (2004) to set further conditions to licences in addition to those set out in the Act.[8] These powers

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7 Fuller Inquiry Phase 2 Report, Written Ministerial Statement by the Secretary of State for Health and Social Care; Statement UIN HCWS824; 15th July 2025; Available at: <Written statements - Written questions, answers and statements - UK Parliament>. [Link accessed 29th August 2025]

8 Schedule 3, paragraph 5, Human Tissue Act (2004), **'Power to impose conditions'**, states: *'The Authority may grant a licence subject to such further conditions as it thinks fit.';* Available at <https://www.legislation.gov.uk/ukpga/2004/30/schedule/3/paragraph/5>. [Link accessed 29th August 2025]

The HTA web pages dealing with licenses includes information on Standard License Conditions for each sector; For the Anatomy sector, see the following link: <Anatomy Sector Annexes B-D.pdf>. [Link accessed 29th August 2025]. **Standard Condition 3 (Annex B)** states that: *'The HTA shall be provided, within fourteen days of a request in writing being made* ***(or within such other period as the HTA may determine)****, with such information as is specified in the written request or in Directions, to enable it to undertake its regulatory functions and duties and to enable it to exercise its powers under the Act.'*

underpin the formal system for reporting certain incidents ('HTA Reportable Incidents' or 'HTARIs') in the PM sector.[9] The HTA has made good progress in developing a comparable HTARI process for the Anatomy sector for implementation this year, including suitable communication and engagement activity.

16. The HTA is also preparing summarised guidance to be published on our website shortly to set out our approach to managing activities to protect the security and dignity of deceased. Whilst this guidance is set within the context of our regulatory remit, for the benefit of any of our sectors and the public, it may also be of interest to any other organisations beyond our remit who are involved in managing and caring for the deceased.

17. The HTA has already committed to starting this year the process of determining how to review, and where relevant revise, our current Codes of Practice (CoP). The CoP are practically-focused statutory documents whose purpose is to provide advice to practitioners as well as incorporating the mandatory licensing Standards.[10] The current CoP came into force in April 2017 and aside from the significant changes to Codes F arising from the introduction of deemed consent for organ donation, have mostly had only relatively minor changes since then, such as some changes to Code D (Public Display) regarding consent expectation for imported bodies. The HTA is mapping the findings and recommendations of the Inquiry's Phase 2 Report against HTA CoP, Standards and Guidance and our wider range of guidance products to inform decision-making about what, if any, changes we might wish to make to further enhance the measures that establishments can be expected to take to protect the dignity of the deceased.

Summary

18. In conclusion, whilst the way forward in relation to Sir Michael's recommendations has still to be considered by Ministers, we can at this stage note the following:

9. HTA guidance document for HTARIs; see page 4 **(Reporting requirements)**; *'Establishments licensed in the Post Mortem sector must notify the HTA within five working days of a serious incident or near-miss occurring or being discovered*'; which references footnote 1 (re Standard Condition 3); Available at <HTARI Guidance for establishments>. [Link accessed 29th August 2025]
10. Human Tissue Act (2004); '**Section 26 Preparation of codes**
(1)The Authority may prepare and issue codes of practice for the purpose of—
(a) giving practical guidance to persons carrying on activities within its remit, and
(b) laying down the standards expected in relation to the carrying-on of such activities.'
Available at : <https://www.legislation.gov.uk/ukpga/2004/30/section/26>. [Link accessed 29th August 2025]

a) we thank all those in the HTA who have contributed to supporting the work of the Inquiry – this has been extensive over several years.

b) we also note the work HTA has undertaken since the dreadful offending of David Fuller came to light and we note that the Inquiry was very positive about the actions and activities the HTA has taken; and

c) we are working in support of the Department in their assessment of the options and in their role of putting advice to Ministers. We will support the work to implement those recommendations agreed by Ministers.

Recommendation

19. The Board is asked to note the report and the ongoing work by the HTA to improve how establishments within our remit protect the security and dignity of the deceased people in their care.

Annex A: Recommendations of Sir Jonathan Michael's Phase 2 Report

No.	Recommendation	Organisation/ Body
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
6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously.	NHS Trusts

	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.	
7	The NHS should ensure that the security standards NHS England and 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
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	NHS Trusts

	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.	
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 NHS body stores.	NHS Trusts
21	NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS Trusts	NHS England and the body that subsumes its functions
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
24	All organisations providing anatomical education Medical and training using donors should make sure that other clinical policies and procedures are in place to ensure the faculties of security and dignity of donors. These should universities and medical include: • security and access policies and the training providers 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
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 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**	**Human Tissue Authority**
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 in Chapter 11.	UK government
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 subsume 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 subsume 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
35	There should be a process to routinely review who is permitted to access the mortuary unsupervised.	Local authorities with an HTA-

		licensed mortuary
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, 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
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
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 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 audits reported to the Designated Individual and head of service or equivalent.	Local authorities with an HTA-licensed mortuary
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

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.

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
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
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 review 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
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
69	Where organisations work together to care for the 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
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

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
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