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Event:	Fuller Inquiry Regulation Seminar Seminar on the regulatory and oversight measures that are in place to safeguard the dignity and security of the deceased
Date:	8 November 2024
Attendees:	Sir Jonathan Michael, Chair, Inquiry Rebecca Chaloner, Secretary, Inquiry Jane Campbell, Deputy Secretary, Inquiry Kathryn Whitehill, Head of Investigations, Inquiry Jonathan Landau, Facilitator Isabelle Brown, NHS Providers Dr Esther Youd, Royal College of Pathologists Mark Norris, Local Government Authority Joyce Frederick, The Care Quality Commission Janet Monkman, The Academy for Healthcare Science Gavin Larner, Department of Health and Social Care Steve Russell, NHS England Declan Maguire, Society of Allied and Independent Funeral Directors Andrew Judd, National Association of Funeral Directors Lydia Judge-Kronis, Association of Anatomical Pathology Technology Dr Colin Sullivan, Human Tissue Authority Matt Gantley, United Kingdom Accreditation Service Brendon Edmonds, The Health and Care Professions Council

SIR JONATHAN MICHAEL: Good morning to you all. For those of you who don't know me I'm Jonathan Michael and I'm Chairman of the Independent Inquiry into the issues raised by the David Fuller case. I very much appreciate your joining us today and I appreciate you're all busy people.

Probably the least important thing I have to inform you is that there is no planned fire alarm today, so if the fire alarm goes we'll need to exit the building. Colleagues will tell you how to do that.

I'm joined here today by Jonathan Landau KC, who is counsel to the Inquiry who is going to facilitate our discussion today. I'm also joined by Rebecca Chaloner, the Inquiry Secretary; Jane Campbell, the deputy Secretary and Kathryn Whitehill who is the head of Investigation with the Inquiry.

As you know, David Fuller committed despicable crimes in the mortuaries in 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 to make recommendations to the government to prevent anything similar happening again.

Then in Phase 2 I was asked to consider whether procedures and practices in other settings across the country where the deceased are kept safeguard the security and dignity of the deceased and to make recommendations to the government to improve practices and protection of the deceased prevent possibilities of abuse.

I published my Phase 1 report in November 2023 and an interim report on the funeral sector in October of this year. I'm, as I say, very grateful for you attending this seminar. In doing so what I'm hoping

that you'll do is to help the Inquiry gather evidence and draw conclusions on the current regulation and oversight in England that would ensure security and dignity of the deceased in all settings.

So from my point of view it is an information gathering, information collecting process for me, so I'm going to be largely listening and hoping that you'll advise me about the current arrangements and where things may need to change.

I'm now going to hand over to Jonathan Landau who will explain the session to you in more detail.

JONATHAN LANDAU: Good morning, everyone. I should first of all thank the Chair for elevating me to KC status. That's yet to come but everything in due course.

SIR JONATHAN MICHAEL: I'm ever an optimist.

JONATHAN LANDAU: Very good. I am counsel to the Inquiry. I have been asked to advise the Inquiry particularly around regulatory matters. And as you've heard I've been asked to facilitate today's seminar.

First, let me repeat the thanks from the Chair to all of you for coming to this session. We know you are all busy, we are grateful for you setting time aside to join this session.

It is of vital importance that the Inquiry hears the views of a broad section of organisations with an interest in regulation or oversight in relation to the security and dignity of the deceased. 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 lessons for the NHS and to other settings with a particular focus there cannot

be a recurrence of the matters raised by the case of David Fuller.

This is one of a number of seminars that the Inquiry is holding to gather views for its Phase 2 work.

Some housekeeping matters. There are a lot of us here. Everyone will be given an opportunity to share their views, 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. The aim is to elicit the best evidence we can from all of you.

I will facilitate the session which means I will endeavour to ask questions from each of you as we move through the topic areas. I will do so by referring to you by name and asking you to speak. Please do not interrupt anyone else when they are speaking. If you would like to reply to the answer given by someone else please raise your hand and I will come to you if we have more time to cover that particular topic.

The session is being recorded so 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 work for. We will produce a transcript of this seminar and this will help to ensure it is always clear who is speaking, because speaking fast or too quietly I will remind you that you are being recorded and to speak as clearly as possible.

I know this may be unfamiliar, try to be as natural as possible. Just speak up, speak clearly and give concise answers. Please address your answers to the Chair who is sitting next to me. Chair may sometimes also have questions he wants to ask. This is to ensure we have the best evidence that will help cover the issues that the Inquiry is investigating.

You can also see other Inquiry colleagues at the table. They are Rebecca Chaloner, Secretary to the Inquiry; Jane Campbell, deputy Secretary to the Inquiry; Kathryn Whitehill, head of Investigations. Each of them 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 that we can ensure that the Inquiry does its job as best it can, informed by key stakeholders.

Language and terminology. If we touch on topics that require details about what happens to a person after death and the steps involved in death management etc, that is perfectly fine. We want you to be candid but you can flag if anything you would like to say will involve graphic or sensitive information.

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

Report. In due course the Inquiry will publish a report. That is some way off 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's clear to everyone that the core purpose of this seminar is to assist the Chair's investigation in gathering information that may be used in the Inquiry's report on Phase 2. All attendee organisations

have been sent a protocol for this seminar and I would ask you to remind yourselves of its content after this seminar.

Turning then to the agenda. We have four core sessions for the seminar. You have agendas, I think, in front of you. They will be as follows: What is in place currently? Do we have a shared view of the regulation in place that is intended to protect the security and dignity of the deceased?

Two, the effectiveness of the current system. We will consider how well the regulation and oversight currently in place protects the security and dignity of the deceased.

That should take us to about 11.15 when we will break for 15 minutes.

Three, what needs to change? We will consider if there are weaknesses in the current system of regulation and oversight of the deceased. What needs to change?

Four, the benefits and challenging of implementing professional regulation of those who care for the deceased. An opportunity to consider if and how professional regulation of staff working in this sector would lead to greater protection of the deceased. How might such professional regulation be provided?

Five, finally, concluding remarks. We will finish with some final remarks from the Chair and aim to wrap up the session by 1.00 pm.

So moving straight to session one, what happens now? Start by setting the scene. The reason we are here today is because of the awful crimes of David Fuller, how they can be learned from so they do not happen again in any setting where there are deceased. I'm sure that is a view everyone shares.

The central question for today is the role that regulation and oversight plays in safeguarding the security and dignity of the deceased.

Background, by way of brief introduction it seems that the current regulatory regime can be characterised as partial, piecemeal and devised for particular purposes.

By partial I mean that it covers some activities, locations and professions, but not others. For example, the Human Tissue Act provides a regulatory framework covering specific regulated activities. Where no such activities are provided legislation does not bite. Accordingly the HTA has no jurisdiction over body stores or the funeral sector. CQC also regulates specified regulated activities that do not include care of the deceased. Safeguarding duties similarly have no application in relation to care of deceased.

Some professions such as medical practitioners are subject to mandatory professional regulation. But others, such as anatomical pathology technicians and funeral directors are not. Where there is mandatory and professional regulation in some cases guidance touches upon care of the deceased and in others it does not.

Enforcement options are also partial. For example, it is not an offence to fail to comply with the HTA Codes of Practice and the designated individual rather than organisation has a duty to ensure compliance with licensing requirements.

By piecemeal I mean that the regulatory regime has developed over time across a range of different frameworks including Human Rights law, civil law, criminal law and assorted regulatory regimes covering various professions and organisations. There is no single overarching duty towards the deceased.

When I say that frameworks are devised for particular purposes I mean that they were not designed specifically to deal with the sort of abuse committed by David Fuller. The Human Tissue Act, for example, was designed in response to scandals involving the use of body parts without consent. The main objective of the CQC is to protect and promote the health, safety and welfare of people who use health and social care services.

These are just examples of what I have said is just a summary. The Chair wants to hear from you about your views on the current regulatory regime, its effectiveness and what needs to change.

In its Phase 1 report on matters relating to David Fuller's crimes at Maidstone and Tunbridge Wells NHS Trust the Inquiry found that there were many external organisations involved in assessing the Trust's mortuaries over the years all with the different and often unclear roles.

The framework of external oversight did not detect and address serious issues at the Trust's mortuaries including lack of security, non-compliance with policies and inadequate management arrangements.

Despite a plethora of regulation David Fuller was able to offend undetected for 15 years. First as an NHS staff member and then as a contractor until his arrest in 2020 for the murders of two young women in the late 1980s.

Over the years the regulatory requirements that should have protected the deceased in the care of Maidstone and Tunbridge Wells NHS Trust were either insufficient or not followed by those in a position of responsibility.

The Inquiry stated it would review the national regulatory framework and its effectiveness in Phase 2 of its work. Similarly the Inquiry's Phase 1 report set out the regulation of mortuary staff would be considered in Phase 2. Today there's an opportunity to consider and contribute to both of these.

With that background which we can return to as we develop the discussion it would be helpful to bring in our participants today. We have representatives from various organisations. Systems regulator, professional regulator, some play a role in oversight of a system, all have an interest in the regulation and oversight of services that care for deceased people. Welcome all of you.

Please now start some questions. I'd like to start with some introductions. So if each organisation, each delegate, can please give your name, the name of your organisation you work for and a very brief description of the role it plays in relation to the regulation or oversight of the deceased.

When I say very brief I mean just one or two sentences because we'll be going into more detail as we develop the discussions.

If I perhaps could start on my left. Welcome.

ESTHER YOUD: Hi, my name's Esther Youd. I'm a pathologist at the University of Glasgow but I'm here representing the Royal College of Pathologists. We are a membership organisation formed of pathologists so we are involved in the care of the deceased primarily in performing autopsies when required.

JONATHAN LANDAU: Thank you.

JOYCE FREDERICK: Hello, my name is Joyce Frederick. I am the director of Policy and Strategy at the Care Quality Commission. We follow the Health and Social Care Regulations 2008 to 2014. Our regulations don't specifically look at the care of the deceased, they look at the living that we would be concerned in and similar activities related to our regulations like the security and the dignity of the deceased or the living.

JONATHAN LANDAU: Thank you.

STEVE RUSSELL: Good morning, my name's Steve Russell. I'm Chief Delivery Officer at NHS England. NHS England doesn't manage all of the NHS organisations that make up the service but we have a role in providing national leadership. And we exercise a number of statutory functions including the commissioning of some services but also oversight of the sector.

JONATHAN LANDAU: Thank you.

DECLAN MAGUIRE: Good morning, my name is Declan Maguire. I represent the Society of Allied and Independent Funeral Directors. We are one of two trade bodies within the funeral profession and a policy membership organisation. We have, as part of membership, a Code of Practice that all members have to stick to, but that's all kind of self-regulation function.

JONATHAN LANDAU: Thank you.

JANET MONKMAN: I'm Janet Monkman. I'm Chief Exec and Registrar of the Academy for Healthcare Science and we run a Professional Standards Authority, called PSA, competitive register for healthcare scientists. It's a voluntary register and available for professional groups who are not regulated by statutory registers to use.

JONATHAN LANDAU: Thank you.

MATT GANTLEY: Good morning, Chair. Good morning, everybody. My name is Matt Gantley. I'm the Chief Executive of UKAS which is the United Kingdom of Accreditation Service. Our role in this context is to accredit conformity assessment bodies. And in this case that relates to clinical pathology laboratories and more specifically the connection and through to the body, biological samples that will then go into the mortuary to the medical pathology setting for the testing of that sample.

JONATHAN LANDAU: Thank you.

BRENDON EDMONDS: Good morning, everyone. My name is Brendon Edmonds. I'm here from the Health and Care Professions Council. We are a statutory regulator, professional regulator, 15 different allied health scientific and psychological professions that we have varying degrees of contact around service pathways rights related to the deceased. So yeah, pleasure to be here.

GAVIN LARNER: Good morning. I'm Gavin Larner. I'm director of workforce for the Department of Health for Special Care which includes responsibility for the professional regulation system for health professions.

ANDREW JUDD: Good morning, everybody. Andrew Judd, the Chief Executive of the National Association of Funeral Directors. We've been established for 120 years as the membership organisation. And we work in parallel with our colleagues from SAIF. It is very difficult to know how many funeral directors there are in the UK and we hope that we'll be able to do something about that. But between both our trade associations about 80 per cent of the funeral directors that are currently trained are under some oversight. But there is obviously approximately 20 per cent of which there is no scrutiny. Thank you for inviting us today.

LYDIA JUDGE-KRONIS: Good morning. I'm Lydia Judge-Kronis. I actually work for Maidstone and Tunbridge Wells NHS Trust. However I'm here representing the Association of Anatomical Pathology Technologists today. I am an anatomical pathology technologist by profession. We are a membership organisation. Our members are made up of students and qualified staff. We provide them with support, best practice. We have a Code of Conduct. We have advisories that we put in place. However, we have no overarching authority. So you don't have to be a member. But we do our best to improve and standardise the care of the deceased from the minute they're with us. Our members are made up of not only NHS organisations, they're also Local Authority and I did want to mention that because there's often a lot of focus on NHS and not so much on Local Authority.

COLIN SULLIVAN: Good morning, I'm Colin Sullivan. I'm Chief Executive of the Human Tissue Authority and as has been said in the introduction the Human Tissue Authority created by the Human Tissue Act. Our role is to superintend compliance with the Act. And we're an arm's length body of the Department of Health and Social Care.

MARK NORRIS: Good morning, I'm Mark Norris. I'm from the Local Government Association, Principal Policy Advisor there. We're a membership body for councils in England and Wales and our members are responsible for providing support to coroners and the investigations they conduct including postmortems. And earlier on this year we were also responsible for liaising with governments about their requests that councils go out and inspect funeral directors following events in Hull.

JONATHAN LANDAU: Thank you.

ISABELLE BROWN: Good morning. My name's Isabelle Brown and I am representing NHS providers which is a membership organisation which represents full NHS Trusts including acute, ambulance, community and mental health providers. I lead our Quality of Care Policy portfolio which looks at patient safety as one of the domains of Quality of Care which extends to the safety and dignity of the deceased, it’s lovely to meet you all.

JONATHAN LANDAU: Thank you very much. You are all very welcome. So we are going to start now with session 1 which is, What is in place currently? So

perhaps I could start by trying to establish whether we have a shared view of the regulation in place that was intended to protect the deceased. You heard I gave a very brief summary, an overview of how the current regulatory regime seems. I'd like to hear from you, the Chair would like to hear from you, about whether there was anything in that outline that any of you consider is not accurate. And if you just want to raise your hand if you want to comment on that.

SIR JONATHAN MICHAEL: Does silence mean assent?

JONATHAN LANDAU: Perhaps we should have an answer to that, Chair. Yes?

COLIN SULLIVAN: Yes, thank you. Colin Sullivan, Human Tissue Authority. I thought your summary, from my perspective, pretty much summed the landscape as I understand it to be, which is that in terms of our role we are responsible for the scheduled purposes within the Act. But there are other areas where we have no role, such as body stores and further outwith that.
So I think it does paint the picture of partial coverage of regulation.

JONATHAN LANDAU: Thank you. Yes?

STEVE RUSSELL: Steve Russell, Chief Delivery Officer, NHS England. I recognise the points that were made. I just wanted to clarify one thing, if I may, which was I think there was a point made about the role of the designated individual and entirely recognise the role and the way that you described, or the way it was described rather.

But I'm not sure that I would completely recognise the thought that there is no organisational duty to following the HTA regulations. From our perspective, from my -- I'm a former Trust Chief Executive. From my perspective and from NHS England's perspective Trusts do have a duty to follow relevant statutory regulation and guidance. And that includes the HTA regulations and standards.

So that designated individual absolutely does have a role. I'm sure we might get into how that is operated. But the organisation as a statutory body and the accountable officer on the Board, do have responsibilities to comply with those regulations.

I accept the point that that may not be consistently applied but I just wanted to clarify that point.

JONATHAN LANDAU: Yes, thank you for that. I think the point is that the statutory role of a designated individual is to have that duty of overseeing and ensuring compliance with the requirements and that falls on the designated individual as individual person in the legislative framework.

I think you'll recognise that in (Overspeaking) -- yes?

COLIN SULLIVAN: Colin Sullivan, Human Tissue Authority. I would agree with that assessment that within the legislation there is no reference to a corporate licence holder. The only reference is to the designated individual so there isn't a legal duty placed on the corporate body.

JONATHAN LANDAU: Again just we'll get into more detail about that but I think there's also something to discuss around who is the licence holder in fact in relation to the HTA licensing requirements. But we will come to that when we go into more detail.

Any other observations? Yes, thank you.

GAVIN LARNER: Just to clarify whether the pre-employment checks, if there was to have been scope within this discussion or whether that's, you know, not within the scope of regulation.

JONATHAN LANDAU: I think we're here to hear your views. So to the extent that you think its relevant, by all means. And certainly it's going to be relevant to consideration of professional practice which feeds into professional regulation and the need for it.

GAVIN LARNER: It was (Inaudible) from reading the Inquiry way back failed (Inaudible) seems kind of relevant to what additional layers of regulation might provide a certain set of safeguards.

JONATHAN LANDAU: Did you mention your name and organisation?

GAVIN LARNER: Gavin Larner from the Department of Health and Social Care --

JONATHAN LANDAU: I've just had very clear instructions to remind people. Thank you very much for that. Yes, please. Go ahead.

JANET MONKMAN: Janet Monkman from the Academy for Healthcare Science. If I could, the Professional Standards Authority oversees accredited registers and the statutory registers.

The issue I think here is that where the profession would be willing to move on to an accredited register in the first instance, that isn't

necessarily endorsed within the NHS or through contracts with Local Authorities outside of the NHS.

And a part of that registration within employment checks and being able to specify that within role descriptions etc, I think it's a disadvantage. And by not recognising that from the work force perspective it means the education and training for this work force is not what it should be.

JONATHAN LANDAU: Thank you.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. Just to touch on DBS checks I'd like to point out that anatomical pathology technologists only need a basic and it's very difficult to try and get an enhanced. And I think that is something that needs addressing.

As an association we go out and we do peer reviews and we assess students. There's quite a lot of organisations that come to us for advice. But who's regulating us? We actually self-regulate so we are members of the Academy and the Science Council where possible. But the concern is that there is no expectation for our staff members to be registered or even qualified because whilst the HTA does say it needs to be suitably trained there is no clear definition of what qualifications each person should hold according to the practice that they are carrying out.

And again we go back to all mortuaries who are autopsy mortuaries will have pathologists visiting. Not all mortuaries are fortunate to have home pathologists who are on site and available for advice and comment.

So again you are leaving that mortuary in the care of the anatomical pathology technologist, which I would argue is the right place. However, it's very difficult to enforce best practice and recommendations without the support of higher authorities.
For example, in a job description you can explain once you get to a certain level, so senior APT, you must register. There is no way of enforcing that.

JONATHAN LANDAU: Thank you. Yes, please.

ANDREW JUDD: Andrew Judd from the National Association of Funeral Directors. Just to put a bit of context on the structure of really the only oversight in the funeral profession at the moment which are the trade bodies.
It's the firm, it's the firm of funeral directors that's the member. And each firm will have, in our case, two nominated representatives. So it's the firm that's the member which means there is the scrutiny of the individuals within the firm are subject to the overall operator. And in the spectrum that we cover that could be a single owner operator that may conduct 25 funerals a year, the tip of Cornwall. Or it may be one of our larger consolidated members who may have 4,000 plus staff working for them across the whole of the UK.
But it's the firm that's the member. So the scrutiny of the individuals, that is dependent upon the owner operators and to make sure (Inaudible)

JONATHAN LANDAU: So in relation to your Code of Practice, your inspection framework, does that include any criteria for looking at the suitability of staff? So there are other regulatory frameworks where it's a provider or an

organisation that is the registrant or the licence holder. But then the regulatory framework will include measures for assessing the suitability of staff.

ANDREW JUDD: We've done some work with the Scottish government both SAIF and NAFD in terms of the Scottish Code and there were discussions about the fit and proper person. But we DBS the directors of the organisation who want to join us. But whether those organisations DBS their own personnel is an employment decision at the moment for the individual members.

So we have an aligned Code of Practice that asks for evidence of training but it is not and cannot be explicit about which training that is at the moment as there is no mode of training at all in the funeral sector. Both of our organisations provide training but it's elective and the majority of training is done inhouse.

JONATHAN LANDAU: Thank you. Can I just turn from the NAFD to SAIF?

DECLAN MAGUIRE: Declan Maguire, SAIF

JONATHAN LANDAU: Sorry, is that the same position?

DECLAN MAGUIRE: It is, yes. Frustratingly so. I think there is a drive from the professional funeral sector to make this manageable. There should be some minimum requirements for individuals, particularly who have a functional -- sector of the care of the deceased. And then potentially that every funeral home can then attract a little individuals

who have responsibility for the care of the bereaved but that's further down the path.

But there is -- I think everyone -- I've yet to meet a funeral director who does want regulation or does want some form of minimum criteria before you can actually do your job.

So yes, unfortunately the situation is you have to go -- or do it yourself. And the companies are responsible for the staff they have. But we'd like to see that changed.

ANDREW JUDD: Andrew Judd from the National Association of Funeral Directors. If either of our associations choose to expel a member or discontinue membership because they do not meet our standard that has no impact at all on their ability to trade, no impact at all. So actually by removing them from either of our associations, and there are a number of members that are members of both of us, by removing them it doesn't help at all. It solves nothing. It just means they're operating outside the scrutiny.

In the same way that if somebody's dismissed for whatever the employment reason may be, then they can just go to the next funeral directors.

JONATHAN LANDAU: Thank you. Yes.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. Likewise with the association if we do expel a member they can carry on working. There is no expectation from most employers that the staff members are members of the AAPT or registered. And even when organisations, because we do quite a lot of (Inaudible) meetings, even when do suggest that they're

going to ensure that all of their staff are members of the AAPT there is no follow up as rule. So I would agree with that.

And as an aside, because I'm very aware this is regulatory, but I think this is very important. Many mortuaries do not have enough capacity. We are reliant in temporary units and funeral director colleagues to help us. It's essential that that is mentioned as well because we are also trying to long distance care for our patients, work with companies who are businesses who have other things going on and we have started to risk assessment thanks to the HTA and their wonderful unannounced inspections. I'm a massive fan.

But we have to go and risk these premises but actually if you risk assess a premise that you then don't want to use you've still got to have a relationship with that funeral director. And as you say, if they're not part of your organisation that's very difficult when we're looking at care and dignity of the deceased.

JONATHAN LANDAU: Esther?

ESTHER YOUD: Esther Youd, Royal College of Pathologists. I just really wanted to add the opposite end of the spectrum. So as pathologists we're doctors. We're probably the most heavily regulated profession. Well, it seems like it.

So as a doctor, mandatory regulation through the General Medical Council, cannot work as a doctor without that registration. I have to keep up to date, I have to do annual appraisal, I have to undergo five yearly revalidation with all of the criteria that are set down for that.

As a pathologist I also face regulation from two bodies that are here today, from the Human Tissue Authority and from the United Kingdom

Accreditation Service, both of which have their own rules and regulations. They're there to look at how the service is provided but as an individual, as a doctor working in that service, obviously that feels like oversight and regulation of what you're doing as a doctor, as a pathologist.

I'm not saying that it's perfect and there's probably lots of things that don't work very well, things that do work well. But it's, I guess, just the opposite end of the spectrum in terms of regulation and oversight. Doctors have a huge amount. It means that all of those things that are mentioned that are not mandatory in other professions are absolutely mandatory for doctors and pathologists.

It provides, at the very least, a degree of reassurance. It doesn't stop bad people doing bad things. But you would hope that it stops more times.

JONATHAN LANDAU: Thank you very much.

REBECCA CHALONER: I think Janet was wanting to come in.

JANET MONKMAN: Janet Monkman, Academy of Healthcare Science. I'm not sure what I was going to say is necessarily for this part or a later part actually.

JONATHAN LANDAU: All right. We'll come back to you, thank you.

BRENDON EDMONDS: Brendon Edmonds, Health Care Professionals Council. Just to add to that thread around the other end of the spectrum from the professionals that we regulate. Actually, regulation in particular paramedics, they're probably the profession that comes into the most

contact with the deceased in their role, particularly at community settings. They are bound by all the things that were mentioned previously in relation to doctors. Their training routes are all approved and work fine. And importantly where their practice falls below standards you have the statutory power to be able to remove them, not only remove them from the register but that effectively stops their practice as a paramedic within the service.

We also set ethical and professional requirements, importantly the duty to report. So as paramedics it's about keeping your standards to a certain level for professional regulation. It is about making sure that when you see something that is concerning that you have a professional duty to report that as well.

JONATHAN LANDAU: Thank you.

SIR JONATHAN MICHAEL: I just wanted to -- Steve, you said that although there's no specific reference in the legislation to the organisation there is a general duty of responsibility on Boards and accountable officers in the NHS, the expectation anyhow. I am just wondering if the same applied in local government even if the local government, Local Authority, isn't identified as a having a statutory responsibility, is there a general expectation in the same way as the NHS was describing?

MARK MORRIS: Mark Morris from the Local Government Association. I think we could probably -- I can't give you a definitive answer to that one because I think it would depend on what the views were from a Local Authority when they were looking at the issue.

I think we would probably expect that like the NHS that it would be a corporate responsibility that would sit overall with a Local Authority because that's the employer. But there is that issue that was raised by Colin in terms of what the actual legislation says about individuals and where individual responsibility sits.

So I think from a Local Authority point of view one would hope that the better performing councils would be in a position where they treat it as a corporate responsibility. But some of them may rely on the fact that the statute says it relies on an individual and expect the individual to take responsibility. So I suspect it's probably not entirely consistent across the sector as to how to handled and how it's viewed.

SIR JONATHAN MICHAEL: Okay, thank you.

JONATHAN LANDAU: I just want to come back very briefly to what's been said by several of you in relation to voluntary frameworks, both in relation to the funeral sector and pathology technicians as well.

In terms of the being able to either carry out businesses without membership or, in your case, being able to carry on a profession without membership, to what extent are customers using membership to inform their decisions and make decisions whether or not to use a particular funeral director. And likewise for employers and membership of your organisation, to what extent does it influence employers?

So, what we're interested in there is whether, albeit it's voluntary, there's an effect; because it's important, how, in practice services are used.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. We can't enforce membership to the AAPT because that would be seen discriminatory to those people who choose not to be members of the AAPT.

So that's -- it makes no difference whether we employ the member of staff necessarily.

Regarding use of the mortuaries, it doesn't necessarily impact our contracts because Local Authorities will use whichever mortuary is nearest to them if they don't have their own designated council mortuary, which outside of London there are only a few other areas that do. It's ordinarily district general hospitals that will pick up contracts with coroners, for example, and research centres.

But that's more about geographical areas rather than whether you're members or registered. It's an advantage and they will use it when they're talking about that however it doesn't really affect what we do and don't do.

They always want to hear about the HTA reports and for an unregulated profession working in an NHS mortuary, often a mortuary manager is exposed to CQC, UKAS and the HTA within a year. So that does happen but again that's a small percentage of mortuaries now as more and more remove from pathology. Because we don't quite align with UKAS rules because we don't quite fit into that criteria. We do fit with HTA but only if you're an autopsy mortuary, not just a regular mortuary without autopsy facilities.

So that's where it sits with us.

JONATHAN LANDAU: Thank you.

ANDREW JUDD: Andrew Judd, National Association of Funeral Directors. People choose funeral directors for very different reasons. There is no singular approach to it.

But what we do know is that about 69 per cent of the survey that was done in the UK the general public already think that you can't be a funeral director unless you're trained, unless you're supervised, unless your staff are vetted, unless your mortuary's inspected. And there is a real assumption out there that the funeral profession is a profession in the sense that lawyers and teachers and doctors, all these pillars of society, but the reality as we've established, it's voluntary.

In terms of reassurance from a funeral director being a member of SAIF or a member of the NAFD, I think people do see that as reassuring but it's not, at the moment, everybody's choice because they don't know enough about it.

There is a huge assumption that there is already scrutiny of the funeral sector and we do what we can as membership organisations that the assumption of the public is it's far, far deeper than that.

JONATHAN LANDAU: Thank you. SAIF, do you concur with that?

DECLAN MAGUIRE: Declan Maguire, SAIF. Yes, there is an odd -- I run a research team within SAIF which is working on a completely unrelated project to do with funeral director websites. But oddly it gave some insight into the importance of credibility of the funeral director.

And we hadn't quite worked out -- we generally monitor behaviours of people to see whether they're going and what they're doing. And interestingly enough most people don't get past the landing page.

They're not really interested in the "about us". And that was something we were reviewing and examining. And ever since Hull and the events in Hull we've seen that there's been an increase in people researching funeral director websites.

It took us a long time to figure out why this was and of course we should have really put the two things together. But people are taking more time and I think they are looking at accreditation and the value. Because that was a wake up call I think for everybody to think that there's nothing unless you actually go towards self-regulation and the trade associations.

So there has been a change in the last seven, eight months in terms of consumer behaviour but only because then that's the project but the cause had to be something, it had to fit in that sort of box.

JONATHAN LANDAU: Thank you. Yes, UKAS.

MATT GANTLEY: Matt Gantley, United Kingdom Accreditation Service. Chair, I just wanted to take a step back and actually just address some of the important points to deal with the current position.

We've used the word "accreditation" a few times in order to define generally what that means in practice and perhaps more precisely what that means in the context of the United Kingdom Accreditation Service.

So we talk about accreditation in a lay sense in many different contexts. But there's probably two major ways in which it's applied. The first of all of course is to professional registration. And we see that in many different forms through the Academy of Royal Medical Colleges and all the professions that come through that. We see that

through then the registration from the Science Council, the Engineering Council and other appropriate professional bodies per registration.

And then we see accreditation and how we would define it and that's precisely defined in terms of accreditation of those conformity assessment bodies. So that is testing, inspection, certification and verification

I know that all sounds very similar, two layers but they precisely defined according to specific international standards. And that creates a systematic framework that can be heard across nations, across industries, of how conformity assessment works.

So conformity assessment and the accreditation of that ensure that it has integrity, the advice of standards consistently, is done to international standards. But it's there to ensure a system functions effectively. Where a system is (Inaudible) to framework it's very, very broad and it can apply to a voluntary setting or a regulatory setting or a mixture of all of those applications.

Very specifically here in the context that this Inquiry we see that UKAS has accredited and does accredit pathology laboratories. We've seen in the reference earlier to the work that we do in accrediting clinical, medical laboratories, we accredit 600 medical laboratories. And that then has a connection to the input of body samples from mortuary or a body store.

So but the approach to accreditation and conformity assessment is very flexible and could point to many different areas from water testing to food safety to forensic science to aerospace parts to automotive parts to -- potentially to other areas which is the competence and the application of schemes for funeral directors.

So there is a framework through accreditation to be able to adapt a system to create the appropriate standards and then to ensure that those standards are achieved with practice.

So I should just say in its current context the system, the methodology, is there to be able to achieve this.

JONATHAN LANDAU: Thank you. Just two more points and then we will move on in a moment. So the Academy of Healthcare Sciences.

JANET MONKMAN: Janet Monkman, Academy of Healthcare Science. If I just qualify one of the points that you made. The Science Council is not a Regulator. We're accredited by the Professional Standards Authority in terms of the standards. And we have governance systems so, for example, fitness to practice practices.

The Science Council is not that… similarity okay? It's a different type of organisation.

MATT GANTLEY: May I respond Chair? Matt Gantley, UKAS.So sorry if I referred -- I didn't think I referred to the Science Council as Regulator but --

JANET MONKMAN: It's a register.

MATT GANTLEY: As a register, excuse me. Okay. So yeah, okay.

JONATHAN LANDAU: Thank you. Yes?

ESTHER YOUD: Esther Youd, Royal College of Pathologists. I actually just wanted to add a similar clarification. You talked about regulation through the

Academy of Medical Royal Colleges. That is a body that's just a group of leaders of the various different Medical Colleges, the Royal College of Pathologists being one of those.

The Royal College of Pathologists itself is a membership organisation. It's not a Regulator but our regulation is through the General Medical Council.

JONATHAN LANDAU: Thank you. Before moving on, anything not mentioned that might assist our discussions today in terms of recognising where we are in characterising regulatory landscape?

MARK NORRIS: Mark Norris, Local Government Association. We touched on it I think but I think probably we'll need to go and consider it in a bit more detail is just the issue of transport.

Obviously we're talking about primarily facilities where the deceased are held, stored, kept, and those individuals who are working with them and caring for them. But what we haven't yet kind of touched on is, and I think we do specifically, is that point about actually, there's a point made to me by a number of Coroner's Officers was that the issue of transport of the deceased from one location to another ought to be within the purview of what we're talking about in order to consider that. And I don't think we've explicitly touched on that yet.

JONATHAN LANDAU: Thank you for that. We will be looking later on, considering what settings there are where the deceased are cared for. And that, I would include transport -- and we would be interested to hear views on that.

Going to move on now then to discuss the effectiveness of the current system. I appreciate you might have already made some points on that but the Chair wants to consider how well the regulation and oversight systems currently in place protect the security and the dignity of the deceased.

So first of all, what is working well in the current regulatory framework in protecting the security and dignity of the deceased? Perhaps we can start with the HTA?

COLIN SULLIVAN: Yes, Colin Sullivan, Human Tissue Authority. So the areas that we regulate over the last numbers of years we've certainly been much more rigorous than what was the care previously and in terms of the number of inspections, for example.

In the PM sector that's virtually doubled. So a few years back we were doing about 40, we're now doing 80 overall. The number of inspections was increased for 140 to 222 per year. Which means that typically a postmortem mortuary will be inspected about every two years. So before it was every four years.

And on top of that we've introduced a number of different regulatory tools. The unannounced inspections were mentioned earlier. We've also introduced evidential compliance assessments which are questionnaires that we sent out and then explore the results of those. And that helps to drive where we spend our time so it's much more risk based.

We've also introduced mandatory webinars for designated individuals, there's 164 of those. That's across England, Wales and Northern Ireland.

We do have standards that we look at and review on an episodic basis. The last time they were updated was 2017. We have revised our guidance for the postmortem section back in 2022 and also for the anatomy sector. But we are awaiting the outcome of the Inquiry's final report before we update the standards for postmortem and anatomy. That quite a significant piece of work involves consultation. These are statutory Codes of Practice with standards that are laid before Parliament. So we feel rather than do them now and then do them again we'd be better to wait.

But I think that's the approach that we've applied to what we cover. As I've said earlier there are areas where we do not touch and that is a concern to me.

JONATHAN LANDAU: Thank you. I think you just listed quite a lot of the activity and the increase and the ramping up in the activity. In terms of what's working well how are you finding that that's impacting on outcomes on detecting the need for improvement and ensuring that improvement takes place?

COLIN SULLIVAN: Colin Sullivan, HTA. I think one of the ways of measuring that is by the number of shortfalls that we're finding. So the number of shortfalls that we're finding, if we compare the year before last with last year, that has come down.

It is more significant in the PM sector than in other sectors. We regulate six sectors. So it was 9.2, it's now down to an average of 7.8 shortfalls per inspection report.

All we've noticed is whilst the number has come down the severity of them has gone up and I think that's a recognition of the fact that we're being more assertive as we regulate that space.

That compares, for example, with -- that 7.8 compares with 1.5, 1.5(a) in the anatomy sector which we consider to be much safer and not have the same risks.

So that's one measure of the impact and what has happened in recent years.

JONATHAN LANDAU: Thank you very much. If I turn to you, the Royal College, you mentioned the different regulatory regimes that members are subject to.

Can you help us with how that works well to the extent of what works well?

ESTHER YOUD: Yeah, as I said earlier the mandatory regulation by the General Medical Council is the key thing for pathologists and/or doctors. I mean there are aspects of that regulation. I mean appraisal and revalidation was introduced as result of Harold Shipman.

I think many people that Harold Shipman would have passed appraisal and revalidation with flying colours as well as by all of his patients. He would have got excellent feedback on those aspects and he kept up to date and things like that.

So it's not a perfect system but it does provide us with, you know, you cannot work as a pathologist and therefore in this sector, care for the deceased without that mandatory regulation. So that in itself is a positive.

We're very used to the laboratory accreditation by UKAS. I think most pathologists recognise that the HTA is probably better placed to regulate mortuaries rather than UKAS. So most people opt to not have the UKAS accreditation for their mortuary by they're obviously required to comply with the HTA.

I'll just add a personal experience in terms of how effective the HTA can be. In a hospital I used to work in we had a very difficult inspection by the HTA which produced a very long list of findings. And it was a tool to raise awareness within the organisation that improvements needed to be made within the mortuary in many different aspects.

But we do find that in different mortuaries money is not very forthcoming particularly in the NHS. I think people would far more spend the money on living patients that dead people. Similarly in the Local Authority there are far more pressing demands on how you spend your money rather than on the dead.

And so it can be very, very difficult for a mortuary to make improvements even if the staff know that those are required and even without the HTA telling them. So sometimes the HTA inspection can be a lever for change which is positive.

JONATHAN LANDAU: Thank you. Yes, UKAS.

MATT GANTLEY: Matt Gantley, UK Accreditation of Service, UKAS. I just wanted to clarify, Chair, just a point Dr Esther made there. But accreditation of mortuaries by UKAS, there's no mortuaries that are accredited alone for that activity. It's done in connection with the medical laboratory or

pathology laboratory. It's seen as the secure storage of samples of which then go into the laboratory for analysis.

So we don't currently accredit any pathology, sorry any mortuaries -- or body stores separately.

JONATHAN LANDAU: Thank you. Yes.

GAVIN LARNER: Gavin Larner, director of Work Force Department of Health and Social Care. I've been thinking this question, there's two things, I'mtrying to get more granular on it. And one is effectiveness of doing what, so what is it we want to achieve and what is the number of things there? And second is effectiveness with whom?

And in the first one there are a number of things regulation can do. So it can check whether people are qualified, whether they are competent. It can try to look at their previous behaviour to determine whether they're suitable. And it can monitor ongoing practice whether it's inspection or revalidation. And then it can take action where there are concerns.

So I think it's worth, when you're getting down to the actual recommendations about what you want to achieve as in where it's worth having those kind of questions we are there in terms of effectiveness of what we want to achieve through regulation.

And then the second dimension is with whom? I mean I confess I looked on chat GPT this information.But you know, I asked who works in a mortuary and you've got pathology technologists, consultant pathologists, bereavement officers, mortuary assistants, admin staff, security personnel, chaplains, electricians, which is quite then a broad range of people who you might want to capture through

a regulatory system. And so how you target those kind of "what am I trying to achieve" questions against that kind of group of people in a way that really gets to the essence of the safer context that you want to create, I think is quite a complex piece. And then we could sort of regulate everyone in this room and not get to the essence of what we're trying to do.

JONATHAN LANDAU: Thank you.

ESTHER YOUD: Dr Youd, Royal College of Pathologists. I was actually going to make the same point that you made. When we talk about mortuary staff it is not just APTs, it's not just pathologists. There's a large number of staff that work in mortuaries but there's also a large number of people that require access to mortuaries. And you know, David Fuller is an example of that and we haven't talked about regulation of the hospital porter and whether that would be even appropriate.

So it's the people who require access to mortuaries or where the deceased are cared for is much, much wider than we're talking about.

JONATHAN LANDAU: Yes. Thank you. Yes, please.

JANET MONKMAN: Janet Monkman, Academy of Healthcare Science. Something about the conversation that we've been having which fits with the idea of triangulating all of the regulation reports and things that come together. And I'm not sure how that happens because if you think about any data that you're collecting and performance information, any employment recommendations in an organisation, are there patterns or trends that would lead you to suspect that you've got a

problem? Or that you need to change the training or that you need to do something?

So I'm thinking about areas like surgical wards, for example, if you, like, triangulate all of those with things like compliance etc etc. It's really, is there a way of bringing all of those things together to give you a picture of what's happening in your particular department from all of the things that are being regulated that we've been discussing today? Just something that --

JONATHAN LANDAU: That's helpful and the Chair is interested in measures specifically about information sharing. And that includes also between organisations as well and is something we'll come back to.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. Just to reiterate about the HTA inspections. One of the most challenging things is when the HTA don't find something that you need them to find because there is no money available and it is an absolute fact that we are reliant.

As I say, very few mortuaries have enough capacity. We can't ignore that fact.

The other thing with the HTA is it's often guidance and recommendation. It's not fact. There's a lot of grey areas and depending how you interpret that depends how well you can explain yourself away to an inspector.

So we do need to be very mindful. I think the fact the HTA are reviewing is fantastic. But the other thing, and it's a very positive thing which is why I wanted to raise it, is the recognition that a DI does not need to be a consultant pathologist or a senior member of staff, one of the execs.

A DI needs to be somebody who is on the ground, who can see what happens, who understand how patients can deteriorate or not, who understand the implications of when we need to be mindful of that patient's care. And I think that is a real positive.

So because this is about effectiveness I do think that recognising that actually your DI may be better suited to another profession is fantastic. But this is also the problem because your APTs aren't regulated so you've got another grey area.

And actually the management of other people coming into your mortuaries is manageable, you just have to change your thoughts, change your way of working and it is time that that whole mortuary, funeral director service, we actually get some attention and look at how can you achieve it? Because we can achieve that electricians don't go in on their own. We can achieve that your porters come to a certain standard and are trained and are competency assessed.

We can do all of that. It's time consuming and unfortunately it costs money but that's the reality. But there is a lot of effectiveness coming from the HTA inspections and I did want to raise that because I think it's very important. We rely on it.

JONATHAN LANDAU: Thank you. Did you --?

KATHRYN WHITEHILL: I just have a question if that's okay Sir Jonathan, so from a lot of the discussion at the moment and I'm thinking about the effectiveness particularly.

If we think of the effectiveness of other regulatory regimes and frameworks, really it is at its optimum when there's an intersection and an integration between. And that could be an integration

between professional regulation and organisational regulation. And I'm thinking in particular the intersection between GMC and CQC and NMC and how they work to support each other.

So I'm wondering for this area accepting the limitation of professional regulation and understanding the limitations of the HTA in terms of organisational regulation, how effective is the interaction and intersection between the limited regulation that is there? And I think that follows on from your point, Lydia.

And apologies, Jonathan, I didn't say Kathryn Whitehill, Fuller Inquiry.

JONATHAN LANDAU: Thank you. Yes.

JOYCE FREDERICK: Joyce Frederick, Care Quality Commission. I'll come to that but to answer your first point about partial and piecemeal regulation and what has gone well.

I think what CQC learned from phase 1 is to be really definitive about our interpretation of our regulations so that our regulations apply to the living and not to deceased. And we are concerned about security and dignity of the deceased.

And then in coming to that conclusion we've changed the way we do our assessments based on that interpretation of the regulations. But in doing that there's a recognisable gap between where we start and stop.

So we're working with the HTA on a memorandum of understanding so that we can collaborate more effectively. And we are working with others like the GMC and NMC and updating our MMUs,

memorandum of understanding, so that there are these issues about where people fall between the gap.

On the effectiveness point, I don't think regulation is ever the complete answer. I think what we've got here is two aspects of regulation, perhaps three if we include accreditation.

You've got your professional and you've got your systemic which includes regulation and accreditation. But where you have to marry this all up is to be really clear about the responsibilities of the providers themselves.

Our regulation doesn't work if we don't tell the providers what standards will be expected in terms of their governance arrangements and their compliance. And if the Phase 2 can do anything it can say, "How can we fill the gaps and reduce any duplicate of effort with regulators? But what is the responsibility of the provider as well?" And that will help in terms of that effectiveness bar.

JONATHAN LANDAU: Thank you. Yes.

COLIN SULLIVAN: Colin Sullivan, Human Tissue Authority. So if I could just pick up a number of points that have been made.

As Joyce has said we do have an MOU of the CQC and we're updating it currently. We have one with UKAS as well and we're seeking to develop one with NHS England.

Part of our submissions, the Darzi report, was to highlight that in mortuary services are we think a Cinderella service of the health service.

That's not the case everywhere but in some places there has been challenges with resources and perhaps not surprising, given that the

health service is primarily focussed on keeping people well and getting them better.

In terms of the DI role, if you go back to Hansard when the Act was first put in place back in 2004 there was quite a discussion in the wards about at what level the DI role would sit. And I think the DI needs to be someone who is familiar with the facility, the establishment, but has also got sufficient senior clout to be able to engage with a corporate body. And where that works it works well, but in other cases it doesn't always work well. And that's this issue about using the report to try to influence people more senior in the hierarchy of the organisation.

JONATHAN LANDAU: Thank you. Yes.

MATT GANTLEY: Matt Gantley, UKAS. I just want to add to the points of the CQC and HTA. We are in the process of finalising a memorandum of understanding between UKAS and CQC and separately between UKAS and HTA. And that covers data sharing, sharing of information from the assessment reports, or looking to schedule the assessments so that they can be done in a way which it is more effective for the assessed organisations.

Also the opportunities of digitisation for presenting that information on an ongoing basis as well any issues that are highlighted from the marketplace itself and through our 10-fold advisory committee that is then back into a two-way dialogue as well as then training and awareness of the bodies of which we are accrediting or inspecting to enforce it. But that is in train right now.

JONATHAN LANDAU: Thank you.

STEVE RUSSELL: Steve Russell from NHS England. So I just want to build on a couple of points, if I may.

So I think there is an important opportunity, this might be straying into the what needs to change so apologies. But I think it's an important question to consider in terms of the guidance that is potentially shared with providers about how their clinical government systems operate, which is partly to your point. And in what respect the designated individual interacts with the clinical governance system. So for example, it's a completely different set of arrangements. But the Guardian of Safe Working was introduced to support doctors in training.

They have… the organisations and the Guardian of Safe working has to produce an annual report and has to go to the Board and be considered by the Board with some of the points around visibility. It's not a perfect system but there is a question, I think, that we should give some consideration to about and the designated individual locked into clinical government systems. Because in general you would expect, although as said this probably doesn't happen consistently, that designated individuals would be part of a clinical government system which have access to the Quality Committee chaired by a non-executive director and so on and so forth.

Now we don't issue guidance. We haven't issued guidance that sets that out but it's one of the things that has been prompted by actually the discussion with the Inquiry colleagues.

The second thing just to say is we are about to ask provider Boards to complete a self-certification on a quarterly basis, this is something

that was previously in place. It was stopped during the pandemic. And that asks a provider Board to self-certify against a set of statements, half of which is about the governance within the organisation and any risks that have been identified.

And we've updated that to strengthen the previous component which was a requirement to notify NHS England of any third party reports that flagged significant issues.

So that would include HTA report, not every single report, but an HTA reporting that included one of the more significant findings. And we are about to publish guidance on what provider Boards should look at through their Boards and clinical governance systems. And one of the pieces that we've included in there is HTA reports and HTARIs.

And as colleagues have said we're in the process of looking at information sharing and I think we can probably do better on how we've informationally shared between all of us. There are some forums that exist, for example JSOG. Everything in the NHS has an anacronym. But sort of more operational sharing between bodies, I think, is something we've started work on but we could do a little bit more.

And if I may, sorry. I absolutely recognise the points about strengthening regulation and simplifying the regulatory landscape. And I agree with that and am very supportive of it. I think it's a necessary and not sufficient piece and I know that the Inquiry team will be very focused on this as will everyone else in this room.

One of the really important things, and I think it comes out of your Phase 1 report, is the importance of compassionate leadership, curiosity and connection. And regulation alone would not stop this happening again. And there are too many examples, even in

regulated professions, where bad things happen. And so I think kind of a concurrent emphasis on compassionate leadership, curiosity, connection to the front line. And I just wanted to make clear that from our perspective the continue of care extends beyond death in an NHS organisation.

It extends whilst a patient, whether they were alive or deceased, is in our charge and in our care. And that includes dignity and respect alongside all of the other components that we've talked about.

I'm sure that we'll get into some of the gaps that might exist but I just defend very cleary from our perspective that continuum doesn't not stop at the point a patient ceases to be alive.

SIR JONATHAN MICHAEL: Can I just check, Steve, whether or not that's a change since the Phase 1 report was published or whether that's a position that NHS England took beforehand.

STEVE RUSSELL: That's a very good question. What I've just said is the product of the conversations that we've been having in NHS England, partly in response to Phase 1.

I think we would always have said that said that, to be fair, and I would always have thought that as somebody working in a hospital. But I think the Phase 1 report has caused -- well I'm sure it's caused all of us, to reflect quite profoundly. And although we haven't publicly stated the words I've just described—it's what I've said to you in my interview with you, it's what the Chief Nurse, the Chief Medical Officer, NHS England and I have been discussing are very clear about that.

What we need to consider in light of your Phase 2 findings and particularly the work you've been doing with providers is whether there is benefit in us being then even clearer with the sector about that and in the context of the broader guidance around clinical governance mechanisms.

SIR JONATHAN MICHAEL: Thank you.

JONATHAN LANDAU: Thank you. Can I just ask just following on just from the Chair's point, and I'll come back to those of you who want to make further points. But the Chair is also eager to hear about any other changes that have been put in place since Phase 1. I wonder whether anyone can summarise those changes.

LYDIA JUDGE-KRONIS: I think it's important that since Phase 1 it's been there's been much interest in mortuary services from other professionals such as safeguarding obviously Chief Nurse which is excellent and it's been very much welcomed in NHS facilities. So I go back the Local Authorities don't necessarily have this oversight.

It's also very interesting because certainly different organisations have now restructured their mortuaries and some have created whole new directorates, so exactly what you're saying.

I'm very fortunate I'm a head of Service for a directorate myself. That wouldn't have come about if it wasn't for the scrutiny and for the updating. And it's a case of leading by example but talking to the right people.

In other organisations what's happened is that for example the

Chief Nurse has got involved but potentially not with their nursing hat on. But I also wanted to point out that CQC, I have never worked in a mortuary yet, I've been around a very long time, where the CQC haven't been in.

And whilst they were focused on things like the family facilities and what we would do with bereaved families they often got dragged around the whole mortuary facility as well to evidence the care and the compassion that goes into looking after our patients. And it does carry on into the funeral directors' world.

And it's very difficult to evidence because your mortuary staff don't quite fit, we don't fit in with nursing. We kind of align more to funeral directors to a certain extent because when everyone else goes away we're the ones left with those patients. They are the most vulnerable patients in hospital.

So I'm really happy that there's collaboration but don't forget the AAPT because we're a tiny organisation but we can explain to you what's gone on previously but there have been changes and the mortuary staff are now being given a voice. However, we're also been reminded, "But you're not registered. So what we'll do is we'll put a registered professional ahead of you and you can tell them what they need to know".

So that needs to be recognised as well. So changes are happening but it's a slow burner and we actually need this to help everyone progress and to help the care of those patients and their families. Remember, we get left with bereaved families on our own. You know. We need to look after those families. They're very vulnerable and that leaves them open.

So again, we do need to be looked at and we do need the HTA and we do need you, all of you, but there are changes definitely in NHS mortuaries. Local authorities, it's much trickier.

JONATHAN LANDAU: Thank you very much. I'm just conscious of time. I think we've reached our morning break. With the Chair's permission we'll break for 15 minutes.

SIR JONATHAN MICHAEL: Yes, unless there's anything, any just final sort of -- I mean I just wanted to come back and I'm hearing every now and again comments about, "Apart from the Local Authorities and the vulnerability". I'm picking up that there is more vulnerability in Local Authorities' areas than there are in the Health Service in terms of there's perhaps more oversight. And I just wondered whether that's a fair impression to be picking up.

MARK NORRIS: Mark Norris, LGA. I suspect it is in terms of the general approach on Local Authorities will be, as Lydia has indicated previously, is much of the provision will be contracted out. It will be from the Health Service generally for most Local Authorities but not for all. And there some Local Authorities who will do it. Some will be regulated by the HTA. But overall in how councils will approach this, and Coroners' staff in particular I suspect, they will be reliant to a heavy degree on what they believe are existing regulatory environments. And particularly the professional qualifications for staff even if they've not, as we've been discussing, they're not as robust as we might think they are. But councils will probably rely on that as their main indicator of how well run, and what they should do in terms of running a mortuary.

SIR JONATHAN MICHAEL: The only other thing I just wanted to ask about was whether or not in this you're talking about improving collaboration between regulators and having meetings where things are discussed. A little bit more specific about the, for instance, the reports that come following inspections, to the extent how much they're shared. And whether or not that's something which people are looking at at the moment.

I suppose first of all I'm looking at you Colin--

COLIN SULLIVAN: Colin Sullivan, Human Tissue Authority. So every time we do an inspection we'll send it to the designated individual, we'll send it to the corporate licence holder. And we are now part of the NHS England Mortuary Oversight Group which is an opportunity to have that collective conversation.

JONATHAN LANDAU: Yes.

JANET MONKMAN: Janet Monkman, Academy of Healthcare Science. Given the integrated care groups above Local Authority and NHS, is there a link between that-- I'm just asking as a question for --

JONATHAN LANDAU: Maybe I'll address it to you then. (Overspeaking)

STEVE RUSSELL Steve Russell, NHS England. Sorry, just to clarify. Integrated care boards are not joined with -- between the NHS and local government. They're NHS organisations. Their commission is primarily for services.

So then the partnership with the Local Authority co-exists through, apologies for the jargon, but what's known as the Integrated Care Partnership. But that does not have any regulatory lens or an oversight lens in terms of delivery.

Where a commissioner arranges services with a hospital, then you would expect a dialogue about quality and risk between those organisations.

And so again, you wouldn't talk about every single issue. But if there was a significant issue raised in an HTA report, for example, we would expect that that would be shared by and noted by the relevant ICB.

And there's a set of quality arrangements that exist around integrated Care Boards and then they feed up into NHS England.

JONATHAN LANDAU: Thank you. Did you --?

REBECCA CHALONER: Please, if I may, Jonathan. Just interested really to the extent that people have been describing changes they've made in response to the Phase 1 report which is heartening to hear. But how can one ensure that those changes are enduring and not just a tactical response to an Inquiry report that's current? How do you hardwire them in so that they sustain beyond the life of the Inquiry?

STEVE RUSSELL: Steve Russell, NHS England. So I think it's a combination of hard and soft things. So I think the hard things are ensuring that the oversight of mortuary services, services for the bereaved, are properly and consistently connected into the organisations' governance and leadership systems.

I know that the Inquiry team have asked the provider organisations a lot of questions about how things work in practice and I think we're eager to work with the Inquiry team on what that tells us in terms of whether guidance etc is helpful in that context and if so what it should say.

And then the second is, I think, in the well-led category, if you like. So back to what I said earlier about a lot of the work that we do in the sector, that the CQC do with us on well-led organisations. Again being clear that that leadership duty and responsibility is for all of the services within a provider organisation.

I do think that providers have many, many things to tackle on a day to day basis. And that can lead to some services receiving less attention than you might like. And it is often closed environments, whether that is theatres, maternity units on occasion, and mortuaries. So think there is that, we have to find a way to keep visibility and the conversation going on closed environments in particular.

That's not a perfect answer to your question but I hope that helps.

JONATHAN LANDAU: Thank you. I think the last comment and then I think we need to break for coffee.

ANDREW JUDD: Thank you. But I just to make a point. So from probably Declan and my perspective at the moment of having very high level, very professional conversations about lots of different bodies that in one way supervise, assess, regulate and control .

It wasn't until the CMA Inquiry that really the funeral directing profession came under scrutiny. We were really pleased about that. But we came under scrutiny for pricing, not for care and standards.

And there was an anticipation but we were glad to be part of the CMA Inquiry.

Covid came and we were brought into the Cabinet office. And that is really interesting because what it exposed is people don't really know what funeral directors do. They don't really know. They think they know but they don't know.

So again we were down to participate to that. And funeral directors played an outstanding role during the pandemic and often seemed unrecognised but that's not what we look for but we like to be involved.

So the third part is Sir Jonathan inviting us to be part of this Inquiry, again for us this is a wonderful opportunity to share how we want to be closer to the others who care for the dead.

But we published a report recently called "Picking up the Pieces" which analyses all the delays at the moment along that whole death pathway. And that can go from registration right through to availability in crematoria.

And the long and the short of that is people are in the care, deceased people are either in the care of hospitals or Coroners' mortuaries or funeral directors for a much longer period of time. What that means is there's a greater risk for all sorts of reasons.

Declan and I were in Ireland last week where it's one of the few places you can pass away on Monday and probably have your funeral by either Wednesday or Thursday. But there are parts of the southeast of England where you could be waiting three or four weeks.

So the capacity issue both in the infrastructure of the Trusts and in the sort of capital infrastructure of funeral directors, some of them more large, some of them small, is another enormous pressure.

And my final point is that there are about 1,200 sites operating in the UK. So when we talk about how effective is it, we cannot be effective in the 1,200 sites currently that do not elect to join one of us. And we don't think the safeguarding of the deceased should be optional. It can't be optional.

So in terms of the effectiveness we do what we can do as membership organisations for those that are our members. But we want the scrutiny and a register of anyone that trades as a funeral director, because the general public will trust that a funeral director brings with it certain care and standards. And whilst in the majority of cases that's absolutely true there is that small gap, and you saw what happened in Hull and other situations around the UK at the moment. and there's that small gap where currently the deceased can be cared for.

And you talk about mortuary. A funeral director may refer to their mortuary and you'll refer to your mortuary as facilities but they could be worlds apart. We just need to understand when we're talking about mortuaries are we talking about *Silent Witness* or are we talking about a small, tiled room perhaps with lino on the floor?

And I'm only saying that because it will help funeral directors understand the terminology of, what is a mortuary?

JONATHAN LANDAU: Thank you. I think one last comment perhaps from --

COLIN SULLIVAN: Yes, thank you. Colin Sullivan, HTA, in response to Rebecca's question. I think there's two things. One, in terms of what the Regulator has done. We publish what we're doing at the last Board meeting of the Authority in September. It has our work plan, our 10

point work programme for activity that we have progressed in terms of in response to Phase 1.

In terms of our interaction with those establishments that we regulate in the PM sector. We don't just write the report and walk away. We have a corrective and preventative action plan and we then work with the establishment to make sure that the shortfalls are rectified.

JONATHAN LANDAU: Thank you very much. Well, thank you for all of your input so far. I suggest we take a slightly truncated break because we're slightly behind time and perhaps reconvene at 11.40. Does that give enough time?

SIR JONATHAN MICHAEL: How quickly people get coffee. Yes.

JONATHAN LANDAU: Thank you very much indeed.

(Brief adjournment)

JONATHAN LANDAU: Thank you all again for your input into the first half of this morning's seminar. We may be returning to some of the issues raised as we develop the discussion.

SIR JONATHAN MICHAEL: If I may, there's one area that I wanted just to pick up.

JONATHAN LANDAU: We can do that now.

SIR JONATHAN MICHAEL: No, just before we were talking about the communication between Regulators and so on and so forth and how that's changing.

I wanted just to clarify whether or not regulatory reports, inspection reports etc, were actively shared with people other than those immediately involved in the organisation, in the mortuary and/or the organisation themselves.

For instance, you will remember of course that 79 of Fuller's victims were coronial cases. And so are organisations, are people such as Coroners relevant to a particular locality engaged in any sense in any of these discussions? Or is information shared with them?

COLIN SULLIVAN: Colin Sullivan, Human Tissue Authority. So we routinely send them to -- the reports that we complete, our inspection reports, to the DI and to the corporate licence holder within the organisation. And we also publish them on our website.

We do not send them routinely to Coroners.

JONATHAN LANDAU: Is there any reason not to do that? Because by publishing a report on the website the Coroner might not be aware that it's there, that you've even inspected.

COLIN SULLIVAN: It's not current practice.

JONATHAN LANDAU: Thank you.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. As a result of Phase 1 I have heard that more Coroners are asking to be informed when there is an HTA inspection and are being given the report as well. Same as within the NHS organisations there are many of my colleagues who are now involved in the end of life care workstreams even if they weren't

before. And they also have quality governance which they are reporting to and sharing any HTA report even if it's an informal visit or a conversation, HTARI reports, they are being shared within the wider organisation.

Some were previous to Phase but there has been a lot of shift since Phase 1 and certainly the Coroners' departments are becoming more interested.

JONATHAN LANDAU: Thank you.

SIR JONATHAN MICHAEL: Yes, that's helpful.

JONATHAN LANDAU: Thank you very much.

REBECCA CHALONER: Think Matt was wanting to comment.

MATT GANTLEY: Thank you very much, Chair. Matt Gantley from UKAS. Just to build on some of the points made earlier from HTA on the process of sharing reports from UKAS.

So our process of accreditation is largely voluntary and that is the case for things like pathology laboratories which then extend to that connection to the mortuaries and the body stores.

So there isn't an enshrined right for us to share that information because it is voluntary really between us and the laboratory.

However we have changed our bereavement contract with those accredited bodies. In the event that there is an issue of safety, of concern, the first point of call is we -- the question of why the

conformity assessment body to disclose to any relevant regulator to ensure that that significant issue is addressed, appropriately.

And as I highlighted earlier we are working closely with CQC and HTA to ensure that there's a process for sharing our assessment report with both parties and for them to share back.

So if there are issues to highlight on the activity -- the mortuary, or Trust or pathology laboratory we can then act on that appropriately.

JONATHAN LANDAU: Thank you very much.

SIR JONATHAN MICHAEL: Can I just finally ask Steve whether or not within the NHS if there is any expectation or sharing of reports?

STEVE RUSSELL: So I think there's an expectation that, as I said earlier -- sorry, Steve Russell, NHS England. I think that there's a general expectation that reports that highlight significant issues will be shared with the commissioner and with NHS England in its oversight role. However, I think that is likely to be variable which is why we will strengthen that guidance in the quarterly self-certification to require people to say, "Have you had any third party reports? And if so, you need to let us know what they say".

JONATHAN LANDAU: So we're going to turn now to session three of the seminar, What needs to Change? Which should take us to about 12.15 or so. We will want to hear about what are the settings where deceased are kept that are not currently covered by a regulatory framework? And these might include NHS body stores, non-undertaking regulatory

activity, funeral sector storage, Local Authority body stores, hospices, care homes, nursing homes, private hospitals and the like.

Should those settings be regulated? I appreciate they're regulated for other purposes; we've heard from CQC. What is the level of risk to the security and dignity of the deceased in those settings?

So if we're happy to have that.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. So there's a lot of talk about -- and I know the Human Tissue Act specifically says "body" and you'll find very few of us will refer to people in our care as "bodies". We'll call them, "deceased" or "patients".

So there's a lot of talk about a mortuary and a body store. We believe that all mortuaries, regardless of their use, whether they are autopsy mortuaries, funeral directors' mortuaries or our mortuaries, should be mortuaries and they should be licensed and regulated in some way. That's the first thing.

Secondly, there needs to be an entire overview of the mortuary system. So often you have minimal staff. They are qualified and they are very caring. There is no backfill like there are with other professions within the NHS. So if you go for mandatory training the other staff have to pick that up.

So there needs to be a full review of the service and a full review of the educational pathway. This is essential.

It has changed. It changed approximately 10 years ago. It needs to change again and it needs to be more robust and it needs to be more detailed and there needs to be a clear pathway to align us with other healthcare professionals.

Regarding the funeral directors. The difficulty we have as APTs is the fact that often have to hand over care of that patient to a funeral director who potentially doesn't send the correct amount of staff, who doesn't bring the right equipment and, "It's all right, it'll be fine". There needs to be a full review and we need to work together to ensure that that care of deceased is continued. And in lots of places and lots of examples it does. But there are times, and I have certainly been involved where I have refused to release a patient because there were different circumstances, and then the family are angry that we haven't actually done what they wanted us to do.

However, we have a duty of care to that patient all the time they are on our premises. And handing them over is still part of our care.

So for me that's what is an essential change that we need to look at.

JONATHAN LANDAU: Thank you. Not heard from NHS Providers that the issue of body stores -- we've heard about the issues of terminology. That obviously applies to your members. Does NHS Providers have a view on the need for regulation in settings that might not currently be regulated?

ISABELLE BROWN: Of course. Isabelle Brown, NHS Providers. Thank you for the question. I think we are keen to kind of consider regulation as part of a wider piece of oversight. And we would encourage consideration of DIs having more visibility and access to Board level and having routine opportunities whether it be through line management, team conversations, for staff to be able to raise issues and to have that psychological safety so that there is better oversight of what's happening in these settings.

Also from reading the report, which was really useful, there was talk about how there was Health Board to Ward oversight -- there were less opportunities within mortuary settings. And I think more Board visibility in those settings would also be useful and to have that included within guidance specifically.

I think there's something about making the implicit explicit in guidance when it comes to mortuaries because I think Trusts all are really aware that is part of their role but it's kind of just really bringing that out, as I think was mentioned earlier.

So I think probably coming at it from a whole puzzle piece in addition to the regulation, looking at culture, looking at psychological safety and supporting Boards to really be aware of things that they can do to have better oversight and visibility in these areas.

JONATHAN LANDAU: Thank you. Can we hear from the Local Authority perspective as well?

MARK NORRIS: Mark Norris from the Local Government Association. So I think in terms of starting point there's a very -- as we've heard this morning, there's a very diverse range of provision in terms of where the deceased are stored and who's responsible for them.

And I think there's an issue around clarity of who is responsible and what their duties are rather than those people who are responsible for looking after the deceased.

So I think there's something here about possibly a statutory duty, something that specifies in law what the expectations are of everybody in the system when it comes to looking after the deceased and ensuring their security and dignity.

That interacts I think with the conversations we have had about whether or not it's a DI or a corporate responsibility in terms of where that sits. And I think expressing something which is an organisational as well as individual responsibility is needed in that.

I think there's a question about whether you can have a whole system approach to this. Can you have a regulator who is responsible for the totality of the system? I'm not sure how that would work necessarily but there are clearly areas where, as we've identified, there are gaps. And our experience in those of both SAIF and NAFD in terms of events post Hull show that actually where we wish to do something and we wish to ensure there are good standards, whether it's the industry itself or Local Authorities acting in temporary role as a regulator by default is that actually you need to have a proper system, regulatory system, in place with structures to it in terms of clarity about roles, clarity about powers and actions that you can take as a Regulator where standards are not being met and people are not doing as they should be doing.

And I think the final point in this would be that with all of that comes an issue about capacity and resource and ensuring that you can do that. So providing people with, if you're in the regulatory side, ensuring people have got the right training to be able to go in and to carry out the role that they're expected to do, the capacity to be able to do that. And others have alluded to the issues that Local Authorities are under in terms of financial pressures.

One of the areas where we -- and there are lots of regulatory functions that Local Authorities carry out, but one of the key points that we have, both that are around for example, Health & Safety at Work Act and Food Standards Agency and Food Hygiene

requirements, is that we don't have enough staff on the Local Authority side currently to be able to carry out the statutory requirements that we're supposed to be doing under those regimes already.

So there's a clear thing about making sure that any regulatory regime that is in place needs to be resourced to ensure that it's effective otherwise you'll still have people falling through the gaps in terms of doing it. And Colin was talking about the increase in HTA inspections. You need to be able to, if that's what you want to do, and expect that X number of premises would be inspected on a regular basis bi-annually, annually, whatever, there needs to be resources that go with that. And that's quite a difficult conversation with government about where the resourcing for that comes from.

So those are some of the key points I'd make.

SIR JONATHAN MICHAEL: Can I just follow up on that, if I may? Mark, is there anything that you think needs to change in relation to the support that Local Authorities have or in the Providing Services whether they're mortuaries or body stores? Local Authorities don't employ clinical people on the whole or don't at all other than the occasional, sorry, mortuary staff and so on don't employ pathologists. You don't have background clinical awareness and domain knowledge.

Is that a problem? And if so, is that something that should be changed?

MARK NORRIS: Mark Norris from LGA. So yes, so councils will be heavily reliant on what they assume is happening in terms of professional standards that others are operating to when it comes to the running of those

facilities, particularly where they're contracting with others to provide them.

And I think what we've discussed already this morning in terms of changes to how that might work and would provide a degree of assurance for councils in terms of understanding standards are more likely to be adhered to because they have got people who have been properly trained. That that training is properly checked. That if there's a voluntary membership scheme it actually becomes more of a compulsory membership scheme in terms of membership of a professional body.

I think it's a slightly different issue about where responsibility, for example in terms of DBS checks where it sits, at the moment it probably sits more with the employer.

I think there is an issue specifically for Local Authorities in terms of where our responsibilities sit in terms of what we do versus where responsibility sits with Coroners and where Coroners are answerable to.

And as I've discussed previously with the Inquiry the Coroners are independent members of the judiciary ultimately and their responsibility is upwards to the Ministry of Justice and the Chief Coroner rather than directly to us. So I think there's a question about how do they fit with any kind of framework and the work we do.

So I think that's one of the key points that we would highlight is that if some of those things are right then from a Local Authority point of view in terms of provision of services you can rely on, is a contract with a provider the best way of regulating the environment?

I'm not sure that necessarily it's a good way of providing regulation. It may provide you with a degree of assurance that things are being

done right. You may see reports from the HTA and others. I just question about whether in a contractual arrangement, when you get the report from the HTA or from any other regulator which says there is something awry, how do you then, as somebody in a contractual arrangement, seek to change that in a fast and efficient way which ensures that the dignity of the deceased is being properly secured? And I'm not sure, as I said, that that's the best way of doing things.

JONATHAN LANDAU: Can I just come to CQC, please? You mentioned there are various different settings and I noted some of them are regulated by UK Quality Commission. And you mentioned earlier that the CQC recognises that the care of the deceased and regulated activities, that the CQC is concerned for care of the deceased.

And we've heard experience that CQC does in fact go into mortuaries. What is the current and ongoing position in relation to whether CQC, during inspections, is going into mortuaries is considering the care of the deceased in those other settings, if it falls outside of regulated activities where -- what's the framework for that? Is that part of performance assessment or in what way is it related to CQC's activities?

JOYCE FREDERICK: Joyce Frederick, Care Quality Commission. Our current guidance and assessment framework does not direct our people to go into mortuaries. So I don't know the timescale by which you last saw somebody within a mortuary.

But we would be directed to be concerned if the care of the deceased wasn't to standards of dignity, the cultural expectations or religious expectations of the individual or there are safeguarding or safety

concerns. So we're thinking about the families or the carers who are left and the experience that they have with the deceased.

But we would not be going into the mortuary to do any kind of accreditation or registration to see if the storage was at the right temperature or if things worked or the individuals who work there, that's not the role of the CQC.

I do accept that in other settings a care home, for example, well it might not be any cold storage equipment where the care of the person deceased might be in a room which is closed for a day, we hope, but it could be slightly longer unfortunately.

We cover the regulation of that. We would be thinking about infection control, about what happens with relatives, about how quickly the funeral directors or the GP has been contacted. But we wouldn't be looking in terms of what the HTA might look at or whatever organisations might look at in terms of their accreditation standards.

So it is about the living.

I recognise the overlap because we are thinking about security and dignity of the deceased but it's not the structural -- what does a mortuary do and who works within it? It's more about have they done the right -- has the Provider done the right arrangements for the person who is deceased and then for the family or the carers of that person?

JONATHAN LANDAU: Thank you. Yes.

STEVE RUSSELL: Steve Russell, NHS England. So I think in the spirit of the parting areas where better clarity could be surfaced, I think we think that this is one of them.

And so, because, yeah, I think there are -- perhaps inspectors approach this in a different way. And end of life care, my understanding -- and I don't want to get this wrong, but my understanding is end of life care is a core service as one of the CQC's core services. And in the fundamental standards that are published it does talk about that including people who are approaching the end of life and following death.

And of course that could be open to interpretation as to where that starts and stops particularly because there is guidance to inspectors to talk to ward staff and to the porters to ask porters how wards handle the bodies of deceased people. And it does include the viewing areas in mortuaries and specifically encourages to people to look in the viewing areas.

So I think that's an area where further clarification about scope would be helpful. I think from our perspective, recognising it's not our decision, it would make sense to us to see that scope extended.

I'll give an example and then I'll come back to why I think it's important on the guidance on what inspectors should look at.

As was said, it doesn't include looking at fridge temperature ranges or whether somebody, a person who is deceased, is in a fridge after 30 days etc. But on a ward colleagues would look at temperature control for medicines, as an example.

And the reason I think it's important as an opportunity to clarify is colleagues have quite rightly said that fundamentally organisations need to make sure that the arrangements are in place. And many organisations use the fundamental standards that are published as their own sort of internal inspections, if you like.

So many organisations, they call them different things, whether it's "peer review" or "mock inspections", but because you are interested and keen to ensure you are meeting your fundamental duties you'll have arrangements in place. So you're inspecting yourselves rather relying solely on a periodic inspection. And those standards often guide them.

So I think, we think, this is an area that could benefit from some clarity.

JONATHAN LANDAU: Thank you. Do you want to come back on that? I don't know whether these references to looking at those particular areas remains in the new single assessment framework or not.

JOYCE FREDERICK: So that is probably plugged to the Phase 1 report. In the new assessment framework it has changed. There may still be discussions because you're right, the fundamental standards talks about following the death. But there may still be discussions on how was this person cared for and was it done with dignity. But we wouldn't be directing people to go to viewing areas, we wouldn't be directing to go into the mortuary to check on temperatures.

It is not the same thing as, "We'll give them the guidance to do it and they can regulate in those areas". You have to have an understanding of what good looks like and what do standards look like? And that's a whole different area of regulation.

I mean it's not my job to decide who does it and how they do it. But I do take the point that if you've got duplication and overlap it doesn't help oversight. But I do think that they are probably better regulators who can look at care of the deceased rather than the CQC and our

interpretation, I think that would need regulatory change, it's about the living.

So to do what you have asked, which I can't say whether I agree or disagree, but I would say that that would need a regulatory change and also a follow up in terms of regulatory resources and understanding of how the fundamental standards work then for a deceased individual.

ANDREW JUDD: Andrew Judd, National Association of Funeral Directors. So we gave a follow up call for evidence for the Justice Committee Inquiry into the Coroners' Service. And the reason I mention this is because the Coroners' jurisdictions all operate so differently around England, Wales, and to a degree, Northern Ireland.

What we've been trying to do is to get some consistency and to get the Coroners and the Chief Coroner to actually bring some alignment. And that hasn't happened but we've been banging that drum for a long time.

The reason I mention it is many of the coronial deaths are young people, they're children. They are very emotive and sensitive situations. And the delays that we were talking about earlier that come from different systems and different capacities or resource, those delays impact the living. Categorically they're difficult, traumatic and tragic types and the families of those who've passed away who are in the care of the Coroner do suffer. They suffer detriment because nothing's happening and they can't tell people.

We met with Mike Freer and Simon Hoare just ahead of the call for the last election and we set up the arrangement with the Environmental Health Officers. And it's the first time we've ever been

able to have representatives of the Local Government into funeral directors and we worked together to put together some champions, if you like, what good looks like. I think you used that expression. And I have to say the Environmental Health Officers have been absolutely superb. They've been engaged, they've been interested.

But we are very mindful that while they're visiting us they're not visiting the other places that they need to. But we have been really interested and appreciate the feedback that's come from the visits. And I think it's shown that in the art of the possible we can work with those people.

But final bit on what needs to change. We spent an awful lot of time batting between the MoJ, Department of Health and Social Care, the Law Commission. It just depends on what particular subject but when it comes to death the running between the MoJ and the department as to social care is quite a frustration because it's, "Well, that's not us, that's them", or, "That's not them, that's us".

And what we would like to see at government level is, I don't want to use the word "Tzar", but somebody that actually joins together all of the departments that have an impact on bereaved people in this country so that there is some kind of consistent body that sits above. Because just by definition it cuts across so many different areas of really important government activity. So in terms of what needs to change we would like to see somebody that says, "We will help bring these departments together to the degree they need to to make sure that the bereaved people are not caught up in a disconnected part".

JONATHAN LANDAU: Thank you. Yes.

COLIN SULLIVAN: Thank you. Colin Sullivan, HTA. So I think in terms of my framing in my mind about the areas that are unregulated that need to be considered that the Inquiry are actively considering I think there's three areas for me. Two in the Health & Social Care family and one in the Ministry of Justice space.

So we know that there are body stores in health facilities and also Local Government as well. But we recon about 100 of those in England, maybe 120 or so. We don't have the definitive numbers. It's not something we regulate but that's our estimate.

That compares with 168 licences for PM across England and Wales and Northern Ireland. So that's the sort of magnitude of this in terms of body stores.

And the question is, do they need to be licensed. And that's a question for consideration.

Then as you know too there are these other places within the Health & Social Care family where people die, or people are- their bodies are transported when they've died.

So you've got the likes of hospital wards initially, you've got care homes, you've got hospices, you've got portering services, ambulance services. And do they need to be licensed? Or is there some other way of catching those and the activity that they are engaged in? And you will be aware that one of our Board members, David Locke KC, has written throughout that by correspondence from our Chair to the Inquiry about our duty to respect, which may be some way of catching that without actually having all of that activity licenced.

And then I should say in terms of body stores that there are 12 of those in Wales. And we have, at the request of the Welsh

government, we have undertaken advisory visits and inspections. They're not statutory, they're advisory. And we've done that in six of them and we've found a number of shortfalls which obviously we've fed back to those hospital Trusts in Wales and then action will be taken.

And then there's the third area which we've also been talking about and that's the funeral sector. And I suppose the question there is, if there is to be regulation there is it about the people or is it about premises, what is it about --?

JONATHAN LANDAU: I just want to come back to you on the issue of the duty of dignity to the deceased as perhaps being a substitute or alternative to some licensing or inspection process for where there's currently gaps. From your experience at the HTA, where there is that inspection function and you've described what you're finding and how it's driving improvement, would a duty to preserve the dignity be effective without an inspection and licensing framework?

COLIN SULLIVAN: Well, the duty to respect could be on the basis of guidance. You could go to the other end of the spectrum where you licence everything. But the question is, is that proportionate? And a judgement could be made where you sit on that spectrum.

Some of those things that I mentioned may lend themselves to licensing. Other things may not. And the duty to respect might be one way of catching all.

But I'm not saying that none of those services could be licensed or should be licensed. I'm simply saying that that's something to be considered.

And the question is how frequently are they encountering people who die? It's as -- that will not happen that often. In other cases it will be routine.

JONATHAN LANDAU: So in relation to body stores, and you mentioned that it's almost an analogous situation in terms of the numbers, the HTA's view would be that that indicates a greater need for a registrational regime with inspection as compared to, for example, the care home where it might be occasional or not for very long.

COLIN SULLIVAN: Yes. Colin Sullivan, HTA. I think the reason for that is because you look back to the reason of why the Human Tissue Act came into being which was around the retention of organs without consent in certain facilities, which then looked at the scheduled purpose of one, which was determining the cause of death, which was PM mortuaries and other mortuaries were left …

JONATHAN LANDAU: Thank you. That's helpful. Esther?

ESTHER YOUD: I've got a number of comments about a number of things that have been talked about. Esther Youd, Royal College of Pathologists. First of all, I think your estimate of the number of body stores is an underestimate, quite a large underestimate. I just think about our current hospital where I work in Glasgow at the moment, is a centralised mortuary for postmortem activity. But there's probably four or five hospitals around that have body stores that then feed into us for the postmortem activity.

Where I worked in Wales I'm sure there were four body stores and one mortuary just in the one Health Board that I worked in. So I think the numbers are an underestimate. To say that's just an observation. In terms of the discussion around regulation and the extent of the CQC.

And also there was a comment about what inspectors find and what they pick up on and different inspectors potentially having a different approach.

So it strikes me that if, as was suggested, the scope of the CQC was to expand or there was to be a new regulator in these unregulated spaces at the moment, we need to be really careful about multiple regulators doing essentially, or looking at the same areas, and potentially having different messages because that's a real problem.

I mentioned earlier on about most mortuaries don't opt for UKAS accreditation for the mortuary they look to their HTA accreditation. And that's because a UKAS inspector might pick things that are -- or might say things that are very different to what an HTA inspector might do.

And so you really don't want that, first of all, duplication of effort, but also mixed messaging. So I think that's really important that we ensure that that doesn't happen if the regulatory framework was to be extended or an additional regulator identified.

JONATHAN LANDAU: Thank you.

DECLAN MAGUIRE: Declan Maguire, SAIF. Just to make as well on some comments that were made. But definitely agree with Andrew and everything he has said.

One of the things that's become clear to me this morning is there's a lot of complexities within the relationships around this table.

And I think as Andrew and I were speaking about at the break the solution is actually quite simple. It really is.

We already look after 70 per cent of the sector, we just don't have the legislative backstop in order to enforce it. And so when I kind of look at how we could potentially work in with the HTA. I did make an approach to the HTA on co-Regulator proposing, I think last year. But then we're still looking at how that could work.

The reality is we just need to support the government to get it done. It's as simple as that. We've already got two inspectorates. We're quite lucky. We need to centralise a lot of this. And SAIF's position is co-Regulator model. And I believe that proposal was submitted to the Inquiry, I think, last year.

You know, companies do need to be licensed. Individuals do need to be registered, particularly if they're involved in the care of the deceased. And we need a minimal standard of education. We just don't have it. They've got the education it's just not enforced.

So I do respect the complexities around the table. And I do fear a little bit, given the urgency to regulate the funeral sector.

And our own belief as well is that we could do it quickly but do it well, is that, yeah, some things I wonder if getting involved materially, whether that could slow things down, if that makes sense.

Representation from all the key parties would be required in order to make it work. But yeah, that was just my comment around that.

JONATHAN LANDAU: Thank you. Yes.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. I just want to go back to basics on something. We discussed licensed and non-licensed with the HTA and we discussed the fact that they specifically set up to look at the postmortem sector.

However, if you're a licensed premise they don't only look at your postmortem activity. They look at releasing, registration, all of the other activities that go on.

So of the issues that we struggle with on a daily basis is the terminology, nominated representative, a person's next of kin versus nominated person. And we desperately need to go right back to basics and have some awareness that when a patient enters a hospital or whichever organisation that they nominate, the key person they want us to talk to, it's very difficult because when you're in a licensed mortuary and you're following your HTA licence, so you'll work with the nominated representative which is kind of called "the next of kin". And it's certainly something that on a personal professional front I am addressing currently but getting a lot of pushback because nobody really wants to be the first people to use it, next of kin doesn't have a legal standing and often we'll get two or three family members. So who is that?

So we look at the qualifier relationships but often they're equal to each other. So we desperately need more conversations about death and dying, more conversations with patients while they're living and an actual acceptance that we either fall with a nominated representative or we stick with next of kin. But it's such a grey area and we often have competing family members.

So who is correct? So we need to be aware of that. And the minute that that person leaves our care or is in an unlicensed facility then the same rules don't apply.

So for example we ask for identification when families come. We ask a lot of questions when families come because that is expected because we are licensed. Other places don't have to do that. So they still have rules and I'm not saying they're just out there doing whatever they want. They still follow guidance. But this is why I'm very keen that anywhere there's deceased people that we have an overall -- you will have the person you're dealing with.

And any of you that are used to dealing with variances at a funeral directors you'll know this. You have two family members that will go to one funeral director and book a funeral. The family will go another. And then you've got that complication of who do we release that patient to?

So we've got a lot going on and there does need to be some kind of standard. Whether you're licensed or not there needs to be a minimum standard. And as the AAPT we're out there. We'll do peer reviews. We'll give advisories and we'll get involved in investigations. But we're a small voluntary body and we all want what's best but we've all got day jobs as well.

So I just need to say we really want to be involved and we really want to engage with everyone. But we need, you're quite right, the overarching assistance and we need government support because there is a lot going on out there that isn’t under the radar and that's the worry.

JONATHAN LANDAU: Thank you. I'd like to move on to what other constraints or possible gaps there are. It's not necessarily in relation to settings, locations, but in relation to the current approaches and frameworks.

There was some discussion earlier on about the role of the DI and different views on where governance sits and who's responsible for that and the regulation of that.

If I could start with that, and perhaps coming to you, if I may, from the HTA's perspective. Do we think that the legal responsibility sits at the right level with the DI, designated individual, should the legal responsibility be elsewhere in the organisation or jointly within an organisation? And in relation to the governance piece, does the HTA look at the governance arrangements as part of the inspection process?

COLIN SULLIVAN: Colin Sullivan, Human Tissue Authority. So we look at the governance arrangements in the mortuary facility. We don't look at the governance arrangements in terms of the Trust Board. That's obviously outwith the establishment that we are licensing.

Where should the responsibility lie in law? In many cases if you get the right DI it works but in other cases it doesn't. And we can use influence to discuss with the establishment as to who is the best person, or who's best placed to be the DI when considering different aspects?

As I said earlier I think having a DI that's close enough to the action but also senior enough to actually influence and perhaps the links to the wider quality system, as Steve was saying, in terms of medical director. Being able to ensure that if they have concerns that they can raise them with senior people in the organisation at Board level.

So I think it would be helpful if it was strengthened in law that as well as having a DI that it was clearly also a statutory legal responsibility for the corporate body.

JONATHAN LANDAU: Okay, that's perhaps analogous to CQC framework where you have registered providers but also registered managers. So it doesn't need to be either/or, it can be both.

JOYCE FREDERICK: Yes, Joyce Frederick, CQC. When we register providers, we have a registered manager for adult social care, independent healthcare and non-NHS Trust Services because NHS Trusts we treat as a Provider and they nominate individuals that have a relationship with us, rather than a Registered Manager in that context.

The regulations don't apply to a Registered Manager in the context of NHS Services.

JONATHAN LANDAU: Thank you. And then in relation to safeguarding legislation. We've heard that safeguarding in the sense that we know it currently doesn't apply to the deceased. And should Providers extend consideration to the deceased and to the local safeguarding arrangements? So should there be safeguarding duties from a legislative perspective in relation to the deceased?

So if I can come to the Local Government association first, because Local Authorities lead on current safeguarding statutory duties.

MARK NORRIS: Yeah. Mark Norris, LGA. I'd be wary of framing this in the context of safeguarding because under -- and I'm no expert on social care and the Social Care Act. But obviously there are statutory duties on Local

Authorities in terms of adult safeguarding and children safeguarding. And there's very specific statutory regimes which apply. And obviously there's a link across that into CQC in terms of the adult social care environment.

I think something that's more of a duty, as Colin's been describing from the HTA perspective seems to me the right way to kind of frame it, which is something along the lines of whether we refer to it as security and dignity of the deceased or respect, it seems to me something like that is more appropriate in these circumstances. Because the safeguarding regimes as they currently exist and the work that Local Authorities do under them relates very specifically to alive individual in potentially coming to the remit of adult social care and children social care. And that's where the responsibilities lie and there's a very legal framework that sits from a Local Authority perspective in relation to that of which CQC's another regulator in that space and regulates Local Authorities in that space.

So I would distinguish between the language specifically on that one. And if we're going to look at this I would distinguish particularly about that language around safeguarding and put something very specific in which is around how you treat the deceased and the expectation from it.

So I think broadly Colin's outline seems to me, as an initial starting point, the right place to be and I think there's probably discussions about how you frame that and who it extends to. But that would seem to be the right kind of point.

JONATHAN LANDAU: Leaving aside the terminology then. So then according to having duty and respect for the deceased or duty of dignity for the deceased.

Are Local Authorities well placed to be leading on investigations relating to that?

MARK NORRIS: Not currently, no. So I think, as I kind of alluded to earlier, if the expectation was, for example, that there was requirement -- a statutory duty placed on the bodies that are represented around this table, some of whom don't currently come under regulatory regimes and are colleagues in terms of SAIF and NAFD, and that we looked at something different from that.

Our experience I think in terms of what happened in Hull and events earlier on this year showed that where you have a cooperative regime, and we were very grateful to colleagues from SAIF and NAFD because Environmental Health Officers were going into an environment which they don't actually normally go in to. It wasn't something that they statutorily do, it wasn't something usually within their experience. And one of the first requests they were making was, "How do we know when we go in to inspect a premises that what does good look like in terms of care for the deceased?" And it was only because SAIF and NAFD were able to produce that guidance that EHOs had an ability to be able to go in and make some kind of assessment.

I think there's a question there about if you're thinking about for example regulation for those unregulated, currently unregulated, parts of what we're talking about, what ability do you have to go in to inspect premises or talk to individuals currently? Certainly in the case of funeral directors, it was an entirely cooperative process.

Fortunately in terms of it being a cooperative process I don't think we're aware of any instances where Environment Health Officers had

the door slammed in their face by any funeral home. But there's certainly a possibility that it could occur because we don't have the legal powers to cross the threshold and go in and inspect. As against in other regulatory environments the Local Authorities do give a statutory power of entry, for example.

And within that I think the other aspect of it all is where Environment Health Officers, for example, were going into funeral homes and if they had found something that didn't reach the standards that had been set by SAIF and NAFD the big question was, "What do you do about that?" And actually there isn't really anything from a Local Authority point of view at this point in time that you could do.

Are councils the right people to be in the space of regulating it? I don't think from an association point of view we're convinced necessarily that Local Authorities are. I think that's something up for discussion.

There is, as colleagues from SAIF were saying, there's potential alternatives on the table which could work just as effectively, I think, in comparison to Local Authority regulation. And I think there's a question about if you were looking at councils potentially as a regulator in these spaces, expertise in terms of understanding what you're looking for when you're going in to do that inspection, where does that sit, given that colleagues in the HTA have that experience and knowledge already, which Local Authorities don't.

And then I'll come back to -- because it's always a refrain that the Local Government Association makes, which is resourcing and capacity in this and the ability to be able to deliver a regime if it was in place. And having the people to be able to make sure it works and is acted upon.

JONATHAN LANDAU: Thank you very much. I think we need to move on. So I'll come back if there are any other comments at the end.

Session 4 is to discuss the benefits and challenges of implementing professional regulation of those who care for the deceased. I know there's already been some discussion around that but it's an opportunity for us to consider in more detail how professional regulation would lead to greater protection of the deceased.

So to start, yes.

JANET MONKMAN: Thank you. Janet Monkman, Academy for Healthcare Science. So one of the real benefits of regulation, whether it's voluntary or statutory, is the commitment an individual makes towards the care of whoever they're looking after, whether it's a patient or a deceased person.

Alongside that regulation comes things like governance. So we have things like standards that our people need to work to. So many things we've been talking about now in terms of things like safeguarding, for example, would be part of the standards that you set with that particular profession.

Also looking at the educational training requirements for that particular group in that workforce really helps to standardise some of the approaches. But the benefit of the Professional Standards Authority Accredited Registers is it does give an element of flexibility as new roles come in, being able to move that forward.

Equally, as a regulator we're able work with the organisations that develop the education and training. We can look at trends. We can influence that. We work with professional bodies.

A big challenge that I experience every day in my work is that it's not mandated. But equally, it could be encouraged. It could be as an essential part of any job description or role descriptor.

And I think we've had conversations over lunchtime about how that could happen. And really an instruction would be helpful and make a big difference.

The other area that I think we should consider too is the workforce and the benefits that regulation can have on impacting on the culture, helping the self-esteem of that profession. But also in the areas these people are working, what the wellbeing initiatives are, the sort of research that you can undertake with that particular professional body and group really can make a difference.

So I'd absolutely 100 per cent recommend that a form of regulation for the workforce is really essential. And there are systems around it already that are not being fully utilised and I think that's an important consideration.

And even as a transitional approach endorsing registration could now make a really big difference because that is something that could be implemented really quickly even if there's a move towards statutory regulation, in which case my organisation would work with the statutory regulator to look at a way of transitioning people on to it.

But without that endorsement from employers, whether it's funeral directors or the NHS or whomsoever, that's extremely challenging.

And recognising this workforce does move both inside the NHS and outside. I personally feel that there's a huge change that could come about with that endorsement.

JONATHAN LANDAU: Thank you. In relation to professional regulation, we talk about presumably for the professions that you're involved with; we've heard earlier on that that David Fuller wasn't a professional in any of the senses that would describe in terms of being a physician or technician.

And that raises the question that if there's a form of professional regulation, which staff should it apply to? So what types of function, what types of profession, what types of staff?

GAVIN LARNER: Gavin Larner, Director of workforce, Department of Health. I think it's worth looking at multiple regulation in terms of what impacts they have.

So I was saying earlier in the professional regulation is good at assuring a qualification that someone's got an approved state of knowledge effectively to do the job. It's less good at managing real time behaviour.

So like Lucy Letby, registered by the NMC. Shipman, registered by the GMC, had no conduct behaviour whatsoever but it considered mop up afterwards and then try and find an educational training preventive.

So I think it depends on what you want to achieve with particular staff groups, whether you go for the kind of voluntary over there or full blown regulation. Or whether if you think the main things are behaviour and character rather than qualification, whether you're looking to things like DBS and whether that's being applied effectively can try and pick up previous offending that might predict future offending.

So I think it's what do you want professional regulation to actually target in this, and in which particular bit of that mortuary workforce that we're trying to get.

And so I think you should look at the case re. profession. My inclination is actually this thing about the setting and the governance in a particular setting where you've got a multitude of different people around about what's happening in there, who's responsible where, for making sure that whatever the regulation, people coming in, whether they're public or staff or others that affect the safeguarding instincts and practices around that.

JONATHAN LANDAU: Thank you.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. APTs need to be regulated. They are looking after your mortuaries; they are looking after the deceased and they are looking after the bereaved.

So from my point of view the reason they need regulation is they are managing the people that are coming into the mortuaries. So any of the portering staff nowadays you will find in different mortuaries are being trained. They are actually being competency assessed. They are actually being held accountable if there are any failings at certain of times of day.

We are the ones that have to write the rules for our particular facilities and work with Chief Nurse or whoever else it is that we've got governance. Certainly I feed into the governance leads and I'm very involved with quality.

The other reason we need to be registered is people do need to be held accountable. Currently there are mortuaries whereby an APT

will make a decision and it will be a decision made on potentially staffing, care of patients, other activities going on. They can be overruled because somebody else is a registered professional and they are in the hierarchy. And they can come down and they know best. So actually what happens is the entire workforce gets disturbed.

You have a whole profession of people that have been under the radar. When we speak to families they are astounded we're not registered. When we speak to other professionals they are astounded that we have no regulation.

Yes, we do have quality control and all of these processes if you are engaged with that. Not every mortuary is engaged with that. So I do feel very strongly that if this is our opportunity to raise the bar -- and certainly when you look at the offending and how did it happen, I'm not here to answer that question. But the reality is is if you give those professionals the professional status then they are obliged to uphold what is expected.

JONATHAN LANDAU: Thank you. I'll come back to you but can I just – looking to the funeral sector and NAFD and SAIF around their views on professional regulations you've mentioned. And I'll start with you, your views, on what should happen in relation to providers and a suggestion that you could have involvement in that. What about in relation to professions and staff members?

DECLAN MAGUIRE: Declan Maguire, SAIF. Yeah, absolutely. I think there's the original proposal, and it's evolved a little bit since then, deliver requirement for the individual involved in what we called "The three key acts".

So that was the individual care of the deceased, transport of the deceased or in invasive procedures to the deceased.

And that essentially fall into two categories, one should be -- probably number one and number two there. And the third invasive procedures with your mortuary sciences or embalmers. So essentially with a new profession. And there would be a minimum requirement of education on those two as part of registration as well as the DBS check.

So they go down the line that I think everybody would expect it to. But I think as things currently stand there is no requirement for anyone involved in embalming to have a qualification. And that to me is mind-blowing, completely that that shouldn't be the case. Anyone who's not been trained in dissection and, you know, learning the human body…

I think it's a three year course, I think it is pretty much, for someone to achieve that qualification. There's nobody checking.

Now the employers technically do, if you look at the overwhelming majority of the adverts for embalmer position it will say, "You must be qualified", but there's nothing to catch it when it's not. So it's not acceptable.

So our position has always been that it's again registration of businesses for individuals with any kind of involvement in the three key acts as a start should absolutely be registered and (Inaudible) requirements.

And I think as I said earlier, that would be Phase 1. We would then look to the individuals who are involved in care of the bereaved. Again it's kind of if you do it in phases, just get it right, then move on to the next stage. But 100 per cent (Inaudible)

JONATHAN LANDAU: Thank you. Just briefly from NAFD and --

ANDREW JUDD: Yeah, that I'd support what Declan is saying. I think it's very difficult because the funeral, the structure in the funeral businesses is so diverse. We have a lot of low skilled people, okay? It's a lot of low skilled people who are very caring and very loyal and very dependable. But it's very difficult for some of those to go through formal qualification.

So I think proportionality is always the word that we want. But we do have fully qualified permanent embalmers in proper facilities and that's what they do, day in day out. But we will have semi-retired people that might come in, might help on a funeral and then do some, what we would call, "First offices", which is a very sort of basic preparation of the deceased.

Both of those matter and I don't think it's, you know, talking about David Fuller, I don't think the risk of these terrible things happening is whether you're highly trained, highly skilled or low skilled. I think that's about bad actors.

But what we need to do is make sure it's the supervision. It always comes down to the supervision and what's appropriate to supervise people who have access to deceased people.

But yes, I think we have to be careful if we're looking at a registry that's based on qualification for everyone in the funeral service because there are some people who have worked in the funeral service and have never go anywhere near a mortuary. But we can help with that.

SIR JONATHAN MICHAEL: But when you say "access" do you mean the three key things that Declan was talking about? Or do you mean other forms of access?

ANDREW JUDD: Well, just access --

JONATHAN LANDAU: Physical access.

ANDREW JUDD: -- unsupervised access.

JONATHAN LANDAU: Janet?

JANET MONKMAN: Janet Monkman. We've actually done quite a lot of work with the life science industry, people who visit hospitals, different levels of things. And potentially that particular group that you're describing would fit well with that. So that's not about qualifications, that's about skills, knowledge, expertise.

And that's really important because then whoever does whatever wherever will have some way of acknowledging that.

And the other area that's I'd just like to raise as a thought is around the barring system that exists for teachers. So if somebody gets excluded, and from your perspective, that may be the area to consider looking at, just to think about. And teachers get excluded from teaching in some circumstances.

But the credentialing system is really important. It's something that we learnt from New Zealand in terms of the approach and it does cover a range of people from individuals who drop off incontinence pads right up to people who may well be visiting theatres.

So I suggest that might be something to look at. Thank you.

JONATHAN LANDAU: Thank you. Steve?

STEVE RUSSELL: Steve Russell, NHS England. I just wanted to make a couple of points if that's all right. I agree with a lot of colleague's points.

So I think -- I was quite sure about a colleagues point on a general duty to protect. And I think that it's definitely worth consideration partly because -- well, partly because of what I'm about to say.

So I think there are definite advantages and benefits in both registration and regulation. It is not a silver bullet, I don't think. And I think consideration would need to be given to the scope because -- for those in health and care settings largely. But there will be a large number of people of different professional backgrounds, many of whom are not registered who care for the deceased.

So when a person dies in a ward they will receive care from registered nurses. They'll receive care from unregistered healthcare assistants. They may receive care from unregistered physiotherapy or occupational therapists who are assisting with basic care.

They'll receive care from porters who often transport the bodies and so on and so forth.

So I think it's just worth considering scope in the context of the question where it says people who care for the deceased, because there are a very large number of people who that could apply to.

And if you're looking at regulation and registration that could have quite a significant broad implication. So I'm not saying that's bad or good. I'm just saying it's a consideration.

The second thing is, and it's a point colleagues have made, being professionally registered and obliged to uphold standards does not mean that people do, unfortunately.

And then the other point to make I think is relating to DBS. And I think it would be worthy of exploring some of the limitations of DBS as well as the perceived advantages. And the reason I say that is many people in the NHS consider that if you do a DBS check, bear in mind that that DBS check is based on your role, not on your professional group or your registration. It's based on who do you have access to. Many people think that if you get a clean DBS back it means that there are no problems. There is a very complicated set of arrangements between the DBS regulations, the police regulations, etc that mean many acts will not be surfaced on a DBS, giving an example of domestic abuse and sexual violence. That would be convicted as common assault. There are many circumstances in which that will not flow through onto a DBS.

So I think there's a much broader question about DBS in itself, not just in this context, that we're dealing with some other things that have been relevant in that context.

And then the final thing I wanted to just highlight was the point about sort of barring. So number one. You can bar people through DBS from working in health care. You don't have to be a registered professional to be barred. You can be put on the barred list which, if you are on the barred list, you're not to get through a DBS check. But in both the DBS barring part and also removal from a professional register, those thresholds are very high.

That's not to say the acts associated with David Fuller would not meet that threshold because I'm certain they would. But there are many

acts of behaviour, or patterns of behaviour, that may be indicative of future offending that wouldn't necessarily meet the threshold for a professional regulator to remove them.

If you look at the thresholds that are applied across nursing, medical and others, those thresholds are higher often than employment action.

So I think it's just worth considering those aspects in the context.

JONATHAN LANDAU: Thank you.

ISABELLE BROWN: Isabelle Brown, NHS Providers. To follow on your point that you raised. I think there's something about adopting, in addition to regulations, also about adopting a low tolerance approach to those who fail to demonstrate required values and behaviours which needs to be there on top of regulation. And it's sort of having that training and development but ultimately making sure there is that overarching calling to account through performance management and other policies that already exist.

So I think it's looking at what is already in place and how you maximise that in addition to adding anything additional. Because we know that particularly speaking about the NHS it's an extremely pressurised environment at the moment and additional things need to kind of really be duplicating or kind of not, "We need to maximise what's already there", in the first instance.

Any new regulatory system also needs to be really progressive and positive. It needs to be positive in its approach and in the language it uses. It needs to avoid blame, retribution or punishment.

And I think they key thing is to really ensure it enhances professionalism, recognise and build on the value of those who are caring for the deceased and incorporate support and development and opportunities for growth.

And my final consideration was any kind of new regulatory system there also needs to be an understanding of how we're going to measure it and how we know that it's actually achieving the objectives that we want it to achieve. And I think this will help understand how all the regulation is adding value. So those kind of three considerations, I think, or tests, should be sort of central to talking about what we add in.

I think it's looking at what we have and then what the value is of what we add in and that measuring that value as well. So keeping it kind of under review.

JONATHAN LANDAU: Thank you very much. Just moving on to consider who would be best placed to regulate professions if that occurred. It seems to me that the areas where there's the greatest numbers of deceased people is mortuaries, whether that's mortuaries or body stores and then the funeral sector.

So if we start first with the mortuaries, body stores. Again, excuse the terminology if that's not the best way to describe it. Who's best placed to regulate professions who work in that context and what would that look like?

Perhaps we could start with you, Brendon, with relation to HCPC's views on that. Because HCPC regulates quite a disparate number of professions at the moment.

So is it well-placed to extend that to professions working with deceased persons in mortuaries?

BRENDON EDMONDS: Brendon Edmonds, Health and Care Professionals Council. Yeah, we certainly are a multi-professional regulator originally set up to regulate allied health professions. But in the years since establishment in 2001 it's broadly that remit around scientific professions, psychology professions and so talking therapies as well. So the model shows it's adaptable where it's clear about what we're regulating and the individual being regulated.

It's really important that statutory regulation is ultimately set up around public protection as its first and foremost remit. Yes, there are benefits that flow out from that primary core purpose around a raising of professional standards and a level playing field in terms of how individuals access that profession.

But it is inherently different to other models of regulation which are about other things to do with the standards of practice in and of themselves.

So from my point of view in terms of the Health and Care Professionals Council, we would have a lot of questions that we would need to ask that have come up today about exactly what it is we are regulating in terms of the individual. Is that a clearly defined profession that is encompassed in terms of recognised protective titles that we can protect in law? Is there a body of knowledge, skills and abilities that that profession encompasses that can be expressed in standards? Are there professional Codes of Practice that individuals practising that area already cover this around? What would the jump be from no regulation to full blown statutory

regulation? And importantly, what would the cost be to be able to achieve that within the remit of public protection?

Out of that flows an understanding of training environments, qualifications, how individuals enter the practice, how they're both supervised in terms of the structures but also their responsibility to supervise as well.

That can all be understood though from the professional regulation point of view when it comes to statutory regulation. But in the end what it does is it closes what is currently an open system.

Now we're talking about the shortfall to the open system but statutory regulation certainly closes that loop and effectively places burdens on that individual once they've achieved registration to be accountable.

Now they're all really good things, right? But they do have costs associated particularly when individuals get to the sharp end of regulation around things like fitness to practice and what it would take for those individuals to be able to represent themselves in those kind quasi-judicial processes.

So there's lots to unpick around professional regulation from our perspective. But our model demonstrates that an umbrella around -- which one or many professions can coalesce under the statutory regulation is certainly achievable. But some professions are more achievable than others.

JONATHAN LANDAU: We've heard some of the limitations of professional regulation. But we've also heard about revalidation which is an example of ongoing monitoring within a professional regulatory framework.

What ongoing monitoring activity is there within current HCPC frameworks?

BRENDON EDMONDS: So we have what's called Continuing Professional Development. So once an individual is registered with us they will, as part of their renewal of their registration, be asked to provide evidence of their continuing professional development.

That is based on an audit. So we will sample a small portion of the register at the renewal. But any individual could be in that audit at any given time. And they need to be able to demonstrate in relation to our CPD standards that we set that the activities that they've undertaken to maintain their scope of practice, so what it is they're currently doing is appropriate. And we'll of course assess that and then work with those individuals where there are shortfalls.

That in and of itself is a process that an individual needs to be able to engage in. So when it comes to things like CPD or even revalidation there needs to be mechanisms in place that sit more widely within the sector enable the individual to maintain their (Inaudible) practice over time.

So achieving registration is one thing but being able to maintain that and showing that it's being maintained if that was required is another.

JONATHAN LANDAU: Thank you.

ESTHER YOUD: Esther Youd, Royal College of Pathologists. I was just going to point out that amongst regulated healthcare professionals there's probably two different models for how that works. The HCPC and the GMC are examples of a regulator that sits outside of the professional membership bodies.

So for example with pathologists our regulator is the General Medical Council but the Royal College of Pathologists provides input into training, curriculum provision, examinations all with oversight and approval by the General Medical Council to ensure that education and training to the point of registration is appropriate for a doctor but also appropriate and informed by the profession.

So the interaction between a regulatory body and professional bodies like the Royal College of Pathologists or the AAPT, that it can be two different relationships.

The NMC is completely different in that they do both. They're a membership organisation that will supervise the regulation for nursing and midwifery, it's all just --

JONATHAN LANDAU: -- the RCM is a representative body?

ESTHER YOUD: Yes.

JONATHAN LANDAU: It's an important point you raise though because it's a fundamental point as to whether professional regulation should be done by a representative body or by an independent regulator and the extent to which that makes it -- Janet, do you want to come in on that?

JANET MONKMAN: Janet Monkman, Academy of Healthcare Sciences. The Professional Standards Authority oversees all of the statutory regulators and runs the programme of accredited registration. And they are a groups that aren't represented here but who are extremely important in terms of regulation and registration. And I'd certainly recommend that conversations are had with them about the approaches that have

been described today because they really do understand all of the aspects of that. Thank you.

JONATHAN LANDAU: Yes.

GAVIN LARNER: Gavin Larner, director of Workforce. Actually, reset (Several inaudible words) voluntary registers in PSA, you're kind of given an intermediate thing between just pure self-regulation which might be construed as self-interested and just kind of doing professional demarcation lines. And independent regulations, you oversee style but it's generally, in theory, just interested and depends what the assuring model does.

The PSA have some accreditation around it but they're just not looking after their own but are genuinely doing something that's for the public good, effectively. So it's a kind of halfway house between the two.

JANE CAMPBELL: Jane Campbell, Inquiry team. Just to pick up on a point Brendon made about public protection. It may be a silly question but would the deceased be classed as the public then?

BRENDON EDMONDS: Yeah. Brendon Edmonds, HCPC. Absolutely, so the deceased but also all the other individuals that would be impacted around that individual as well, of course.

So yeah, absolutely, the deceased would be, as they are now. So with our professions that do have contact with the deceased, their professional statutory responsibility to those individuals is no different to the living.

JANE CAMPBELL: Right.

LYDIA JUDGE-KRONIS: Lydia Judge-Kronis, AAPT. Because we've been trying to encourage members to join voluntary registers we obviously offer a CPD scheme. It's one of the things that we're very passionate about. We also encourage cross-departmental training, webinars etc, because we're so keen action modern practice is followed.

But the issue with the "voluntary" word is that that is exactly what it is. And unfortunately a lot of our workforce are either in a position where they've only ever worked with one team, so the progression necessarily happen naturally because if nobody's engaged with CPD because it's not been an expectation then things don't necessarily change.

There's the others, so actually physically saying, "Please don't join that because then you're accountable for what you do".

So there's a lot of -- this is why for us HCPC or some form of regulation is very important but also we should be upholding professionalism and we should be caring for our patients. And it's not only those, it is the families that we're also dealing with and the other professionals. Because actually, as I said earlier, other people come into our environments and potentially have more power than we do to actually carry out activities. And we have obviously licence guidance to follow.

So I just wanted to say CPD is essential in my opinion for all APTs. But it's just how we can formulate that so that it is mandatory and not something that is quite nice to do.

It also often comes with a cost. We go back to, "Who's going to fund that, then?"

So I just wanted to raise that. And also, if you've got a small mortuary of four, how can they all attend the same training session if there's only one a year?

So there's lots to think about and my biggest worry about this is that we move forward but we don't move forward so quickly we don't have time to put the foundation because that is the most important thing.

JONATHAN LANDAU: I'll come back to you. Thank you.

MATT GANTLEY: Thank you. Matt Gantley, UKAS. I just wanted to put a bit on some of the points that have already been made, particularly the right balance between the benefits and the cost of implementing appropriate registrations.

Ultimately it comes down to what type of assurance do we want to achieve? What type of level of competence we want to achieve on an ongoing basis? And for what trades? All the professions we are trying to deal with.

And for many cases some of areas where there's gaps been highlighted through from the funeral directors or embalmers, it's a profession or it's a trade or if there's something very specific about it that it creates a risk that we're trying to address through assurance. It doesn't necessarily have to be done through professional registration. Or it could build upon a degree of assurance is given through the -- the assurance given to the enterprise.

So whether there's quality systems, quality approaches driven by an industry based approach or accredited through conformity

assessments, certification for example, or personal competence. It's specific to the assurance you're trying to achieve, rather than trying to regulate the whole profession, regulate the specific thing that you're trying to achieve for that trade. Or the enterprise is given specific requirements in the licensing part and within that it's competency requirements down to the relevant trained individual. There's a number of approaches to pick.

ANDREW JUDD: Andrew Judd, NAFD. We have IFSO learning platforms in the centre where we are actively pursuing CPD. And there are other safeguarding environments that I'm involved with personally where CPD is a really good tool to raise people's awareness of the sort of things that we should be looking at in the workplace through your own behaviours and through the behaviours of others.

So I just wanted to give a shout out. Even in the funeral world we have CPD.

JONATHAN LANDAU: Thank you. Does anybody else on the panel want to ask?

ESTHER YOUD: Esther Youd, Royal College of Pathologists? I just wanted to pick up really, just to emphasise the cost of a lot of the things that we're discussing. Because I'm just very conscious that the workforce that we're talking about, APTs, but also in the funeral services as well, are often low paid, low trained individuals.

And we do need to be very conscious of the burden that we are placing on those people. I mean obviously they are dealing with the deceased, it's a very important duty that they have. But I think we really do need to be conscious of the cost and who is going to bear

that cost. Is it individuals? Is it organisation? And how is that going to be met?

JONATHAN LANDAU: Thank you. Yes.

KATHRYN WHITEHILL: Thank you. I have a question to ask the HTA. It relates to something that was said much earlier but it was something that is of great interest to the Inquiry.

One of the approaches that we've taken when we're looking at the vast array of settings, so NHS, private hospitals, medical settings, ambulances, we've tried to understand risk in each setting.

I was very interested when you said earlier Colin about the risk in anatomy arena, you perceived to be lower. And the risk in the postmortem sector you perceived to be higher. Can you tell me how you've understood that risk, please?

COLIN SULLIVAN: Yes, Colin Sullivan, HTA. So we actually work with six sectors and we have a number of factors which help us determine where we think the risks are the greatest, the number of shortfalls being one of them. And that creates a segmentation model where it then drives our schedule for inspections the following year and that's something that sits in the public domain because it's something we've discussed at our Board. And that's something that we continue to develop, it's evolving.

It's very difficult for me to comment outside of areas that are regulated because it's not something we've looked at. So those areas that I've mentioned that fall outwith these scheduled purposes, we have not looked at. So I can't give you any comment in terms of

the relative risk there. But I can tell you about rails of risk across the six sectors that we have.

KATHRYN WHITEHILL: And what about the difference? Why have you come to the decision that the anatomy sector is a lower risk than the postmortem sector?

COLIN SULLIVAN: The number of shortfalls primarily. But also because there tends to be fewer people involved. They tend to be professionals. There tend to be fewer bodies involved. And as a result there are fewer shortfalls. As I said, the average number shortfalls, and they were minor shortfalls, all of them were minor shortfalls last year, was 1.58 whereas it was 7.8 and more of them were major..

So in numerical terms that's how we assess where the risks are greatest.

KATHRYN WHITEHILL: Thank you, that's very helpful. And I should say Kathryn Whitehill, Inquiry. Sorry, I failed on both counts.

JONATHAN LANDUA: I think I haven't been introducing myself each time. Right, unless there are any other questions I'll hand over to the Chair for closing remarks.

SIR JONATHAN MICHAEL: Well, just to say thank you very much. It's been really helpful and very informative.

Obviously we'll take away and I will consider what I've heard this morning very carefully and use what I've learnt to assist the development of findings and recommendations to the government.

The recording and transcript of the session will be placed on our website and we'll let you know when we do this so that you've got the heads up.

I'd be grateful if you'd keep the discussion confidential as Jonathan said earlier on until then.

And the last thing is just to say thank you very much for your time and for your assistance in what I think we all recognise is an important bit of work. So thanks a lot.