Independent Inquiry
into the issues raised by
the David Fuller case

Fuller Inquiry Designated Individual Seminar

Event:
Fuller Inquiry, Seminar on HTA Designated Individuals and their role in relation to the security and dignity of the deceased

Date:
11 November 2024

Attendees:

- Sir Jonathan Michael, Chair, Inquiry
- Simon Whale, Facilitator
- Rebecca Chaloner, Secretary, Inquiry
- Jane Campbell, Deputy Secretary, Inquiry
- Kathryn Whitehill, Head of Investigations, Inquiry
- Christina Houghton, Hammersmith and Fulham Council
- Clive Graham, North Cumbria University Hospitals NHS Trust
- Daniel Shingleton, Manchester University NHS Foundation Trust
- Dr Catherine Hennessy, Brighton and Sussex Medical School
- Dr Kaushik Dasgupta, North Tees and Hartlepool NHS Foundation Trust
- Jahran Allen-Thompson, Tower Hamlets / Waltham Forest Council
- Karen Mizzi, Surrey Council
- Louise Fox, Hampshire Hospitals NHS Foundation Trust
- Mark Croxford, Birmingham Council
- Mark Lankester, Norfolk and Norwich University Hospital
- Mark Pietroni, Gloucestershire Hospitals NHS Foundation Trust
- Mudher Al-Adnani, Guy’s and St Thomas’ NHS Foundation Trust
- Rachael Waddington, Imperial College School of Medicine
- Stephen Davison, Royal Cornwall Hospitals NHS Trust

Monday, 11 November 2024

(1.00 pm)

SIR JONATHAN MICHAEL: Good afternoon everybody.

I am Jonathan Michael and I am chairman of the inquiry into the issues raised by the David Fuller case. I am are joined here today by Simon Whale, the communications adviser to the Inquiry who will facilitate our discussions today; by Rebecca Chaloner, the Inquiry Secretary; Jane Campbell to my left, the Deputy Secretary; and Kathryn Whitehill, who is the Head of Investigations to the Inquiry.

As I am sure you all know, David Fuller committed despicable crimes in the mortuaries, Maidstone and Tunbridge Wells NHS Trust. As Chairman of the Inquiry, I was asked to undertake two things: in Phase 1, to understand how Fuller was able to carry out his terrible actions for so long, apparently unnoticed at the Trust and then to make recommendations to the Government to prevent anything similar happening again; then, in Phase 2, to consider whether the procedures and practices in other settings across the country where the deceased are kept safeguard their security and dignity and to make recommendations to the Government to prevent anything similar happening again. I published my first report on Phase 1 in November of 2023 and an interim

report on the funeral sector in October of this year.

I am very grateful to you for taking the time to attend this seminar because, by doing so, you will help the Inquiry gather evidence and draw conclusions on the current requirements, the opportunities and challenges facing those that are holding the role of Designated Individual under the Human Tissue Act. We are keen to understand how the role contributes to the security and dignity of the deceased people in all settings across England.

That is enough from me. I am now going to hand over to Simon, who will explain how the session is going to run.

MR SIMON WHALE: Thank you Chair.

First of all, let me repeat the thanks from the Chair to all of you for coming today. We very much appreciate it. We know you are all very busy and that you all do very difficult jobs. So we are grateful to you all for setting time aside today.

It is of vital importance that the Inquiry hears the views of a broad section of those working as Designated Individuals and to understand your role in the very different settings in which you all work and in particular the challenges you face. This is in order to help the Chair make findings and recommendations for his

final report looking at the broader national picture and the wider lengths for the NHS and for other settings where deceased people are cared for with a particular focus to make sure there cannot be a recurrence of the matters raised by the Fuller case. This is one of a number of seminars that the Inquiry is holding to gather views for its phase 2 work programme.

Can I just start with some housekeeping.

First of all, there is no fire alarm scheduled, no fire alarm test scheduled today, so if the fire alarm does sound, that is for real and the reception staff outside will guide us.

Secondly, there are quite a lot of us here today. I want to give everyone the opportunity to share their views, but we must do so in an organised way. This will ensure we can cover a wide range of topics in a relatively short space of time. Our aim is to elicit the best evidence we can from all of you. I am facilitating the session, which means I will endeavour to ask questions of each of you as we move through the topics. I will do so by referring to you by name and asking you to speak. Please don't interrupt anyone else when they are speaking. If you would like to respond to an answer that someone else gives, just raise your hand and I will come to you if there is time to do so.

The session is being transcribed by stenographers at the back of the room. Please only speak when a question is directed to you. When you are asked to speak, please say each time who you are and which organisation you are from. The transcript of this seminar will be produced and it will help us to ensure that it is always clear who is speaking. If you are speaking too fast or too quietly I will politely remind you that you are being recorded and I will ask you to speak as clearly as possible. I know this may be a bit unfamiliar for all of you but just try to be as natural as you can. Just speak up, speak clearly and give concise answers.

When you do speak, please address your answers to the Chair. The Chair may sometimes also have questions he wants to ask; that is to ensure that we have the best evidence that will help cover the issues that the Inquiry is investigating.

Colleagues at the table, already introduced, may also ask questions to help facilitate the discussion on particular issues.

This is not a court. No one will be asked to give an oath or affirmation that their evidence is truthful and accurate. Nonetheless, the Inquiry is a full and fearless search for the truth and that means the Chair expects everyone to answer questions fully and

accurately. It is the only way we can ensure that the Inquiry does its job as best it can and is informed by key stakeholders.

A quick word on language and terminology; these are important. If we touch on topics today that require details about what happens to a person after death, the steps involved in death management, and so on, that is perfectly fine. We want you to be candid but you can flag anything if you would like to, saying that it would involve graphic or sensitive information.

A word on confidentiality. It is important what we discuss in this room remains confidential between those of us in this room. We do not want you to post anything on social media or publish articles or discuss this session with others, please. This is because the Inquiry's work is ongoing, we have not finished yet. We still have a lot of people to speak to and we want to hear views that are not influenced by others.

In due course, the Inquiry will publish a report but that is some way off at the moment and, until then, we need space to work. The Inquiry may wish to use information that is discussed today in its report. I say that so that it is clear to everyone that that is the core purpose of this seminar: to assist the Chair's investigation and gathering information that may be used

in the Inquiry's report on Phase 2.

Now, we have four core sessions for this seminar. I will briefly outline them. First, the role of designated individuals. We would like to consider how DIs are selected for the role, the training and continuous professional development available to you and the impact of any role you may hold alongside that of DI.

Second, the role of the DI in the management of mortuaries and the associated governance within the wider organisation. This area is an opportunity to discuss the part you play in the general management of the mortuary and how others, including the chief executive and/or the board in your organisation, seek or are given assurance on the quality of services in the mortuary.

After that second session we will have a short 15 minute break.

The third topic area is the challenges of being a DI. The Inquiry heard about the challenges of the role at Maidstone and Tunbridge Wells NHS Trust in Phase 1 of its work. We will explore if these challenges are generic to the role of Designated Individual and if there are other challenges and whether these are particular to different settings.

Fourthly, what needs to change. We will consider if and how the role and responsibilities of the designated individual needs to change in order to ensure the security and dignity of the deceased.

We will conclude with remarks from the Chair at the end. Our plan is to finish by 4.00.

Just some quick words to set the scene for what we are about to discuss.

As the Chair has said, the reason we are here today is because of the awful crimes that David Fuller committed, how they can be learned from, so that they do not happen again in any setting where there are deceased people present. I am sure that is a view that all of us in this room want to share.

The central question for today is the role that DIs play in that. The role of DIs was introduced as part of the Human Tissue Act 2004. They have a legal duty to ensure that statutory and regulatory requirements of the Act are met. They are responsible for supervising licensed activities and ensuring suitable practices are taking place. An establishment licensed under the Human Tissue act must have a Designated Individual. The responsibility is a personal one. Designated Individuals have to be approved by the HTA to act in this capacity.

The Human Tissue Authority licences more than 800 organisations across England. The Designated Individuals in these organisations work in a variety of settings, including NHS hospitals, local authority public mortuaries and medical educational establishments. In its Phase 1 report, the Inquiry found that those who held the position of Designated Individual at the Maidstone and Tunbridge Wells NHS Trust found the role challenging, having significant legal and operational responsibility but without the authority and support required to carry out the role effectively. The report recommended that Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary and that the Designated Individual is actively involved in reporting to the board and is supported appropriately in this. The Inquiry set out its intention to review the Human Tissue Act in Phase 2 of its work.

So, with that background, which we can return to as we develop the discussion, it would be helpful to bring all of you into the discussion. We have representatives from 16 organisations -- shortly, hopefully -- 11 of the Designated Individuals from NHS Trusts and a number from local authorities and two from the medical education sector. Welcome, all of you.

Can I start by just asking each of you, starting with you, sir, on my left, to introduce yourselves. Please just give your name and the name of your organisation.

MR MUDHER AL-ADNANI: Mudher Al-Adnani, paediatric pathologist at Guy's and St Thomas' Hospital.

MR MARK CROXFORD: Mark Croxford. I'm from Birmingham City Council mortuary.

MR MARK LANKESTER: Mark Lankester. I'm from the Norfolk and Norwich Hospital.

MR STEPHEN DAVISON: Stephen Davison. I'm from the Royal Cornwall Hospitals NHS Trust.

MS KAREN MIZZI: Karen Mizzi from Surrey County Council.

MR DANIEL SHINGLETON: Daniel Shingleton, Manchester University NHS Foundation Trust.

MR KAUSHIK DASGUPTA: Kaushik Dasgupta, University Hospital North Tees and Hartlepool NHS Foundation Trust.

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London.

MR JAHRAN ALLEN-THOMPSON: Jahran Allen-Thompson, Waltham Forest and Tower Hamlets Local Authority.

MR CLIVE GRAHAM: Clive Graham, North Cumbria Integrated Care NHS Foundation Trust.

MS CHRISTINA HOUGHTON: Christina Houghton, London Borough of Hammersmith and Fulham.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals NHS Foundation Trust.

MS LOUISE FOX: Louise Fox, Hampshire Hospitals NHS Foundation Trust.

MS CATHERINE HENNESSY: Catherine Hennessy, Brighton and Sussex Medical School.

MR SIMON WHALE: Thank you all very much.

Let's start with the first session. As I mentioned, this is about the role of the Designated Individual. We are going to consider how DIs are selected for the role, the training and CPD available to you, and the impact of any role you may hold alongside that of DI.

The first thing to say is we know there is a variation in who holds the position of DI. Some of you present today might be the technical lead for a mortuary; others, you may be senior managers with other roles. We would like to explore what background and experience you think are desirable or essential to fulfilling the role of the DI. Please tell us your views.

So, to get everyone started, should the DI have a prior understanding or experience of mortuary services and care of deceased?

Who would like to say something? Yes, sir.

MR JAHRAN ALLEN-THOMPSON: Yes.

MR SIMON WHALE: Yes. Good. Succinct. Thank you.

You do need to say your name before you say the one-word answer.

MR JAHRAN ALLEN-THOMPSON: Jahran Allen-Thompson, London Borough of Waltham Forest and Tower Hamlets: yes, I believe so.

MR SIMON WHALE: Thank you very much.

MR MUDHER AL-ADNANI: Mudher Al-Adnani, Guy's and St Thomas' Hospital.

I would definitely agree; definitely, yes. I think for the DI to be able to do his or her job as a DI, they should have an understanding of basically what happens in a mortuary, what kind of activities happen in a mortuary; if samples are taken from the deceased, why are they kept, what happens to them, what are the processes involved in these kind of things. I would definitely say the DI should have some kind of a working within the mortuary, whether it is a pathologist, a mortuary manager or some -- let's say even a senior manager but who has an understanding of the function of a mortuary.

MR SIMON WHALE: Thank you. Yes.

MR MARK CROXFORD: Mark Croxford, Birmingham.

I am not sure that is going to be possible in a local authority setting. We have a limited number of

officers that work inside the mortuary. So what they've done, in Birmingham, is they have chosen someone that has more of a legal enforcement side to hold the licence -- that is my director -- and then the DI, myself, and I'm the Head of Environment Health, and I have three caps on, so three budgets as well as the mortuary tacked on to the side.

MR SIMON WHALE: Thank you. Yes.

MR MARK PIETRONI: Mark Pietroni, Gloucester Hospitals.

I am the Medical Director in the Deputy Exec of the Trust and I think it depends, is the honest answer to your question. It depends on what kind of induction you wish to put in place for new DIs. I am a doctor, so obviously I am experienced in -- I have experience of death and talking to families and looking after people when they die, but I have no prior experience of a mortuary service, except as a medical student going to post mortems, et cetera.

However, all that was just described by our colleague, here, I then did as part of my induction when I took over as DI and I think if you want to balance -- one of the key things for me that we might want to tease out is the board level responsibility with the on-the-ground understanding in running of mortuary, and if your DIs require previous prior experience of a

mortuary, they are unlikely to be senior people within the organisation.

When you reach an executive level post, one of the skills that you have is the ability to manage parts of an organisation of which you have no personal experience or subject matter expertise and you do two things: you find the people that do and you also learn what you need to do in order to manage it appropriately; that is what senior people in an organisation do.

So it depends, primarily, on how you wish to balance the seniority of the role of the DI with the subject matter expertise of running a mortuary or a body store and I suspect there is not a right answer to that question. It is about what we, or you, consider to be the fundamental priorities in that decision-making process.

MS LOUISE FOX: Louise Fox, Hampshire Hospitals.

I have to echo that. I am a nurse. I am a senior nurse, I do report to an exec director and I had no prior knowledge of mortuaries other than as being a ward nurse before. What I do have is an understanding of the governance structure of the organisation and how we report in and out of that structure. So I would agree, it is about the individual rather than the experience, I think, in particular for me.

I was put into the role as an adjunct to my role just because I happened to be moving into the post as somebody exited, but we have had a number of different disciplines as DI over the years and I think there is good overview, it just depends on how you deliver it.

MR SIMON WHALE: Okay.

MR MR STEPHEN DAVISON: Steve Davison, Royal Cornwall Hospital.

Again, I agree. My initial reaction would have been working with a background would be to say yes; but, actually, on thinking about it, the way the HTA is structured, we have PDs in place. So I think you have got PDs in place that actually have that experience as well now, so the DI doesn't necessarily have to have that experience, because if a person is designated in key areas to actually feed back that information to you; so I would say, as long as you have PDs that also have that knowledge and that skill base that can look at these issues.

MR SIMON WHALE: Thanks. Yes.

MR KAUSHIK DASGUPTA: Kaushik Dasgupta, consultant pathologist, and I am from the University Hospital of North Tees and Hartlepool NHS Foundation Trust.

So I think my view is almost changing while I was listening to all these answers. So in a way I think

I sort of strike that balance, maybe favourably, because when I started as a DI, which was in 2017, that was really part of a succession planning and I was one of the very few postmortem active consultant pathologists -- sorry, I started not in 2017, actually, but much before that, maybe 2013 or so, I can't remember.

But then, from 2017, I became the Clinical Director for the whole of the Directorate of Pathology and I was -- I do sit in the Trust Directors Group and then I have got full access to medical directors and other senior management staff, which I use both for my role as the CD and as well as for the DI. Although I am no longer postmortem active, I still have that very good rapport with my person designate in the mortuary, so I sort of really sit between that and the board level, although my personal preference, actually, that it is more sort of -- as long as the operational person and the person who speaks to the board is a good link, then it really doesn't matter, but from the hands-on things that goes on in the trust, my preference would be for a more operational person to be the DI, even if they are not the one directly going to the board, as long as there is another layer which can sort of interact very freely and carefully and represent that. Possibly it is

just maybe my preference but there is a difficult balance to be struck.

MR SIMON WHALE: Thank you.

If the mortuary manager is the Designated Individual, where does the independent oversight come from?

MR CLIVE GRAHAM: Clive Graham, North Cumbria.

I am also the Clinical Director of Pathology but I am also a microbiologist by training and I suppose one of my views is I actually come in from the outside of the immediate mortuary department and I think that does give you -- and I can ask some questions that may not occur to some people actually working in there day-to-day. I also am a medical examiner so I get lots of intelligence from other people who have got lots of interactions with the mortuary and funeral directors and the coroner, and to my mind it is that sort of network of intelligence that gives me assurance around what is going on in the mortuary, rather than just sort of going there on a day-to-day basis.

SIMON WHALE: Yes.

MR MARK CROXFORD: Mark Croxford, Birmingham.

I took on the DI role in about 2012 or 2013, somewhere around then. 99 per cent of my thing was about traceability. It was about reputation, looking

after the dead and making sure the right person goes back to the right family. This has been an eye-opener. It never even crossed my radar that this could possibly happen and I think what you are asking for is how do you stop that from occurring, and it can only be stopped by the quality of the people that are actually inside the mortuary and reporting it. It isn't going to be stopped by a DI or a licence holder; it has to be the truthfulness and honesty of the people in the mortuary. And we don't have background checks, or insufficient background checks, for that.

So that would be my comment. I have more sleepless nights now than I had before and that was all about just identity issues(?).

MR SIMON WHALE: Thank you. Yes.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals.

So if the mortuary manager is the DI, then I think you need to have a process similar to professional accountability. So I don't line manage all of the doctors in the Trust, nor does the chief nurse line manage all of the nurses but all the doctors are professionally accountable to me as medical director, as the nurses are to the Chief Nurse as nursing director. If the mortuary manager is the DI, then he or she needs to have a professional accountability around the legal

requirements of the role as DI, to a senior member of the organisation. I don't think it necessarily has to be the medical or nursing director but it should be somebody senior enough in the organisation to be able to influence change at a high-level in the organisation, if that is required. The danger, if not, is that a mortuary manager, certainly in a big complex multi-site NHS Trust is often a relatively junior member of staff and, whilst he or she may be able to escalate issues up their chain of command, or put issues on a risk register or in the DATIX reporting process, there is no guarantee that they have the influence to make things happen quickly.

I don't think it is inappropriate -- sorry, I don't think it is impossible for the mortuary manager to be the DI in that kind of context, as long as the relationship with somebody senior in the organisation is strong. However, as I said in my interview, I do think it is probably inappropriate for a junior member of an organisation to have a personal responsibility for those legal duties; whereas a senior member of the organisation, it comes with the territory.

That is a personal view.

MR SIMON WHALE: Thank you. Any views from anyone who has not spoken yet?

MS CATHERINE HENNESSY: Catherine Hennessy, Brighton and Sussex Medical School.

So I am the DI of Brighton and Sussex because I am the Head of Anatomy as well and there was talk before about our lab manager becoming DI, but kind of -- I guess I am saying this because I am a slightly different sector to what has already been discussed but it is quite similar. So we did talk about the lab manager becoming DI and I think the issue is there is just a bit of resistance from that person because of the responsibility that comes with it and lack of pay to recognise that and then I guess, yes, maybe the motivation to do the job is not there from that person because they are not being recognised. So it generally falls back to the Head of Anatomy, and in our work I mean the Head of Anatomy will always be working with the deceased and have a good background in it, but it is more the lab manager who is working with the deceased every day and would have a really good idea of, you know, when they come into the medical school, how they are treated from the very start and cared for and everything, and stored.

So, yes, I guess it is kind of similar but just a different sector's point of view on that.

MR SIMON WHALE: Yes.

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London.

So I suppose I am in the position that we are talking about. I am the unit manager and I am the DI. It has been really interesting hearing everyone's points but, essentially, I think it is important to have an understanding of the standards and guidance that you are having to make sure is put in place, as well as ensuring your PDs also have that level of knowledge because, if they are acting on behalf of you, and if you want that strength in your governance, you need them to maybe understand that responsibility to the level if the DI is not going to be present all the time.

For myself, I do have a governance structure through the management team and the licence holder, and I think, as you said, it is very important to have that governance through, so specifically I am not isolated in making decisions that the college doesn't know.

So I think there is probably, as we have all said, some mid-way point to make sure, you know, the standards and guidance and responsibilities of the DI are met.

MR SIMON WHALE: Thank you.

Several of you have talked about gaining experience and induction, and so on. I wanted to ask about training specifically. We would like to understand what

kind of training any of you have had before you took on the role. What kind of training did you receive?

And it is okay to say "I didn't have any", but it would be interesting for us to know yes.

MR DANIEL SHINGLETON: Daniel Shingleton, Newcastle Hospitals NHS Foundation Trust.

I started out in 2012. I was not the DI at that time but the DI was the associate medical director. So it is a large trust, it has a lot of mortuaries underneath it. So a separate role called the Nominated Individual was established, which was essentially 37 and a half hours a week, solid human tissue authority, also managing aspects of tissue taken in the paediatric mortuary as well. So that is the role I took on.

So essentially since 2012 my training has been that role of HTA constantly. So you develop that rapport with the mortuary services manager, you know what a release SOP should look like, you know what a receipt SOP should look like, what a proper postmortem reconstruction is.

So my training was very much a role was established as part of a succession cycle, as it were. So when the Associate Medical Director, it came time for her to stand down from the role of Designated Individual, I was the obvious candidate and the obvious well-trained

candidate as well, which had links as part of working with the Associate Medical Director but also the technical knowledge on the ground floor as well.

MR SIMON WHALE: Is that pathway commonplace?

MR DANIEL SHINGLETON: Not at all.

MR SIMON WHALE: What about other experiences of training?

MR KAUSHIK DASGUPTA: So as I said earlier I was also part of succession planning and I had been involved in a few consultant pathologists who were active in a postmortem , so I had quite a good working relationship with the mortuary team on the ground and I was dealing with the deceased from a medical point of view every day, in and out. And then at that point I was actually sort of nominated, I didn't have to go through the interview process and that I think that it would be better if there was a conflict of interview process, although I doubt whether there would be very many takers, whether very many people would rush to apply for that role, would want to do that, perform that role at all. And then I definitely did the HTA -- at that time at least, there was a HTA DI module. I did the DI module successfully, and after that I also did the consent training and I have taken quite a few hospital postmortem consents around with our senior mortuary manager when I was a PM active. But that is all the training

I have. I didn't have any further training. 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 and if I find then I would very much like to anoint them or appoint them to that role, particularly if there are more than one applications I will go for an interview and actually I wouldn't want to continue in that role any longer than what I have done already. But that would mean my life as a -- and that is the reason.

MR SIMON WHALE: Thank you. What about those of you who are working in local authority or medical education settings, training in those settings, what does that consist of?

MR MARK CROXFORD: Mark Croxford, Birmingham. I did the HTA course when it was online. I haven't received any additional training. I think it is the responsibility of the HTA to try to have a course out there. I don't see any CPD. I don't have any joint working, I don't have any support from any other sector, Birmingham and Solihull, but the other mortuaries appear to be in hospital settings and they are smaller. So we are one of the largest mortuaries in the country as I understand

it. So it makes it very difficult. From a succession point of view, we are looking at succession. I know it is hard to believe but I am no longer a spring chicken and it is proving to be very difficult to get somebody to volunteer. We have got someone but we have not got any formal training. So it is going to be a year or so working with me and then that will be the end of the any training as far as I can see at the moment. But my comment would be the HTA I think they need a formal course and they authorise us at the end of the day.

SIR JONATHAN MICHAEL: Can I just come in and just ask specifically in terms of local authorities whether you actually get support from other -- you mentioned around Birmingham that there are NHS hospital mortuaries, is there any engagement or support received or sought?

MR MARK CROXFORD: Neither. We don't seek it and we haven't -- until very recently there was never even a meeting between DIs. There is -- a meeting has been set up nationally which is really welcome.

SIR JONATHAN MICHAEL: Is that common in terms of local authority experience?

MR JAHRAN ALLEN-THOMPSON: I am Jahran Allen-Thompson, London Borough of Waltham Forest and Tower Hamlets. I will do my background and training first and then I will touch on any support we provide one another.

So I started off a volunteer in 2008, working in the mortuary service of Waltham Forest. The job became available in 2009, I applied for and got it. I was a person designated for some time and did the old diploma and certificate in Anatomical Pathology Technology. I began managing the facility in 2017 and then set up the London Mortuary Managers Group, which was a way of the London team members supporting one another. Yes, in relation to other training, my background is learning and development. I spent nine years working in a company that provided training to hospitality staff working in stadia, so not exactly mortuary related but learning and development as a background, and developed resources that allows them to train person designates.

MR SIMON WHALE: Yes.

MS KAREN MIZZI: Hello, Karen Mizzi, Surrey County Council. I also lean on court service but going from the interaction between the DI and the local authorities, because the bodies fall under the jurisdiction of the coroner, we have twice weekly meetings. One is around any specific instance to be reported because there is that interaction, if there is an injury or damage to a body or there has been a breach of security, they have to report it to the coroner as

well because he has a vested interest whilst the body is under his responsibility. So we do meet weekly. We have been doing that now for four years and on top of that we look at the sessions because Surrey County Council at the moment subcontracts the NHS through hospitals to perform postmortems on the behalf of the coroner. So that is effectively where we are. I think listening to the comments in the previous question, it is an interesting fact that coroners are not mentioned in the answers involving designated individuals and what role they play, the part they play, because those bodies are under his care whilst they are under his jurisdiction, and I think that interaction is really important that the coroner is kept informed at every stage if it involves the taking of samples. It requires Human Tissue Authority specifically as our officers engage with the families around the taking of samples and proactively managing the samples' repatriation, et cetera.

MR SIMON WHALE: Yes.

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London. So from myself, similar. I did the online module training to be a DI. I was selected and had an interview with our faculty to attain suitability but essentially that was as far as the training went.

Now, I did have obviously a background, I think at that point probably about 15 years plus in anatomy. Obviously we worked under the Anatomy Act, which is quite similar to the HTA in some ways and does work slightly differently to mortuary environments. But there is no ongoing competency and I would say there is not really a huge amount of robustness in the event that if I was not available just because it is quite a unique area and obviously the activities we are carrying out are quite specific. So that I think could be improved on.

MR SIMON WHALE: Thank you.

Christina, can I ask you for any thoughts you have got both on the training area but also more broadly.

MS CHRISTINA HOUGHTON: Christina Houghton, Fulham Mortuary, London Borough of Hammersmith and Fulham. I agree with colleagues around the table there is very limited formal training for a DI. And for me personally, I was appointed to the role last year simply because the manager left at very short notice and I was the next person in line and I effectively learnt on the job and I would really appreciate a lot more structured training, I think. And ongoing training as well because obviously as regulations change and develop for this reason, as well.

So yes, I think there is definitely a lack, within public mortuaries, it is such a niche area, you will not have someone waiting who is suitable to replace a DI, should they be on the long term sick or should they leave the organisation and that is quite a risk.

MR SIMON WHALE: That wish for ongoing training, where do you think that should come from?

MS CHRISTINA HOUGHTON: I think the HTA are well suited. They are the people regulating us and giving us advice and they inspect us. I think they are ideally suited to provide the training.

MR CLIVE GRAHAM: Clive Graham, North Cumbria. I think since Fuller they have given one webinar on security in the mortuary, which I think was very welcome. They also have a wealth of data because they have all the incidents coming right across the country in terms of security breaches or other problems. And it is quite useful to learn what other people have encountered because actually you don't want to wait for an incident to happen to learn from it. If someone has had a problem with security around a certain door or around a certain access method then that should be shared across the NHS like other governance issues are shared across the NHS.

MR SIMON WHALE: Yes, Mark, in Norfolk, what are your

thoughts?

MR MARK LANKESTER: Mark Lankester, Norfolk and Norwich. I was lab manager, pathologist but I didn't get any training, I got a hand over -- thank you. Yes, I took over from a pathologist DI. So I had a hand over but there was no training. I contacted, at the time probably about three and a half years ago, I contacted the HTA and they told me there wasn't any training. So other than the previous DI hand over and looking at the information on HTA website, and talking about -- to the PDs, that was all my training had been. Obviously I knew about mortuaries and histopathology, et cetera, so a lot of knowledge there but no formal training or that much support really for the training and not a lot of sort of protected time either.

MR SIMON WHALE: Thank you.

So if during your working life you encounter an issue that is a DI related concern for you, how accessible is advice and support when you encounter an issue and where will you go for that, where do you expect to get that support? Would it be from the HTA, would it be from your peers, your colleagues like this in the room? Where would you go? Yes.

MR KAUSHIK DASGUPTA: Yes, so I think the recent DI group is a very recent phenomenon, it wasn't there before.

Definitely I have ran into many, I wouldn't say difficult problems but run into many queries and whenever I had any query or however trivial it may sound I would always write to the HTA as my first port of call and every time I have been promptly assisted and it has been really, really very good service, fantastic service, always got from the HTA and it really helps me a lot, even more because my senior manager, with whom I have spent a vast amount of my postmortem performing life, is now one of the highest ranking managers within the HTA. So I can just email her, I can just ring her and I definitely get the correct answer, each and every time without fail and I think I am conscious of not yet been part of the HTA DI forum, I would like to be that, I think part of it. I am really hoping that I would be able to pass on to somebody else very soon. I really do not want to continue in this job for a very, very long future.

MR SIMON WHALE: Thank you, we have heard that.

I am assuming not everyone in this room has a former colleague who is a senior manager at the HTA, so where do would you go for advice.

MS LOUISE FOX: Louise Fox, Hampshire hospitals. I am the same. I only started as a DI in April, so a very short time compared to everybody else. The HTA are really

responsive. If I email I get a response straightaway and they usually organise a Teams meeting with me and talk me through everything. We also have a systemwide meeting that is held quarterly. Don't get me wrong, this was borne out of capacity and a strategic direction but actually it has enabled us to network with each other, if there is any particular issues. And also the coroner, just, call the coroner if there is a particular issue that we are not sure about.

MR SIMON WHALE: Okay. Thank you. Any other thoughts on this point?

MS KAREN MIZZI: Karen Mizzi. I was a DI for a short period of time just coming out of the pandemic and the HTA I went to them, sought their advice and they guided me through the emergency licence application process and guided me on what they needed for me to make things licensable for that purpose. And it was a very, very strong interaction, including a panel meeting, with three members of the HTA that interviewed myself and my DP to ensure that we would be able to deal with what, lower level, probably compared to what happens in an NHS hospital when carrying put post mortems, and that facility, but there was issues that required it to be licensed. So I think that in my view would be the right place. I forgot to mention earlier about when I did

that role as DI during that period. Four months, I had no training. I had to do research and rely on the HTA to guide me if I had any issues.

MR MARK PIETRONI: Mark Pietroni, Gloucester Hospitals. I just echo colleagues' comments. I find the HTA respond very quickly. They have got a very good relationship with the inspector, came for inspection. You would get responses if not the same day, next day. And similarly with a local coroner's office, very good. We work hard to maintain good relationships so if necessary we just ask and, again, we get a response within 24 hours.

MR SIMON WHALE: Am I right in saying there is not a support network amongst DIs at the moment and if I am, would that be something that you would find helpful.

MR CLIVE GRAHAM: Clive Graham. There had been one meeting of the DIs. It has literally been a first forum where we have had a discussion, a Teams meeting and a lot of people attended. But that was the first communication with other DIs that I have had. Again, just to say, I do find the HTA very helpful. If you have an incident check with them and they often ask very useful questions and when I came into the DI role, I think they were just about to have an HTA inspection and I tried to spend a bit of time with the inspector, going round and

look -- seeing what they are looking for and learning from others as part of that inspection process.

SIR JONATHAN MICHAEL: Can I ask who set up that DI meeting.

MR MARK CROXFORD: I could dig out the email for the name of the individual.

SIR JONATHAN MICHAEL: It was amongst --

MR JAHRAN ALLEN-THOMPSON: It was Guy Singleton but the HTA coordinated, having all the DIs, I think it was in the UK, present for this meeting, there was about 75 of us.

MR SIMON WHALE: Okay. I am going to move us on because we have other topics to cover if that is all right. I want to move on to our second topic, which is about the role of the Designated Individual in the management of mortuaries and the associated governance within the wider organisation. This is an opportunity to talk about the part you play in the general management of the mortuary and how others including the CEO or board in your organisation seek or are given assurance on the quality of services. Can I start by asking, how well do you think the role and responsibilities of the Designated Individual are understood within your organisation and its management chain?

MS LOUISE FOX: Louise Fox, Hampshire hospitals. I would say it isn't well known at all. Until recently when we were invited to take part in the Inquiry, I don't think

the execs had a real rounded view on what the responsibilities were and I don't think they understood what they didn't know. They were not asking the right questions. I think there is better oversight now but if you want wider than our exec team, I don't think people would have an understanding of what the DI does. There is still limited understanding of what mortuaries do and I think most people within an acute trust will not have to know about it. But they will send a body to the mortuary and that is all they need to know.

But I think there are wider implications to that, people not understanding.

MR KAUSHIK DASGUPTA: I entirely agree with my colleague, I just cannot remember that date when we got that invitation to attend. Actually for us three things, which I, just the words came to my mouth, the terrible triangle, the HTA, the UKAS and Fuller Inquiry, all three things coincided for us. All three things came together and I can't remember the exact date but in my experience I could say before that nobody knew anything about any of us, the system and what happens. But after that, at least I am happy to report that, particularly I speak only for my organisation, they definitely know almost everything and I've got full unfettered access to anybody if I want to discuss anything. Most of the

things are really in place, streamlined, the governance and the accountability structures and all these things are really -- have been sort of tightened up and working very, very well, the assurance… work. And I think just the one invitation and two inspections have made an absolute sea change to the entire landscape. I really cannot thank you enough just for that, that thing has changed everything.

MR STEPHEN DAVISON: I agree and up until probably the last three months, the executive boards probably didn't have much of an idea that we existed other than we put a business case to get new fridges, freezers for the mortuary. But since then I have had a meeting with the chief executive, the chief medical officer was involved, he is the licence holder and he always had an understanding of that but at executive level there was not oversight. But now we have, since this Inquiry has started, and reported there has been a higher level of acceptance and now knowledge that this role exists and what can now do by preparing reports every six months, to report back to an executive team. So that is sort of been borne out of this review process. That is good actually.

MR SIMON WHALE: What about in non-NHS hospitals?

MR JAHRAN ALLEN-THOMPSON: So I mentioned in my interview

that the governance structure for the two local authorities that I work with is slightly different. But in relation to Waltham Forest, where I have been for about 15 years, the local authority, senior leadership and corporate licence holder are all very interested and engaged in what is happening in the mortuary service. Specifically due to capacity, challenges and concerns in East London in relation to the amount of deceased that pass away per 100,000 and the amount of storage we have per 100,000, there is a glut in that space. Meaning that every winter without fail we would take in a large amount of individuals from other parts of the East London Coroner's jurisdiction, especially during Covid. You can imagine what the challenge was then. So yes, the local authority are very interested in what is happening in the mortuary.

We have very recently renovated the facility and that had started during Covid but the original project began before Covid. Significant capital investment in rebuilding the new facility and that was supported by all parties, coroners, et cetera. We also meet, or I also meet with the coroner and my corporate licence holder in that one setting. I think it is a monthly or bimonthly basis, yes. I could keep going. There is tonnes of interest from local authority in SOT and what

we do.

MR SIMON WHALE: Thank you.

MR MUDHER AL-ADNANI: As mentioned, we had sort of a sudden interest in the mortuary activity during the Covid pandemic simply because of the number of deceased people and sort of this as a pandemic went away that more or less went down a little bit and then unfortunately with the Fuller incident, again the interest increased again from the -- certainly as the knowledge of the whole role of the DI or mortuary activities among let's say higher management, whether it is a hospital, pretty minimal I would say, which brings me back again to the first question that we asked, as in who should be the DI, which again goes against the opinion that it should be one of a senior manager because the majority of them don't have a clue what happens in the mortuaries so how can they be the DI? Unless you are very lucky and you sort of have a senior person who is actually interested in the mortuary function.

MR SIMON WHALE: So that waxing and waning of interest, partly down to the pandemic and partly down to this Inquiry. Do those of you who experience that expect that to wane again when this Inquiry is finished.

MR DANIEL SHINGLETON: Very similar things have been echoed. Obviously there has been an extreme surge in interest in

the mortuary. Previously seen as a sidestep on to the pathology directorate. Now, since the interest in the -- we have had risk register items looked at, items of equipment purchased, monthly audits scheduled with senior leadership team. For every single mortuary on our site, my concern is how sustainable is this actually long term and in let's say two or three years' time are we still going to be seeing these monthly visits by people at that particular level or are we going to revert back.

MS REBECCA CHALONER: Rebecca Chaloner, secretary to the Inquiry. I would be interested to hear from colleagues here from the medical education sector how well you feel the role of DI is understood within the medical schools.

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial college London. Obviously I think we are a much smaller kind of unit compared to mortuaries and the various sites and a lot of us will just have one main site and satellite sites. For myself I was appointed by the leadership team and I think it is important that you are visible, that you have those relationships with the head of the medical school all the way up to the provost, so they understand what your responsibilities are. So for me personally they do understand that but I also don't know whether it is because, you know, I have been there

a long time and part of, you know, many committees that go through healthy, HTA et cetera, that gives me kind of more of a presence.

MS CATHERINE HENNESSY: Catherine Hennessy, Brighton and Sussex Medical School. I feel like it is a similar experience to what others have said. During Covid, we were asked to kind of come on board to help with the storage of excess bodies that were around, so I think that that highlighted what the anatomy department does and handling of bodies. And I think that is when, again, the Dean of the Medical School and maybe Head of Medical Education would have been more aware of the Designated Individual's role. And the same thing again with the Fuller Inquiry, a lot of the emails have been directed to the Dean of the Medical School and then it gets passed down eventually to myself or whoever. But up -- I think we had -- we also had an HTA expectation recently as well, so again that kind of brought other more executive people into the communication line. But other than those instances I wouldn't say that the Dean of the Medical School or kind of people on the executive committees would be very aware of the role. There are other Designated Individuals across the university, people who are holding human tissue in research labs and things like that. So we do have a DI group within the

University of Sussex and then we have a corporate licence holder as well. So those people will be aware of the DI and their role but people more like the Dean of the school, I am not sure if they know, if it is in their everyday thoughts, what we would be doing. That is my feeling. It could be different to what Rachael says.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals. I think there is a real challenge in this between the importance of the activity and the scale of the activity. So in the county of Gloucestershire, just under 50 per cent of people who die, die in one of our two hospitals. We employ, including our subsidiary, about 9,000 people. But we have three people who work in the mortuary and a mortuary manager across two sites, plus a licence holder, plus myself. So in directly running the mortuary, there are probably about 5 or 6 people in an organisation of 9,000. Plus obviously our security staff and porters who move the bodies around. But that is only a small part of their role. So it is at the heart of one of the -- all of the issues, which is why is there anybody to take over as a DI, why is it so difficult to find people to take over. But there are just not that many people involved, at least in what is one of the busiest district general hospitals in the

country involved in running our two mortuaries and therefore there are not that many people who know about what is going on.

So the Fuller Inquiry has of course raised attention at executive level. And I agree with colleagues, prior to our invitation to take part in the Inquiry I am not sure that many of the other executives, with the exception of the chief executive actually, had any idea about the role of the DI.

Our governance structures are good and clear and escalation happens but when you report by exception only, if there are no exceptions to report, you are not continuously reinforcing the knowledge. And even if your governance structures are good, when there is only a handful of people involved it only takes one person, a busy medical director to take his or her eye off the ball, for them to fall down. Because processes are only ever as good as the people involved in them or good processes can be subverted by bad people. So it is just very difficult to get this right because of this balance between the importance of the activity and actually the relative small-scale in terms of the number of people employed to deliver the activity in a very complex and large organisation.

MR SIMON WHALE: Thank you. Can I just explore this issue

of routine reporting versus reporting by exception. Is there anyone here who routinely reports on mortuary activity up to executive level? No.

Yes?

MS LOUISE FOX: Louise Fox, Hampshire Hospitals. Only since the Inquiry. We didn't before but now we do on a monthly basis through to our board sub committees.

SIMON WHALE: Right. Every month?

MS LOUISE FOX: Yes.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals. Strictly yes. That is because I am an executive but if I was not an executive there wouldn't be any routine reporting through the governance process because that would be by exception through to our quality and performance subcommittee.

MR SIMON WHALE: What about those of you in local authorities?

MR JAHRAN ALLEN-THOMPSON: yes, so my reporting line sees me reporting into our corporate licence holder who is the director of governance and law. He meets regularly with his exec director, section 151 officer, who sits on the senior leadership team with our CEO of the local authority. I also report weekly KPI data through that chain. And I have mentioned regular meetings of coroners, the coroner for East London as well.

MR SIMON WHALE: Thank you.
MR MARK CROXFORD: Mark Croxford, Birmingham. I don't do any reporting in. I am senior enough that it can get to a senior director and chief executive in two steps. I do think we report by exception. I feel particularly well supported around we have an aging facility and we are looking at replacing as you are probably aware but I am also under financial constraints and restrictions. Most of the stuff that I can get pushed through now is because I can say it is a statutory duty. So Birmingham under the 114 process can only do statutory work. So as long as I can point to it and say it is a statutory duty, it is a statutory requirement to have whatever, it is actually working. So the way in which the dips and peaks, I think the peak will come. I think there will be a loss of corporate memory and the only way we will keep it is by keeping on pointing out it is a statutory duty.
MR SIMON WHALE: Reporting by exception in your case --
MR MARK CROXFORD: It is completely by exception, yes.
MR SIMON WHALE: It doesn't present a problem?
MR MARK CROXFORD: It doesn't appear to. But as I say this is pretty new, this.
MR SIMON WHALE: And in Hammersmith and Fulham- differences?
MS CHRISTINA HOUGHTON: Yes, we have -- I have a weekly

meeting with the mortuary. We discuss storage levels, staffing, any other issues, facilities. And that is filtered up to my manager who is the licence holder and then he will take that up further if he needs to escalate any issues, whether it is to support -- requests for funding, whether there are glitches, blockages where we are not getting things done as quickly as we want to. That is a weekly basis. And then there are occasional reports that we write as well. I would say it is really the responsibility of the Designated Individual, after the Inquiry closes, it is our duty to make sure that we put pressure on management to make sure it continues with the momentum that has been created by this. And, you know, remain in focus because there are plenty of other priorities that the council will be looking at and that is one of our roles I think.

MR KAUSHIK DASGUPTA: As the HTA DI I have my quarterly HTA governance meeting and I get the full briefing on various aspects and on the aspects of the mortuary, but as a clinical director, until now, I used to have a monthly directorate meeting in which again I used to have a full briefing from the mortuary under a long two and a half hours meeting, but now going forward as a result of regional services, collaboration and

pathology merger and centralization, which is almost a precursor to an impending trust merger in the very near future, we have decided that the pathology business meeting now, which is across two trusts, will also be by exception, and that means that as the clinical director I will be having in my main business meeting also reports on mortuary only by exceptions. So I have to wait every quarter to have a full view. Of course I would replace that with a monthly sort of one-to-one discussion with my PD, the senior mortuary manager, but this makes me somewhat uncomfortable that there is too much only reporting by exception rather than a sort of full briefing, which is something I had enjoyed for so long. But going forwards that may not be the case.

MS KAREN MIZZI: Whilst I am not currently DI but I have experienced it, my role is slightly different with the coroner's service. As I have explained our weekly meetings, the Designated Individual from the hospital for the SPS to deliver on the service is present. So we have a key performance framework as well, tracking every deceased that comes under our jurisdiction. Time levels as well, how long that deceased has been with us, are we progressing our work in a timely fashion, this is also the care and dignity of the deceased. We build our weekly -- moving on from my specific responsibilities,

I report into a senior leadership team, which is the coroner who chairs the monthly SLT meeting, which is attended by director from the council and I think if there were any concerns they will be escalated, which has been done in the past. Any incidents that need to be reported in very quickly to executive level they are escalated through that process. We have a good governance structure, even though I am not a DI at the moment, the three hospitals
we have oversight of what is happening from the coroner's perspective.

MR SIMON WHALE: Thank you.

What about formal reporting into the corporate licence holder? Should you be doing that, has that already happened?

MS RACHAEL WADDINGTON: Essentially that is my reporting structure. We have quarterly meetings and it is with the corporate licence holder, which can then feed up through executive committees and how they see fit, and actually I find that really supporting because when there is a request for, you know, some funding, it is a good way of getting that support to be able to deliver the standard that we need to deliver.

MR SIMON WHALE: Thank you. Yes.

MR MARK CROXFORD: Mark Croxford, Birmingham. In our world

it is my director who is the licence holder, again reported by exception and to my immediate boss. Biweekly, every fortnight, one-to-ones I bring anything up through there and I think through the Inquiry it was quite shown that the licence holder is removed. They struggled through the Inquiry questions.

MR SIMON WHALE: Any other thoughts from others on reporting to the licence holder?

MR CLIVE GRAHAM: I think you probably could evolve that into a reporting structure, prevention reporting, examples around other nursing standards on wards, why don't we -- why doesn't a recommendation come out that actually what licence holders should know in what is reporting or receiving from the staff, that seems eminently doable as a recommendation. That would encourage people to do reporting.

MR SIMON WHALE: Thank you.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospital. We are unusual in that I am the DI and the corporate licence holder is a senior member of a lab management team and therefore technically junior to me in the organisation. He is part of the whole governance process. So we meet regularly anyway as part of the governance process for the mortuaries. But actually if, in terms of reporting directions it is the other way

round in our organisation.

SIR JONATHAN MICHAEL: Can I just explore some of the other -- Mark, you raised earlier on the disparity between the size of the retroactivity the size of the responsibility that goes with it because that was the thing which again if you read the Phase 1 report was flagged in relation to Maidstone and Tunbridge Wells.

How do you think that discrepancy where you have got a significant legal responsibility for a relatively small part of the activity of an organisation, the same must apply presumably in local authorities and indeed in medical schools, how is that addressed?

MR MARK PIETRONI: Before I came today I would have said the way that we have set up within our organisation works well, because you have got a senior board member who holds the legal responsibility and I shouldn't be in my role if I am not experienced in discharging legal obligations of this sort, even if they are a relatively small part of my time and commit. Listening to colleagues around the table, I think it is going to be a function of the size of the organisation. As I have described, we simply are not big enough to have a full time DI. It is only ever going to be a portion of somebody's role and therefore I am not sure that there is a one size fits all model. Nor do I think, and

I am reflecting as we go, that it is possible to get away from the significance of the individuals involved in running the mortuaries, because of this scale versus significance issue. And therefore it is really important that whatever processes we put in place in future, ensure the professionalism and the -- I don't know, the professionalism and the ability of those individuals because it is going to hugely depend on those individuals.

Yes, so we could -- we have talked about flipping it round in our organisation and having -- I would become the corporate licence holder and the senior lab manager would become the DI, and listening to colleagues around the table, I can see benefits in that. Largely more time focused on the mortuaries themselves, subject matter expertise, et cetera, but I think at least within our organisation, there would be a risk that we have talked about capital expenditure, needing to replace fridges, CCTV, locks on doors, those are all things I've got involved with at executive level and been able to, fundamentally, in organisational terms, have a quiet word with the finance director. And these things have gone through. Whereas if I hadn't been the medical director, it is unlikely that that would have been as smooth. So I think there are pros and cons to where you

site that legal or formal responsibility.

MR MARK CROXFORD: I think the most important thing with the DI role is actually our employers dedicate some time to it. Because I think, I don't know about the NHS but certainly in the local authority it is just added role. There was no -- I suppose there was a bit of finding the right person but it is very much a case of this is your job, and could you take over this and it is going to be passed over to somebody in executive that the head of grievance services are most likely to become the necessary DI. So they have a full role, everything is full and now all of a sudden you are going to have an extra responsibility. So anything I could recommend coming out of this is the boards and local authority, saying to them you should dedicate some time to this role because I think that is what is missing. I don't have the time. I do my best but I think we need time.

MR SIMON WHALE: Yes.

MS LOUISE FOX: Louise Fox. I have to echo that. For me, this is a job -- it wasn't part of my job description but I have taken it on and I think when I attended the HTA DI meeting a couple of weeks ago, there were people who were actually getting paid for the add-on to their role and I think there is disparity across the piece in terms of time, commitment, salary and obviously where we

sit on a structure and how that is fed through.

MS REBECCA CHALONER: Rebecca Chaloner, secretary to the Inquiry. Just on a show of hands basis, in a totally unscientific way, who has the DI bit of their role added on to their usual job?

MR KAUSHIK DASGUPTA: What do you mean by that?

MS REBECCA CHALONER: So you have your main role.

MR KAUSHIK DASGUPTA: Without any allocation --

MS REBECCA CHALONER: Yes. So, so almost except for two all -- all bar two. Thank you.

MR JAHRAN ALLEN-THOMPSON: I was going to save this bit for the "what needs to change" portion, which I think is coming post break.

I was going to save this for the "what needs to change", which I think is coming after the break but since we are making suggestions on what needs to change I think some benchmarking would be helpful, as you guys can see, at this stage the picture of what it is a Designated Individual does and who does the job role et cetera is skewed from the group we have with us. But I meant benchmarking in terms of that, as well as -- so what are we all allowed to spend on our relative mortuaries or services and is the budget allocated in relation to the amount of individuals that we are processing, how did that work out, sort of thing. I

think that would be a helpful exercise hopefully to come from this.

MR SIMON WHALE: So we will break for 15-minutes and then come back and we will start on session 3 in 15-minutes time. Thank you very much for your contributions so far, it has been really helpful.

(2.15 pm)

(A short break)

(2.31 pm)

MR SIMON WHALE: Welcome back, everyone, and thank you very much again for the discussion in the first half of this session. We all valued it tremendously, thank you.

We are now going to move to topic area 3, which is all about the challenges of being a DI. We have obviously heard a little bit of that in the preceding session but it would be really good to expand on that a bit more and delve into it a bit more.

So this is a reminder that when we conducted Phase 1 of the Inquiry, we heard the challenges of the role of DI as it was at Maidstone and Tunbridge Wells NHS Trust. We would like to explore those a little bit further and really to understand whether those are generic challenges that DIs across the country face or whether there was something specific to what was going on in Kent from a DI perspective.

And we would also like in particular to understand different challenges for those of you in different sectors, NHS, local authority and medical education and research.

So, just a quick reminder for the benefit of the stenographers at the back, please do speak as loudly and clearly as you can so we can capture everything that is said.

So I would like to start with a pretty broad question: what in your view are the main challenges of being a Designated Individual?

MR KAUSHIK DASGUPTA: Kaushik Dasgupta, consultant pathologist, University Hospital of North Tees and Hartlepool NHS Trust. So I think my answer to the question has evolved every since I started and then gradually over the years and particularly after the Fuller Inquiry invitation came in and even today. So my main concern, my main problem that I felt initially that it seemed a lot of responsibility with very little authority or real ability or access to be able to do or influence anything or to ensure or to give that assurance to the trust, to the HTA, that the things are all in the right place. So that was, when I started, that was my main concern or problem. But then, later, when I became the clinical director, then I really

thought I was part of the Trust Directors' Group, I was meeting the medical director regularly, I was taking the things to the Trust Directors' Group meeting, I could meet the chief exec on appointment whenever I wanted. So I really felt that I was making inroads into the thing but I am still not convinced that if I were not the clinical director, if I remained only in the role of a Designated Individual, whether I would have that sort of an access and facility to discuss and sort of leverage these things and that is something I think should happen but I am not sure if that happens in a real life situation.

But on the contrary, I have also felt that because I do not do the postmortems anymore, I am slightly removed from the ward or floor level working side but I think only today I realise that gives me a sort of an independent third party, so I was almost the first, second party when I started but now I have become almost, although I know and understand that fully well or very very well, but I am slightly stepped away from there and I've got a good links with the organisational superstructure above me. So I think that is a positive thing, but at the same time, I think I am really, my problem is a portfolio of roles with a lot of service level merger and Trust level group structure with which

I am involved with in our organisation. I have always thought that this is a too large a portfolio to be accommodated by one person and maybe this is a role that can fall casualty to that, and may be the one which could be neglected at the expense of the others and that is why I think I have been very constant -- want to pass on the matter to somebody else.

MR SIMON WHALE: Thank you very much.

What about others in the room? What do you see as the main challenge of being a DI, yes.

MR MUDHER AL-ADNANI: Mudher Al-Adnani, Guys and St Tommy's NHS Trust. I think, reading the Phase 1 report and what the DI was saying, based on I talk but nobody listens to me, I think that resonates very well with I think most of the DIs, broadly speaking, in the country. Because I think there is very small proportion of the DIs who are at board level or high executive level. I think the majority of the DIs are, you can call them normal staff, junior staff. So certainly sometimes you read off the HTA website or other reports and they think, they assume that the DI is this person who can walk into the chief executive's office and say please can I have £100,000 to replace the mortuary fridges and the chief executive will open the cheque book. That never happens. It is a fight to implement what the HTA standards are. So

I think that is the main challenge, basically. I don't think -- the sort of assumption of the responsibility or the power of the DI is completely different from the actual power of the DI or the authority of the DI. You can tell you are junior mortuary staff, you need to follow X, Y and Z. But go and tell the chief executive or the board members we need X and Y because these are the HTA standards. People will look at you and think who are you, first. Who is this person who is saying I am the Designated Individual. So yes, I think there is a complete imbalance between the assumption of the role of the DI what actually happens in the real world.

MR SIMON WHALE: Okay, thank you.

MS CATHERINE HENNESSY: Yes, Catherine Hennessy, Brighton and Sussex Medical School. I think maybe not the main challenge but another challenge is the time that is needed to put into the role. Because as we have seen, most of us are doing it as an add-on to our normal day job. The things that come up as a DI normally take some time to think about, and to think about what actions. So it is -- I think it is just that it needs time and you don't always have the time to really dedicate to it fully. I am sure all of us do that but it will be at the sacrifice of other jobs that we are doing that day or maybe we are wanting to continue on working outside

of our normal working hours to make sure we are doing the work.

So I just think, yes, it is time that is another challenge to do the role properly. And to make sure all governance policies, everything is kept up to date. Yes, I think time is another challenge.

MR SIMON WHALE: Thank you. Yes.

MR MARK CROXFORD: I agree. I think time and the lack of ongoing training -- I just lost my train of thought. The other thing I think is a hindrance is actually a lot of people do do this very well. So the mortuary staff take a great pride and do the job really well and as a result of that, we don't have to escalate things very often. I think that in itself is -- causes a problem. Why would you prioritise this when you have got other problems that are coming up all the time, particularly around local authority. So if you can keep a good control of what is happening, I think that is also a barrier and that is why I say this thing about having a statutory duty and maybe having it recognised as a statutory duty and more reporting would lift it out of that because the only time it comes up is when there is a problem.

MR SIMON WHALE: Any other challenges, yes.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals.

So I think the lack of clarity around the role and the expectations of the role makes it very difficult, particularly for when you are starting out, to know what the role is. And that is not just the DI role but it is the whole cascade, the corporate licence holder, the PDs, et cetera. And then, secondly, I think because as we are evidence of, pretty much every organisation does it slightly differently. That means that, for example, succession planning is difficult to pin down. So there are a number of legal roles that come to me as medical director. Called to court guardian is one for example, or guardian of safe working or appraise and revalidation of doctors. All of those will be delivered by my successor or at least my successor will be responsible for delivering them. So I am working with my deputy medical director and my associate medical directors to make sure they are experienced in doing those, because I know those are fixed roles that go with what I call the MD office function. The DI role is not so fixed. It could go to the chief nurse. It could go down to the lab manager and there is a -- there is just no clarity over who will take it next. In my organisation, it happens to sit currently with the medical director. That is unusual, as is evidenced by this. So the simple fact that I am having a conversation within the

organisation about where the DI role should sit, implies that there is not a clarity over where the DI role sits within the organisation.

MS JANE CAMPBELL: Can I just come in? Jane Campbell, Inquiry team. We noticed that in HTA inspection reports, there is usually a line that says the DI is suitable for the role. I would be interested to understand how they reach that conclusion, whether that is as a result of another assessment of the DI, when they are doing an inspection or.

MR DANIEL SHINGLETON: Daniel Shingleton. The DI is interviewed separately as part of the inspection, part of that assessment is whether they are suitable for the role. It is the same style of assessment where a new DI is appointed. The HTA has a Teams call with them to establish whether they have sufficient knowledge and whether they are suitable to take on that role.

MR SIMON WHALE: Yes.

MS LOUISE FOX: Louise Fox, Hampshire Hospitals. Just to pick up on that new point because I am relatively new to the DI role, that Teams call is quite light in terms of assurance. It was very -- it was a very lovely chat but there wasn't a lot of rigour to it in terms of an appointment process, I would say.

SIR JONATHAN MICHAEL: Can I just ask whether or not when you were

appointed you were, or before you were appointed, you were given a list of the things that you were therefore required to be able to show to be a satisfactory DI?

MS LOUISE FOX: Yes and they gave -- they sent a lot of links to articles and information on their website which clearly I read before I was interviewed and then I did some wider research. But I don't know if any of that was particularly necessary. I suppose it will depend on the individual -- I mean in terms of the conversation.

SIR JONATHAN MICHAEL: Thanks.

MR MARK LANKESTER: Yes. Mark Lankester, Norfolk and Norwich. I have only experienced one inspection as a DI but when that happened the meeting with myself was cancelled. They said that they didn't need to do it, so they didn't. They didn't talk to me at all other than in the intro meeting at the beginning and one of the other general meetings about consent. So it was very little interaction with me at all.

MR SIMON WHALE: How long ago was that?

MR MARK LANKESTER: That was about two, two and a half years ago.

MR SIMON WHALE: Right. Yes.

MR DANIEL SHINGLETON: Sorry, Dan Shingleton, NFT. I am just going to add an element on to that. As part of the DI approval process the corporate licence holder contact

has to also approve that that person is suitable to be the Designated Individual. That almost looks like it is a shift to the Trust saying that this person is fine when there is obviously no outward training that is involved as that person proving that they are suitable to that corporate licence holder content.

SIR JONATHAN MICHAEL: How does the Trust satisfy itself that it can give that assurance.

MR DANIEL SHINGLETON: Yes.

MR KAUSHIK DASGUPTA: Kaushik Dasgupta, consultant pathologist, University Hospital of North Tees and Hartlepool NHS Foundation Trust. So I just wanted to sort of compare and sort of contra distinct with the other role, sometimes that is common in the pathology laboratories and that is the role of a laboratory director. And that is of course in most instances overseen by the United Kingdom Acquisition Service, and they have got a very specified, very prescriptive as to who can and who cannot be a lab director. Whereas I felt that for the DI, there is no such -- there is no such sort of really strictly specified person specification. It is like a matter of interpretation to the extent anybody and everybody could almost be a DI. So it is a very nebulous or very, very woolly sort of -- undefined area mostly.

MR SIMON WHALE: Thank you. I would like to ask a question about legal responsibilities linked to what we have just been talking about.

Where should legal responsibility lie for complying with the requirements of the Human Tissue Authority? Should it be the DI or should it be the licence holding organisation.

MR MARK CROXFORD: Mark Croxford from Birmingham. I think it should be the organisation that has to be legally responsible because then that is going to give them the imperative to put time and energy into it.

So the organisation that is responsible. As with all public offices, if you are doing something completely wrong, misfeasance in other words, then I think it should come down to the individuals as well. And I think that everybody around the table has some level of seniority because I think that is what the HTA are looking at when they are looking at the DI.

Honesty, so the honesty, are they likely to be reporting incidents, do they have an understanding of the regulations, I think that is what they are looking at.

Yes, so it has to be dual but more the misfeasance side and then the organisation must be responsible.

MR CLIVE GRAHAM: Clive Graham, North Cumbria Integrated

Care. I agree. I think it is for the organisation because some of the issues that I have seen with DIs -- and actually if you want to compete for resources in terms of kind of security cameras, new fridges, staffing, to my mind that is better with an organisation because they are the ones that can actually hold the purse strings and deliver those requirements.

MR SIMON WHALE: Right. Okay. Any other thoughts on this? Yes.

MR JAHRAN ALLEN-THOMPSON: Jahran Allen-Thompson. I believe the individual should be responsible. So that Designated Individual themselves should be legally responsible for the -- insuring that licensable activities are correctly carried out.

MR SIMON WHALE: You think it should be the individual not the organisation.

MR JAHRAN ALLEN-THOMPSON: Yes.

MR MUDHER AL-ADNANI: Mudher Al-Adnani, Guys and St Tommy's. I think if you tell the Designated Individuals you will be legally responsible, nobody will take the job. It has to be the organisation I think. Most of the time the DI or again with a few exceptions, the DI is appointed or the person who takes over as DI, you are lucky to have someone who will volunteer to do it. It is usually passed on or handed on to someone. So if you

add on a by the way you are the legally responsible, I don't think anybody will take it.

SIR JONATHAN MICHAEL: That is the current situation, isn't it?

MR SIMON WHALE: Is that reluctance because of the legal duty, is that why people are reluctant or is it because they don't have time --

MR MUDHER AL-ADNANI: As I said before, if you tell that person you are legally responsible to take on that, to make sure all the requirements are complied with and so forth; at the same time you have minimal authority to be able to actually implement what you think should be that -- again, it is a complete disparity between the expectations and actually what you are able to do.

MR SIMON WHALE: Okay, yes.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals. I would support the legal responsibility being with the organisation rather than with an individual but that doesn't mean you cannot outline legal duties of individuals working within the mortuary service.

Because then I think it would be on a par with every other legal obligation that sits with an NHS trust. I recognise that the difficulty of legislating for different sectors because they operate differently. So NHS trusts for example have something called a fit and proper persons test for people sitting the board level,

which if the DI is at board level, answers at least in part whether or not you are an appropriate person to be the DI.

But as a board we have shared responsibility, and accountability, for delivering the whole of the organisation and I think that is appropriate for this as well, as other duties.

MR SIMON WHALE: Yes.

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London. I think I just wanted to echo your comments and you can -- sorry, you can have that, the organisation being legally responsible but you can have that governance but also making sure that you do capture the PDs or your nominated individuals as well because they are acting on behalf of that organisation. So to just strengthen, you know, the information and outline the responsibilities for those positions.

SIR JONATHAN MICHAEL: Okay.

Can we just have a show of hands as to what people think about the organisation or the --

MR SIMON WHALE: Okay, we are going to do a vote, show of hands. Those in favour of changing things so that the licence holding organisation has legal responsibility rather than the DI, who is in favour of that?

MS REBECCA CHALONER: Everyone except one.

MR SIMON WHALE: Thank you very much for that.

I would like to move on to a different topic within this area. You have touched on some of this some of you already but want to drill into it a bit further. This is about your degree of influence within the organisation.

So do you feel that you have sufficient influence within the organisation that you work in to advocate for mortuary requirements or the equivalent in other areas; and sufficient influence also to fulfil your role and responsibilities as a DI. And it is interesting to understand the disparity or the difference between sectors here. Thinking for example about the shortfall, sorry, the differential in shortfalls. HTA identified shortfalls between sectors, so between the anatomy sector and the post mortem sector there is quite a distinct difference in the volume of shortfalls. To what extent does that link to the DI having sufficient influence to get what they want and get what they need for their mortuary or setting.

MR KAUSHIK DASGUPTA: Kaushik Dasgupta. University Hospital of North Tees and Hartlepool Foundation Trust. Yes, I think, answering two parts, the answer is yes to both those questions, that I have the sufficient influence to give the assurance and guarantee to the Trust and to

myself. But that is not because I am the DI, but purely because I happen to be the clinical director and I want to see that it should have nothing to do with that person being clinical or medical director, being the Designated Individual for that trust for HTA purposes. It should be necessary and sufficient enough to give that cast iron guaranteed assurance irrespective of whatever could be their other roles in their extended portfolio. Which I do not believe is the case.

MR SIMON WHALE: Thank you. Yes.

MS LOUISE FOX: Louise Fox, Hampshire Hospitals. I have to completely agree. I do think that I've got influence in my organisation but I report directly to the chief nurse who is the -- who is not the licence holder but she is the delegated individual for the chief executive for mortuaries. I also lead, as part of a triumvirate, the division that pathology and the mortuary sit within. So in terms of budgets and capital planning, all of that comes through us because the pathology team report directly to me and a doctor and an ops director. But again it is not about being a DI, it is about the other role that I sit within.

MR SIMON WHALE: Okay. What about in the medical education arena? Do you feel you have got enough influence to be able to carry out the role effectively.

MS CATHERINE HENNESSY: So I think having -- again, that kind of extra bit of seniority in your role, it does -- and being DI as well, helps, helps with getting things done and getting -- and being heard.

MR SIMON WHALE: Yes.

MR MARK CROXFORD: Mark Croxford from Birmingham, sorry. From a local authority point of view, I would say that I have enough power for the legal requirements. But anything which is not a legal requirement, I think we are going to be struggling with. So if you take the CCTV, which has just been mentioned, I would really struggle to get that in place because I can't actually

say here it is. I could point to mortuary security but unless I can actually back it up and say this is a legal requirement, I think you are going to find great difficulty. There just is not the money there. So my answer to the question is: with regard to the HTA, I think I am okay; with regard to proactive steps to stop something happening that I might think of, I think I am struggling. I think I would struggle to do that.

SIR JONATHAN MICHAEL: Unless it is a legal requirement.

MR MARK CROXFORD: If it is a legal requirement I could do it. So if someone wanted to bring in a set of regulations, that would be fine. If it is the HTA bringing in the licence conditions, that is fine. But if you are saying we think this could be a risk, you have identified a risk like you do risk assessments, I don't think you will get those addressed.

MR SIMON WHALE: Can I ask Christina, is that your experience in Hammersmith and Fulham.

MS CHRISTINA HOUGHTON: Yes, I agree with the gentleman, Mark. I think to some extent you do have a certain amount of influence but you are never going to get everything you want, particularly in terms of staffing. And that is always a challenge in the mortuary industry, having qualified technicians and pathologists. So yes to a point. But you just don't have the budget to pay

for absolutely everything that you feel is important.

MR SIMON WHALE: Yes.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals. On the actual question, yes, I have influence but as with other colleagues, not as DI but as medical director. I just wanted to pick up the point that Mark made about licence conditions. This is perhaps something for, Chair, you to reflect on, because we no longer do post mortems, I could technically, as an organisation, we could technically rescind our licence and the HTA have made that clear to us. So the danger is if we link legal obligations to licence condition that organisations like mine might say that is too expensive, we will give up our licence. Whereas I think the licence provides a degree of transparency, and external oversight that is important in this field.

MR SIMON WHALE: Yes.

MR JAHRAN ALLEN-THOMPSON: Jahran Allen Thompson. To answer your question, yes, I believe I have what I need to do my job and I get what I require to be able to discharge my duties.

In relation to sort of the different opinions that are around the room about ensuring that local authorities and the NHS facilities can get adequate support, I think in our local authority --

MR SIMON WHALE: Jahran, can I ask you to speak a bit louder?

MR JAHRAN ALLEN-THOMPSON: In our local authority, there have been challenges specifically around how services are funded. In 2017 when I began managing the service, the ask from finance was if you can make the service cost neutral, effectively, you can buy within reason what you would need. Yes, there is still a governance process in place of business cases and taking those business cases to board, for more -- definitely for security but for more resources. Which is something that I have managed to do. Yes, so I just wanted to give you guys a flavour of my challenges.

What I would say though is around pathologists, there is a national shortage of them. Around anatomical pathology technologists, there is a national shortage of them. The NHS has a long-term work force plan, I believe. Local authorities do not have a long-term work force plan, especially one that covers mortuary services and staffing. Most buildings, and I want to be fair, anyone else's but my own one, but most buildings that facilitate mortuary work are old and have not been very well maintained. And as I have said, local authorities, only from my experience, are shifting more towards how do we fund these services. They don't want

to create loss leaders. So there has been times we have been successful in doing, in East London, making sure that the facility is cost neutral. But I think it may be a challenge for some of my colleagues.

MR SIMON WHALE: Thank you. Just thinking about those of you in local authorities and I guess in the NHS as well. To what extent is the pressure of the flow, if you like, the number of deceased people, to what extent is that the challenge for you as a DI, is that a major part of what makes the job challenging?

MR DANIEL SHINGLETON: Dan Shingleton, NFT. As part of the HTA codes of practice there is a requirement to move deceased patients which are classified as long-term after 28 days of refrigerated storage. This is a requirement that came in relatively recently with regards to the HTA codes of practice. I don't doubt if we went round the room and if we talked about freezer capacity at individual mortuaries to accommodate deceased patients which have been stored for longer than 28 days, we would all be saying we do not necessarily have sufficient freezer capacity to store those deceased patients, especially during periods of winter pressures. As part of that, there is a movement towards for example if we combine that with Human Tissue Authority reporting requirements for accidental damage to deceased patients,

and you can then go a deceased patient has been in storage for excess of 28 days, they have deteriorated in storage and therefore it would classify as an HTA reportable incident. There is almost a regulatory requirement which pushes through the facts that we are dealing with -- if we go round the table -- mortuary facilities which have not necessarily been updated in a recent time and a regulatory requirement around that. It becomes exceptionally difficult because we are fighting with the regulatory body on one side and then we are fighting with funding to get that increased freezer capacity on the other side. Which is an ongoing challenge.

MR MARK CROXFORD: Mark Croxford from Birmingham. I would echo what has been said. There is a lack of freezer space and the other thing to remember is we are at the front end. Hospitals are very soon after death. The coroner is pretty soon after death. Some funeral directors, certainly in Birmingham, we are talking of four weeks before the funeral is arranged. So when you are talking about getting the dignity of the deceased, we have got to get our end well because even if we release after a week there could be three weeks while it is in storage with NFT. So there is questions around the storage facilities for NFTs. But it also makes it

imperative at our end that we are doing it well. We have had to have a big push on the council paid for funerals, because a lot of the freezer space was taken up with that. So we had a section that used to sort of -- every six months they could come in say we will move the deceased from there. So that caused us a huge amount of problems with freezer space. So we have had to have really good pressure on social services to get that sorted and that has eased it. But even amongst what we have just said you have got to remember we are at the front end, so the families are going to get their loved one back days before -- so they are going to get it back for sometime but it could be with the funeral director for a couple of weeks and if you want them to be in good quality we need to have better storage throughout.

MR SIMON WHALE: Yes.

MS LOUISE FOX: Louise Fox, Hampshire hospitals. We always have just enough capacity. Freezer space is a challenge and I was going to pick up about not the welfare funerals but the people who sit just outside of that. They don't necessarily meet the criteria but people are struggling economically which is causing some significant delays for us. So we will have patients that we are on the cusp of having to move to the

freezer. It is a bit of a game of chess because people, you know, are working with their local authorities but not meeting the thresholds in terms of their financial situation --

So that is a challenge for us. But also mortuary infrastructure, if you look at the population in terms of bariatric patients, so those deceased who are bigger, that is rising exponentially and that is causing a challenge for us in terms of the very limited capacity in our system to care for these individuals and we are having to relatively frequently make do. And sometimes that is about losing other capacity in order to accommodate somebody that is bigger. And you have to, you know, use a lower shelf for example, which means you then cannot use the rest of the fridge capacity, so that is a challenge that is going to increase, especially where we have got old buildings.

MR MARK CROXFORD: Mark Croxford, Birmingham. Just to give you an idea, if it helps the panel. We have just changed one of our stretchers. The old bariatric standard had 200-kilograms written on the side. The new one has 450-kilograms. It gives you an idea of the monumental challenge. It is about possibly 15 years, more likely 10 years between the two. So it gives you an idea of the challenge. It is not unusual to have

people now in excess of 30 stone and the fridges and the freezers are just not constructed for that.

SIR JONATHAN MICHAEL: Could I just get us to come back to the point that Simon made earlier on, about the difference between the HTA data on non-compliance in terms of the post mortem sector on the one hand and the anatomy sector on the other, where the anatomy sector has significantly smaller numbers of failures to comply, compared with the post mortem sector. Can we just explore a little bit about why that difference may be?

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London. 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 will all of our standards and guidance have been quite controlled over the years and we have much more limited activities. They are for very specific activities. So I think there is just quite a big difference in what we do and the numbers that we deal with donors.

MR SIMON WHALE: Karen.

MS KAREN MIZZI: Karen Mizzi, Surrey County Council.

I think it is about ownership in the death management pathway. From our own experience, our hospitals have -- are feeling that same experience of capacity, because of the footprint of the mortuaries were built many, many years ago. So there is a collective responsibility and we see it from our local authority. We have worked collaboratively with the NHS to provide a body store to be opened in times of capacity. It has reached across all the network. Up to 330. We have improved, we have invested because I think the local authority takes its role seriously. It is required to provide that financial support to the coroner to discharge their legal obligation. So we have worked really hard with the ICB and the NHS Trust collectively and that has addressed the issue around capacity.

I think the other part of it, the ownership, comes -- there are two pathways. There is the natural death pathway and there is the unnatural death pathway. And your bereavement officers really key in how you manage your deceased within your hospitals. We found that there were gaps because there was a lack of knowledge and understanding around the interdependency between the two pathways. We need to keep the capacity available to allow the throughput of deceased -- you will agree I am sure, Jahran -- once you get a glitch in

that the backlog starts and that then impacts on your ability to move the deceased through as quickly and with the dignity that they deserve. The impact on the pathologist availability, particularly those that are not delivering a digital service, so it is a full on invasive service for us at the moment. And I think more importantly the funeral sector. The interdependency with the funeral sector because at every stage, as soon as someone starts in the pathway, it depends when they leave it, when they are collected and when they are allowed have the dignity of their burial or cremation. So I think wholesale it is about collaboration but also recognising the interdependency. It just doesn't sit with the DI. The DI is there to make sure as best they can to look after the deceased and comply with the law, but you have all the other elements within the sector that are not recognising how important their role is to keep the system moving through.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals: I think you also need to factor in the very real differences in the way that the three sectors work financially, and even in a world in which universities, local authorities and NHS were equally funded, which they are not -- which is a political conversation rather than an operational conversation -- local authorities,

having been a senior officer in a local authority for six years myself, they take their legal responsibilities very seriously and they are used to planning multiple year timeframes 5, 10, 15 years, and they do infrastructure products. The NHS, it is very difficult, we don't even -- we have a capital plan for next year that we are writing now. We don't have a capital plan for the year after or the year after that or the year after that.

Universities, I have never worked as a senior officer in a university but again they are used to large scale capital projects and they plan those much better. So the ability for colleagues working in the NHS to get the kind of investment that they need into the mortuaries for example is just much more complicated, because the financial focus of the NHS is fundamentally one sometimes two years, but even when it comes to capital planning and that makes a huge difference to the way in which these large scale projects are rolled out.

MR SIMON WHALE: So the manifestation of that is services which are suboptimal, is that?

MR MARK PIETRONI: Yes and the ability to prioritise -- you are always prioritising in year rather than over a five year or 10-year timeframe. So I might not get the money this year for the mortuary but everybody recognises that

within the next three to five years it needs to be refreshed. And then you have a five year capital plan. But if I am always doing that year in, year, in year in, there is always something that is a higher priority within that immediate year. So that ability to plan over multi year when it comes to capital I think significantly hamperers NHS organisations in dealing with this sort of thing.

MR SIMON WHALE: Rachael.

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London. You are correct, I would love to say that it was always that simple. But it is not. We do also find the challenges. We are subject to budgetary controls we have to request but maybe it is easier for us to plan those. But I think essentially is the purpose of what our scheduled event is. I think that is the difference of -- and I would say ownership, but ownership in terms of, you know, the donors we have, we embalm them and depending on consent they can stay with us for as long as we need them. So the process and the activities do I think massively impact the kind of reporting of incidents.

MR CLIVE GRAHAM: Clive Graham, North Cumbria. Just to give an example of some of the issues. So we are currently having our mortuary refurbished but one of the reasons

behind that was (1) the Fuller report came out. (2) the HTA visited and said you have been using temporary storage for about 15 years. And the combination has allowed us to do it into the PFI and it is going to be more expensive than would be if it was in an NHS hospital. So we do get funding but it is a really competitive process to get that funding compared to other more demanding activities like a cath lab or a new endoscopy suite et cetera.

MR SIMON WHALE: Jahran.

MR JAHRAN ALLEN-THOMPSON: Jahran Allen-Thompson. What I would say very quickly about the Parish Burial Act is as far as I am aware there is no timeline in relation to how quickly local authorities have to execute that burial or cremation of a deceased person. So as far as I am aware, different local authorities interpret that differently. Some local authorities will have a deceased individual that will need to leave within 30 days and others would not. I know of cases where individuals have been "parish", cases and been in the mortuary for 20 years. Not in our jurisdictions at all but I think that would be a recommendation for the Chair to review, the Parish Burial Act, hopefully to try to provide us with that patient flow that we were talking about. And also very quickly I mention bariatric

storage being an issue and freezer storage. And bariatric freezer storage also being an issue and if you have bariatric and super bariatric freezer storage. So these are individuals that are larger than the largest individuals you can think of, so the 30 stones I have heard mentioned, the individuals that are exceeding 40 et cetera or 50 stone, where would they go, how would they be moved safely, et cetera.

One more on musculoskeletal injuries that technicians, technical staff members would find. There is a paper by Mike Osborn and APT, the reference, the sort of physical wear and tear of the job on people that are on that coalface side of things, managing deceased. So yes, more on challenges probably later on.

MR SIMON WHALE: Thank you. Catherine, did you want to come in?

MS CATHERINE HENNESSY: I was probably backtracking a little bit. I think my thoughts on maybe like the difference between the sectors as well, just to kind of elaborate on what Rachael was saying, and maybe to give you an idea. So I think maybe we would take in like a maximum of 60 deceased per year, so I am guessing that is like massively reduced compared to what the mortuaries would be dealing with. And those people are selected very kind of accurately for what we are doing,

for the scheduled purposes, sorry. So like weight, BMI would be considered, we need like an optimal BMI, and infectious diseases, that would be eliminated if they have had a recent postmortem and again they would not be accepted by us. But all of this is leading us to actually have a lack of deceased, lack of donors for our next academic year. But that is kind of our environment and what we are dealing with.

Then also like the -- you know, we are very kind of hot on code of conduct within the lab, so we kind of have to echo that to the students every year. So then I suppose we are very much aware of it as staff ourselves, like the code of conduct within the lab, how the deceased will be treated, all of that. And then, one kind of -- what I see is when, like a shortfall from -- it wasn't a shortfall but a suggestion from our recent inspection was around access into the lab and kind of how the HTA would predict what we need to improve on going forward as a result of the Fuller Inquiry. So we have swipe access into the lab but we don't currently collect who is swiping in. So we are starting to do this, so kind of have like a data report on who is swiping in. We haven't been doing that recently, up until now.

But times when I notice when this maybe access can

drop a little bit will be when there is a very busy course running. So a lot of the time the activities we are doing in the lab are teaching medical students or teaching other undergraduate courses and we know the students coming in, et cetera. But if we are running what we call external courses for surgeons or other clinicians, it is a very busy time in the lab and people, even though we tell them not to they will hold the door open for people to then come into the lab. And I don't know if like how that might be the same or different for mortuaries, like what is the access like or who is coming into the mortuary, but when the courses are not being run it is very limited, who is coming in and out of the lab and we would recognise everyone who is coming in and out of the lab, and the times that they would be doing that and things. So I am just giving you a bit of insight into our practise really.

MS KATHRYN WHITEHILL: Kathryn Whitehill, head of investigations with the Fuller Inquiry.

Catherine, you just said something that I would like to ask you to tell us more about. You talked about a code of conduct for your students. Where does that code of conduct come from and what is it rooted in?

MS CATHERINE HENNESSY: So it is rooted in the HTA principles and their guidance and regulations. So

a respect for the donors, behaviour in the laboratory. So I suppose it is like a combination of the HTA principles but also an ethical and moral compass as well for what we as anatomists and DIs and PDs feel is an appropriate way to behave and give back to the donors and respect for --

MS KATHRYN WHITEHILL: Where does that moral and ethical compass -- how could you locate that, where that comes from? Is it a professional duty or a different form of regulation?

MS CATHERINE HENNESSY: Ah, not a form of regulation. I think -- well I know we have done some recent work in collaboration with the ethical team, so like our medical ethical team in the university, around what is dignity for the deceased. So that was kind of like just a separate project that our previous head of anatomy was doing, like a research project.

Other than that, I think probably maybe just within anatomy, maybe, around what is moral and ethical and how to treat the donors. We use a lot of language around how would you, if you were a -- so we say to the students how would you like your parent or grandparent or other member of your family or friend to be treated if they were the donor who has denoted their body for to you study on.

MS KATHRYN WHITEHILL: I wonder, do we see that in other sectors as a DI? Do we see that articulation, clear articulation clear of the moral and ethical compass in terms of treating of the deceased?

MR KAUSHIK DASGUPTA: Kaushik Dasgupta, North Tees NHS Foundation Trust. Yes, I think so, and actually I never doubted that before all of this incident happened. I had no reason to think otherwise or to doubt that. Because particularly in the NHS, I thought all that comes automatically because all the deceased, they were just many of them were living patients within the hospital or some other hospital or they were just living and breathing members of the public, of the community. They are much a loved relative of other people, so I think and I still think, that it is that extension of the dignity that is accorded to any human being, to any patient, just transfers and this activity is very much sort of as we were trained as medical students and later in our sort of residency training and in our speciality training that it is almost like the last medical service or the last medical rights of service, accorded to a patient. That is what the mortuary, care in the mortuary and bereavement service is all about.

MR DANIEL SHINGLETON: Dan Shingleton, NFT. Just to extend that a little bit further. Obviously there is

a transition from what was previously called last offices with regards to care of deceased patients and it was the care of deceased after death. Often, I can only speak for my own trust of course, but often that is enshrined within the hospital policy about the care of that deceased patient and the journey they go upon. And that is underpinned further from a quality management perspective with the care of the deceased audit as well which is performed within mortuaries to make sure the deceased within the mortuary are being treated with dignity and respect.

So it is actually a documented audit which is done by the ward staff in tandem also with the mortuary staff as well.

MR SIMON WHALE: Thank you. Yes.

MS LOUISE FOX: Louise Fox, Hampshire Hospitals. It is all making me panic a bit because actually, you know, you can talk about all of the policies and SOPs and procedures but the softer side isn't measured really in any way. We talk about, you know, Trust values and about how people behave, but we don't have a formal process for safeguarding that I could point you to, to say actually I am assured because of this. So we work on the basis that we know the staff that work within the mortuaries, but I suppose it is that, it is the

visibility of that, isn't it? It is what goes on behind closed doors that you don't have assurance of. So I need to go away and think.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals. Interesting conversation and of course the difference for a hospital compared with an anatomy protection room is that it is the same people, and so you are not constantly working with a new group of students who don't have those processes. But like my colleague on the other side of the table, it feels very like the last act of care and if you -- when I visit the mortuary, and I talk to the staff, they are caring for two groups of people. They are caring for the deceased, the bodies, but they are caring for the family that are coming to view them. And the degree of pride they take in doing that well and in particular in enabling family, loved ones, to have a last visit with the deceased, is a key part of their activity. And you can express that in an SOP and there are behaviours that are expressed based on the HTA principles but it is the values that they embody in the way they do their work. That is what is so actually inspiring. If you take the time to visit a mortuary and talk to the mortuary technicians doing this work day in and day out. And yes, it feels very much like in a hospital setting the last act of care and

people take that very seriously, both on the ward and in the mortuary.

MR SIMON WHALE: Yes.

MR MARK CROXFORD: Mark Croxford from Birmingham. In our setting, the only people that have got site access to the mortuary are the six APTs and the pathologist is given a swipe card when they come in and it is taken off them at the end of the day. But that is, without passing judgment on it, I was very surprised when I read the report about the number of people who have access to the mortuary from a hospital point of view. If we have any maintenance done, any work, they are always accompanied. They have to step outside if the APT needs to go to the toilet. They are never left alone. We don't have any porters, we don't have any cleaners, it is all done by the staff. So in that sense, I think it is nice to be in a position where I have a lot more control. The coroner is not allowed -- she has got an access pass but unbeknownst to her she cannot fob in. It is not a place for people to go and view, and we have had that for a long time. I can only gain access with another APT. And I think that is the right way to approach it.

MR SIMON WHALE: Okay. Thank you very much.

I am going to move us on to our final topic area, if

I may. Which is about what you think needs to change. This is your opportunity to tell the Chair what you think needs to change, so we can reflect on that and the Chair can decide.

You have touched on some areas already and you may want to summarise or repeat things that you think are important that you have already mentioned about changes needed. But tell us what sort of changes you think you would like to see us recommend in relation to the role of the DI and what should that change -- what kind of effect do you want that change to have?

MR KAUSHIK DASGUPTA: Kaushik Dasgupta. So I think three main things that I would have liked to change is the first specification around the role of who can be a DI is not very clear. It doesn't have to specify the qualification or what their current role is but just a sort of essential and desirable criteria to be a DI, that is not very clearly laid down. And hence the exercise of -- the criteria non-existent, so no one can really exercise those criteria, apply those criteria to any person and say that they are fit or not fit to be a DI. There needs to be not only the initial training but there should be continuous CPD, which unlike all other, for example, particularly I can say for pathology practice, that for any area that I report on a live

patient is covered by external quality assurance, which are very, very rigorous system, and if I am in the bottom -- if I am in the bottom grade in two successive circulations then I will have to undergo remedial retraining.

Of course we forget about all such a high level thing but nothing at all is in existence currently. That needs to change. I think the responsibility must lie, and to me that is absolutely unequivocally should lie with the corporation. It should be a corporate responsibility. It cannot and should not be the responsibility of an individual unless it can be proven that they have knowingly, have not really informed the organisation of the shortcomings on what needs to be done. That I think is not there. And regarding the DI reporting to the board, I think that is generally lost in terms of the DI generally transmits it to another senior member who then reports to the board. I think that that is really not good enough. It should be a DI who should be directly responsible and it should be part of their portfolio to report to the board directly.

MR SIMON WHALE: Thank you very much.

MR MARK PIETRONI: Mark Pietroni, Gloucestershire Hospitals. Something we have not spoken about is data sharing. And so one of my main frustrations is we have a wholly owned

subsidiary which provides our security services and our portering. So technically the Hospitals Trust doesn't employ these staff. They also run the CCTV and it adds additional steps. It is all surmountable, in terms of data sharing around CCTV audits, you have to get DPI's data processing agreements et cetera. But similar to safeguarding children or adults where all agencies have a duty to share information in order to protect children or adults who are at risk, I think a legal duty to share information to protect the dignity of dead bodies would help short-circuit processes because in the NHS at least, subcontracting out of services isn't going to go away any time soon.

MR SIMON WHALE: Thank you.

MR CLIVE GRAHAM: Yes, Clive Graham, North Cumbria. Somebody said it should be brought in, DBS checking, and we talked about the care of the deceased. My understanding from NHS employers is because APTs are not dealing with live patients they don't need to be DBS checked, which seems to sort of contradict this sort of NHS philosophy which is we should be caring for patients from cradle to grave, because there is a little bit at the end where you don't need to be DBS checked for your particular role. And that is despite challenging them in that particular regard following the initial Fuller

Report, and then saying actually we are just waiting for the full report to come out before we make any changes to the recommendation.

MR SIMON WHALE: Thank you.

MR JAHRAN ALLEN-THOMPSON: So what would I like the changes that you guys make to feel like?

MR SIMON WHALE: What would you like them to do, what effect would you like them to have.

MR JAHRAN ALLEN-THOMPSON: I have five things. I think what I have seen in my experience is individuals can work inside of these sorts of places, mortuaries, and get in trouble, something can happen and before they have -- before the investigation is complete, they could be gone, working in an agency effectively, in any one of you guys' organisations. So I think better safeguarding on individuals, record if they have done something in a particular place that is under investigation. How is that information shared between different facilities that could be hiring them or even bringing them in through an agency. I would like to see postmortem CT scanning covered by the Human Tissue Authority. At the moment I could set up a PM CT, CT scanner in the car park here myself and have deceased individuals brought in for CT scanning and the HTA would not cover that activity.

I think I have emailed you guys some recommendations as well, so I won't go through those. I would like to see some benchmarking nationally of how these services are running around staffing portfolios, budgets, and I would also like to ensure that families are not charged for CT scans and that local government, if not the Government, are picking those up. I think I have mentioned some stuff around the Parish Burial Act needing to change as well to specify how long.

MR SIMON WHALE: It is a commendable list of things. I think we have to focus on what the DI's role is here, and some of this may be going a little bit beyond that, but they are points well made. Thank you.

Other thoughts?

MR MARK CROXFORD: Mark Croxford, Birmingham. I think it has been said but I would like to see training modules for the DI and the PDs and I think they should come from the HTA. I think we should have background checks because we haven't currently but we don't believe that we can do background checks. So our staff haven't and any requirements within the mortuary that you want to see observed needs to be a statutory requirement or an approved practice. We say it has to be done.

MR SIMON WHALE: What about those of you in medical education, what would you like to see?

MS RACHAEL WADDINGTON: Rachael Waddington, Imperial College London. I think I would simply echo what everybody has said in terms of responsibility for the organisation, defined roles, more laying and support, especially when it is obviously coming to things that have a budget impact. I would like to just pick up on one thing that Jahran said, which was actually some kind of transparency where there is a link if there has been an issue with an individual that other places are informed or have some knowledge, because we have known of these things in the past and generally if you have a good relationship, as we do particularly in anatomy, but if you are outside of that you wouldn't know certain things that have gone on. 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.

MR SIMON WHALE: Okay. Thank you. Are there any things about the DI role that you think absolutely should not change?

MR JAHRAN ALLEN-THOMPSON: We have already done this one but I feel that -- my belief is that it is my legal responsibility to ensure that the licensed activities are discharged. So I am aware that effectively that

I think that when I started the job I was told there a fine and you can go to prison, so I have kept those two things in one hand each and used them to bludgeon management into helping me to stay out of prison. But that is me. But I understand there is a different consensus in the room but I thought I would nail this last point in.

MR SIMON WHALE: Thank you, well nailed. Mark.

MR MARK PIETRONI: Yes Mark Pietroni, Gloucestershire Hospitals. Two things. I kind of agree with my colleague but I think personal accountability rather than legal responsibility. A named individual accountable within an organisation but with the organisation holding the legal responsibility is how I would construct the role. And the other area, it is a relatively minor point but clarity over who regulates. So CCTV is the obvious example, so it is not an HTA requirement but NHS England have emailed us and told us we have to have CCTV. And we do. But, and I can see that we have not had the CCTV involved in anything around mortuaries but I can see that we might do. So just being absolutely clear who regulates this area. There are areas where there is overlap between regulators. Health and safety is the obvious example. And CQC and the Health and Safety Executive have

a process whereby they have a conversation and they decide who is going to be the lead if it sits in both their jurisdictions. So if there is not clarity or if is an overlap in responsibilities, a requirement for the regulators to have that conversation amongst themselves and be clear. Which may depend on circumstances but at least it makes it easier for the DI to know who they are dealing with.

MR MUDHER AL-ADNANI: Definitely I would say yes, having a person who is responsible at least from the communication between the HTA and the organisation and making sure that the HTA standards are implemented. Definitely that should stay. One issue that also I feel is do we know what the coroner's opinion on the various topics that we have discussed? For example CCTV, do we know that the various coroners are happy for their patients, because their bodies are under the coroner's responsibility, are they happy for them to be visible on CCTV? Do we know, has anybody asked the coroners' opinions on this and coroners have various opinions as we know very well. Different coroners have different ways of doing things. We are, I am sure it is coming, that it would be required to have CCTV in the mortuary, do we know what the coroners' opinions on this are? So again, as a DI, we are sort of, yes, we are supposed to

implement HTA standards but we only deal with the HTA. The coroner, the various coroners that we deal with have their roles as well and their opinions and their requirements. How do we keep both sides happy.

So, again, these are some of the things we have to deal with as DIs and we quite often don't have clear answers.

MR SIMON WHALE: Thank you.

MR CLIVE GRAHAM: Clive Graham, North Cumbria. I know I meet with the medical director and the local coroners, so we often talk about these things, usually more than three of us talk about these things. They are usually abreast of what we have to do in terms of Fuller. What we are trying to do in terms of improving security, because that is obviously the main area of concern, following Fuller. So I think as long as you have got good communication in your area of responsibility, and in your activities team, I think most of these things can be overcome. And I think one of things I do enjoy about the role is some of that joint working we do with the other organisations because it is always nice to speak to the coroner to try to improve things for the patients and for relatives.

MR SIMON WHALE: Thank you.

MS CATHERINE HENNESSY: I just, because I know all of us

would like more training from the HTA from a DI point of view and probably also from a PD, like having PDs having some training tools as well. But I think we have all definitely heard loads of people saying before that the guidance from the HTA can often be quite vague. So I am thinking that they will probably want kind of input from us as current DIs on what training, what the training would look like. So I was just interested, because I am due to go on maternity leave soon and I will have to hand over the DI role to somebody else and I am kind of thinking to myself what a training package would look like. And I was wondering if other people who have also said they are looking to hand over the role in the near future, like have you got an idea in your head about what training would look like. Because it is such a varied job, anything can come you. Like the Fuller Inquiry can come up and how do you deal that as a DI? Or HTA inspection, you are kind of thrown into it. I think training on all those things would be vital and very important but I am sure the HTA would look to us as well for information on that, and an anatomy department would probably be very different to the mortuary/pathology department. So it is quite specific I think for each of the roles. I thought I would just add that in as a thought.

MR SIMON WHALE: Yes, thank you.

Any final thoughts on changes you want to see or things that you feel might threaten change that we need to be aware of?

MR MARK CROXFORD: Mark Croxford, Birmingham. It is a comment really. It would be a success of the Inquiry if more people wanted to be a DI afterwards.

MR SIMON WHALE: Setting us up --

MR MARK CROXFORD: I know it is an impossible task but I do think we have heard from all sectors that the DI role is a difficult one and if there is something we can do to support that, it would be great. If there is something you could do.

MR MUDHER AL-ADNANI: I think carrying on with your comment, I think having a let's say protected time for the DI or someone who is the DI would be given the time to do their job as a DI, because most of us, I am a pathologist, my main job is as a pathologist but I do the DI job as a side role. So if there is a big issue within the mortuary or something, do I have the time to actually do my job as a DI without having my surgeons or clinicians complaining why is my report or biopsy X or Y late? And if I tell then I am busy with an incident in the mortuary and they say that is too bad, you deal with that but I still want my report. I think for the DI

role to be carried out properly by the DI, that role needs to have a protected time within our jobs. So whether it is PAs or by PAs or medical directors, I am not aware of how these things are done but I think having a protected time for the DI to do their job properly, I think it would make a big difference as well.

MS JANE CAMPBELL: Jane Campbell, Inquiry team. Can you think of an example elsewhere in your organisation where that does happen? Is there a parallel at all with --

MR MUDHER AL-ADNANI: For example like if you are the clinical lead for the pathology department, you have a protected time to attend the various meetings that you obviously have to go to. But as a role of a DI, you don't have this time. You have to make it up as part of your role or do it out of hours or whatever. While if you are a clinical lead or manager X or Y, you have a protected time to attend your meetings and at the same time do your clinical role for example.

MR SIMON WHALE: Okay. Final word from Rachael.

MS RACHAEL WADDINGTON: Sorry, Rachael Waddington. I was going to say there are examples but again, it doesn't work in practice, as we all know, we all merge those roles. Even when it is protected time various things come in. It sounds good on paper but in practice does

that actually work.

MR SIMON WHALE: You have left us with a riddle to solve.

Thank you very much from me. I am going to ask the Chair to close the meeting.

SIR JONATHAN MICHAEL: Just really for me to thank you all very much.

It has been a really helpful and informative discussion. I will obviously consider what we heard very carefully and we will use what we have learned to assist in the development of our recommendations, our findings and recommendations to the government. The transcript of the discussion today will be placed on our website and we will let you know before we do this. I would be grateful if you would keep the discussions and the transcript -- or the discussions prior to the transcript confidential. The protocol was sent to you when you, before you came here, so I think you have got all that in hand.

I would just like to thank you all for your time and for your contribution to what is really very important work. Thank you very much indeed.

(3.46 pm)

(The seminar concluded)