Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 29 July 2026

TB2026.61

Title:	**Nottingham maternity review findings on post death care and key actions required following the Fuller inquiry.**

Status:	**For Information**
History:	

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Nottingham maternity review findings on post death care and key actions required following the Fuller inquiry.

1. Purpose

1.1. The purpose of this paper is to provide board assurance statement on the confirming governance and safeguarding arrangements relating to mortuary services.

2. Background

2.1. On 26 June 2026 OUH received a letter from NHSE requesting Board assurance confirming governance and safeguarding arrangements relating to mortuary services, following the Nottingham maternity review findings on post-death care and the key actions required following the Fuller inquiry.

3. Board assurance statement.

3.1. The table below is the complete board assurance statement requested by NHSE. This detailed action plan is provided for reference in the Reading Room.

Board Assurance Statement	Confirmed Yes/No	Additional comments or qualifications
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	Roles and responsibilities are already in place in several documents. These have been collated into one document for easy reference which has been circulated in July 2026 for comment.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	A review has been undertaken of the 29 recommendations and an assurance report has been drafted outlining actions and current status for each point. A full report and action plan will be presented to the Quality & Performance Committee/IAC in August. Based on current assessment: - 3 of the recommendations are not applicable to OUH - 3 require further assurance

In line with updates to the NHS Safeguarding Accountability and Assurance Framework (SAAF), executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	No	OUH policies and procedures will be updated in line with the latest SAAF released in March 2026. The share point page and escalation process will also be updated. This will be actioned by head of safeguarding. To be completed by 31 July for ratification at the next policy group on the 8 September.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	Effective oversight is provided through several committees and processes, including: Trust and divisional, directorate clinical governance structure; Human Tissue Governance (HTG) Committee; OUH Mortuary Long Stay (MLS) Task & Finish group; HTA reportable incidents (HTARIs) are discussed at SLIC and HTG. HTA inspections also provide external assurance.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	Assessment is being completed and will be submitted to board prior to submission on 8 September. The Trust has also submitted a Fuller Recommendations cost compliance (Jan 2026) submission document - outcome awaited.

3.2. From the table above it can be seen that the initial review has highlighted the following areas require further action:

- Inclusion of the March 2026 NHS Safeguarding Accountability and Assurance Framework (SAAF) in Trust policies.
- From the 29 Fuller report recommendations 3 require further assurance.

3.3. A further update and detailed action plan against the outstanding board assurance statement and the 29 Fuller report recommendations will be presented to the Quality & Performance Committee/IAC in August.

4. Conclusion

4.1. This paper provide assurance that all services involved in the care and safeguarding of the deceased either meet the standards outlined by NHSE and the Fuller report; or for the minority of 1 standards and 3 recommendations that are not currently met, that actions have been identified to address this.

5. Recommendations

5.1. The Trust Board is asked to:

- Note the assurance statement.
- Note that a full report and action plan against the 29 Fuller report recommendations will be presented to Quality & Performance Committee/IAC in August.