The Scottish Government
Health and Social Care Finance Directorate / Health Infrastructure and Sustainability Division

Scottish Government
Riaghaltas na h-Alba
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Dear Colleagues

**SECURITY AND GOVERNANCE OF NHS MORTUARIES / AMBULANCE SERVICE POLICIES**

**Independent Inquiry into the issues raised by the David Fuller case - Phase 2 Report**

1. I refer to the above Independent Inquiry Report which is available at the following link:

https://www.gov.uk/government/publications/david-fuller-inquiry-phase-2-report

**Background**

2. A number of recommendations contained in the report relate to the security and management of NHS mortuaries and body stores and to ambulance service policies in England.

3. Having considered the relevance of these recommendations to NHS Scotland, the Scottish Government has decided that recommendations 2 to 6, 8, 9, 14, 15 and 31 to 33 of the report should be implemented by health boards.

4. These recommendations are set out in the annex to this letter and their implementation is mandatory. The Scottish Government has asked NHS Scotland Assure to provide advice on how best to provide assurance of the implementation of the recommendations relating to the security of NHS mortuaries and body stores.

**DL(2026)05**

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**Addressees**

For action
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For information
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5. In addition, the Scottish Government has instructed NHS Scotland Assure to review and update the following:

- Mortuary and Post-Mortem Facilities - design and briefing guidance (SHPN 16-01)
- The Security Services Standards for NHSScotland Security Leads (SHFN 03-02)
- The Security Management Framework for NHS Boards in Scotland (SHFN 03-01).

6. Finally, I would like to highlight the following section from the Inquiry's report:

*'The Inquiry has come across a number of recurring themes during our work. These include the following:*

- *Abuse of the deceased can be deliberate or can result from neglect or incompetence.*
- *Organisations and individuals have a tendency to view any threat to deceased people as most likely to come from outside the organisation.*
- *There is an over reliance on trust and a long period of employment as a mechanism for internal governance and control.*
- *There is a reluctance to explore systemic risks or to 'think the unthinkable'.'*

7. I ask that your organisations reflect on these themes in their efforts to improve the care of the deceased and the security and dignity of their bodies.

**Action**

5. Health Boards are required to implement the recommendations set out in the Annex to this letter.

Yours sincerely

**Alan Morrison**
Deputy Director
Health Infrastructure and Sustainability Division

## Annex – Independent Inquiry Report Recommendations

The implementation of recommendations 2 to 6, 8, 9, 14 and 15 from the Phase 2 Report of the Independent Inquiry into the issues raised by the David Fuller case are mandatory for all Health Boards which provide mortuary or body store services.

The implementation of recommendations 31 to 33 are mandatory for the Scottish Ambulance Service.

References to 'NHS Trusts' in the recommendations should be interpreted as a reference to Health Boards in Scotland.

### Security

### Recommendation 2

'All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.'

### Recommendation 3

'All NHS trusts should routinely audit the access data of all facilities used to store deceased people.'

### Recommendation 4

'The practice of using shared electronic swipe cards for specific staff groups should cease immediately.'

### Recommendation 5

'All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.'

### Recommendation 6

'All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.'

**Recommendation 8**

‘All NHS trusts should consider the installation of ‘swipe to exit’ for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.’

**Recommendation 9**

‘All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.’

**Management of Mortuary Services**

**Recommendation 14**

‘NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.”

**Recommendation 15**

“All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include:

- staffing matters;
- security incidents;
- all serious incidents;
- Human Tissue Authority reports (where applicable); and
- all security audits, including audits of access and any access breaches.’

Please note that the Human Tissue Authority does not license mortuaries in Scotland. Therefore, the reference to Human Tissue Authority reports in recommendation 15 is not applicable.

**Ambulance Service Policies**

**Recommendation 31**

‘Every NHS ambulance service should have a policy setting out where ambulance crew members should sit when conveying deceased patients. This should include reference to the risk of abuse of deceased patients, as well as training requirements.’

**Recommendation 32**

'NHS ambulance services should also have policies regarding the security and dignity of the deceased, including when the deceased should be covered and/or secured.'

**Recommendation 33**

'Every NHS ambulance service must put policies in place regarding taking photographs of deceased patients, including any circumstances in which this may be required, and ensure that ambulance staff are aware of these and comply with them.'