Independent Inquiry
into the issues raised by
the David Fuller case

The Independent Inquiry into the issues raised by the Fuller case

Terms of Reference

Background

1. David Fuller (DF), an electrical maintenance supervisor firstly at Kent and Sussex Hospital and then later at Tunbridge Wells Hospital, was arrested in December 2020 for the murders of two women in 1987. When police searched his house, they found images and videos of him committing sexual offences on the bodies of at least 100 women and children at the Maidstone and Tunbridge Wells NHS Trust mortuary since 2008.

2. In January 2021, DF pleaded not guilty to the murders. He was later charged with the mortuary offences. In October 2021, he pleaded guilty to the mortuary offences. In November 2021, he pleaded guilty to the murders.

3. Maidstone and Tunbridge Wells NHS Trust began an investigation into the activities of DF overseen by an independent Chair, Sir Jonathan Michael. On 8 November 2021, the Right Honourable Sajid Javid MP, Secretary of State for Health and Social Care announced that this was to be replaced with an independent inquiry given the scale and nature of the offences. The Inquiry has not been set up under the Inquiries Act 2005 and will be adopting a non-judicial approach to its work.

Terms of Reference

4. The Inquiry will be split into two phases:

    - an initial report, on matters relating to Maidstone and Tunbridge Wells NHS Trust, reporting by the middle of 2022, and

    - a final report, looking at the broader national picture and the wider lessons for the NHS and for other settings, reporting by the middle of 2023.

5. The Inquiry will review DF's unlawful actions, how he was able to carry these out, why his actions went apparently unnoticed, and will make recommendations with the aim of preventing anything similar happening again.

6. An important part of the Inquiry is to afford the families who have been affected by DF's offending an opportunity to be heard and for the Inquiry to be informed by this. The Inquiry will preserve the anonymity of families throughout the course of its work. Staff of the Trust and of DF's private sector employers who have been affected by DF's actions will also have an opportunity to share their experiences with the Inquiry. The Inquiry will make sure that families and others affected by the actions of DF can share their experiences and information with it in ways that are supportive and sensitive.

7. The Inquiry will also consider evidence and information from other interested parties, including, for example, Maidstone and Tunbridge Wells NHS Trust and its predecessors ('the Trust'), relevant regulatory bodies and subject matter experts. All interested parties are required and expected to cooperate with the inquiry as is normal, professional practice. Findings and recommendations from previous relevant reports will also be considered in the work of the Inquiry.

8. The Inquiry will treat all information and personal data received in accordance with all relevant legal and regulatory requirements, including the UK General Data Protection Regulation (GDPR).

9. The Inquiry will ensure that the families of victims are kept informed of progress. The Inquiry team will remain accessible throughout.

The issues the Inquiry will consider in each phase, but is not limited to, are as follows

<u>Phase 1</u>

- To consider the process by which DF was recruited and employed by the NHS and by private sector facilities maintenance service providers during the period 1989 to 2020 and whether appropriate and adequate checks were carried out prior to and during his employment, whether the current checks are appropriate for individuals with access to mortuary facilities, and whether risks associated with those checks were managed.

- To determine what access DF was given to the mortuary and other areas of the Trust, and whether this was subject to usual or appropriate supervision, oversight and assurance, including analysis of swipe card activity and CCTV.

- To identify any evidence of other inappropriate or unlawful activities by DF elsewhere on Trust premises.

- To review any evidence of complaints, concerns or incidents concerning DF's behaviour at the Trust, and how they were addressed by the Trust and his private sector employers.

- To consider whether the Trust's arrangements for management of the mortuary, including security and access, to safeguard the bodies of the deceased, were in accordance with Human Tissue Authority (HTA) standards, any relevant guidance or regulatory requirements and any relevant recommendations from other inquiries.

- To consider whether arrangements for post-mortem examinations were satisfactory.

- To examine inspection reports of the mortuary by the HTA and any other regulator, and the associated assurance processes.

- To consider whether the Trust's Board received sufficient assurance on the issues raised by the case of DF.

- To examine arrangements for transfer of the deceased between the Trust and other organisations, for example local funeral directors and to identify whether concerns were, or should have been raised.

Phase 2

- To consider whether procedures and practices in hospital settings, including in the private sector, where bodies of the deceased are kept, safeguard the security and dignity of the deceased, and would prevent a recurrence of matters raised by the case of DF.

- To consider whether procedures and practices (including the use of locum Anatomical Pathology Technologists) in non-hospital settings, including local authority mortuaries, funeral directors, the NHS ambulance service, medical schools, temporary mortuaries, direct funeral companies and hospices, where bodies of the deceased are kept, safeguard the security and dignity of the deceased and would prevent a recurrence of matters raised by the case of DF.

- To consider the role of regulators and their use of regulatory measures in assuring that mortuary practices safeguarded the security and dignity of the deceased in all settings, and hence consider the effectiveness of the national regulatory regime.

- To consider any other issues that arose during Phase 1 of the Inquiry.

General

10. The Inquiry will

    - Produce a Phase 1 report on its findings and recommendations on issues arising from its consideration of events at Maidstone and Tunbridge Wells NHS Trust and identify areas of concern for the wider NHS to be aware.

    - Produce a final report which will provide an overview of the information it has reviewed, and which will set out the Inquiry's findings and its recommendations.

    - Publish anonymised accounts, setting out the experiences of the families affected by DF's offending and inappropriate behaviour, and the impact this has had on them.

    - Escalate any matters it comes across that require immediate attention to the relevant authorities.

    - Report any instances of apparent collusion or other conduct of concern (including conduct that indicates the potential commission of criminal or disciplinary offences, or breach of professional codes of conduct) to the relevant employer(s), professional or quality regulator(s), and/or the police for their consideration. The Inquiry does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability.

11. The Inquiry will aim to make its initial report to the Secretary of State for Health and Social Care by the middle of 2022 and its final report with its findings and recommendations by the middle of 2023. The Secretary of State for Health and Social Care will make arrangements for their presentation to Parliament.

12. Although the Inquiry will be restricted to matters concerning mortuary practices in England, its findings and recommendations may have relevance across the United Kingdom.