Explanatory Note

This Explanatory Note is intended to be read in conjunction with the Inquiry's Terms of Reference. It provides further detail of the Inquiry's approach to the Terms of Reference and the scope of its investigations. ***This note relates solely to Phase 1 of the Inquiry's work.***

Matters to be considered by the Inquiry

1. The Inquiry will prepare an initial report, focussing on matters relating to David Fuller's (DF's) conduct in Maidstone and Tunbridge Wells NHS Trust (the Trust). This Trust includes both the Kent and Sussex Hospital and the Tunbridge Wells Hospital in which DF worked from 1989 to 2020. The mortuary offences at the Trust took place between 2005 and 2020.

2. The Inquiry intends to consider the key timeframe of offending by DF between 2005 and 2020. However, in some situations it will be necessary to consider matters dating back to 1989. This is the year from which DF was employed by the NHS and private sector facilities maintenance service providers. The report will make clear the timeframe under consideration where relevant.

3. The Inquiry intends to ascertain an overview of DF's unlawful and inappropriate conduct whilst working for the Trust. This will highlight the offences to which he pleaded guilty on 8 October 2021 (‘the mortuary offences’), and any potential further offences, that may have been committed in the course of his work. The Inquiry will not make any findings as to the criminal or civil liability of DF (or any other person) but an investigation into the possibility that other offences, or inappropriate behaviour, may have occurred is necessary to ensure that the Inquiry is able to consider all issues of relevance to its Terms of Reference in relation to the whole period in which deceased persons at the Trust may have been at risk.

4. The November 2021 convictions of DF for the mortuary offences and the facts upon which they are based will be relied on by the Inquiry. Unless it is reasonable and necessary to do so, the Inquiry does not intend to conduct its own investigation into the specific details of each mortuary offence.

5. The specific matters for investigation by the Inquiry are set out under the heading 'Phase 1' in the Inquiry's Terms of Reference. In turn, these areas of investigation are anticipated to be, but not limited to:

Recruitment and employment

6. Establishing details about DF's work at the Trust between 1989 and 2020. This may include –

I. DF's job title and responsibilities during that period. In particular, the extent to which his job responsibilities changed over time and when, if at all, they came to include any responsibility for maintenance of the Trust's mortuary facilities.
II. What Disclosure and Barring Service check (and checks that pre-date them), security or other checks were conducted on DF by the Trust and facilities maintenance service providers during that period (including any TUPE period) to ascertain whether he had a criminal record or other matters of concern in his background.
III. Any supervision of DF during that period, to include a review of any supervision records in his HR file or elsewhere.
IV. Any complaints against DF during that period, to include a review of his HR file.
V. Any disciplinary investigations or proceedings against DF during that period, to include a review of his HR file, and to identify the outcome of any investigations or proceedings.

Mortuary access and offences

7. The Inquiry will focus on understanding the wider circumstances of the mortuary offences to establish a chronology of when they are likely to have occurred, to identify patterns in the offending, whether there were missed opportunities to stop the offending and to analyse why the offending appeared to go unnoticed from 2005 to 2020.

8. The wider circumstances of the mortuary offences may include –
    a. The date when the offences occurred, to help identify if the offences were committed more often during particular periods and any other patterns.
    b. The time when the offences occurred, to help identify if the offences were committed more often during regular working hours or other times.
    c. Understanding whether DF accessed the mortuary, both to offend and at other times, for a particular purpose or reason. Any documentary or other record of the reasons for access to the mortuary.
    d. What routes DF used to gain access to the mortuary by reference to CCTV, swipe card data and other information, both to offend and at other times.
    e. Understanding what approvals were given to DF to access the mortuary and what monitoring and audits, if any, were conducted of the access DF (and to the extent necessary, others) had to the mortuary.

Evidence of other unlawful/inappropriate acts or complaints of such acts

9. The investigation of inappropriate acts by DF will focus on allegations during the period 1989 to 2020 that may have required disciplinary action by DF's employer or, if reported, may have required a police investigation. A wider

timeframe will be taken to ensure any inappropriate acts can be identified which may be relevant to the mortuary offences.

10. The investigation of the inappropriate acts may in particular include allegations of sexually inappropriate behaviour, dishonesty, inappropriate access to Trust premises or inappropriate behaviour with people working at the Trust, patients of other hospital users.

11. The purpose of investigating allegations of inappropriate acts will be to understand whether they gave rise to opportunities to identify the risks posed by DF working at the Trust and for steps to be taken that might have prevented or curtailed the mortuary offences committed by DF. The extent to which allegations of inappropriate acts by DF are investigated by the Inquiry will be fact-specific and depend on their relevance to the wider purpose of the Inquiry.

Management of the mortuary

12. The policies and guidance in place for management of the Trust's mortuary facilities from 1989 to 2020. This may include –
    a. Establishing what policies and guidance the Trust put in place for its mortuary facilities. This may include policies and guidance to ensure the dignity of the deceased, allowing and monitoring access to mortuary facilities by clinical and non-clinical staff, safeguarding bodies from harm or inappropriate contact and ensuring record keeping of access to mortuary facilities.
    b. Identifying whether policies and guidance used by the Trust adequately considered risks to particular categories of deceased based on age, gender, ethnicity, infection risks and any other criteria.
    c. Analysing what policies were in force during this period, how they changed (if at all) between 1989 and 2020 and whether they were fit for purpose during that time.
    d. Analysing whether the Trust's policies and guidance met with the regulatory standards imposed by the Human Tissue Authority and any other relevant guidance and standards for safeguarding deceased in mortuary facilities that were in force between 1989 and 2020.

Arrangements for post-mortem examinations

13. Reviewing the working practices of the Trust's mortuary facilities. This will cover the period from 2005 to 2020 but the Inquiry may, as necessary, review standards going back to 1989. The focus of this aspect of the investigation will be to understand whether the methods of working and supervision in the Trust's mortuary facilities, in particular the storage and security of bodies before and after post-mortem examinations, was adequate and whether there were lapses in those working practices and supervision that played any role in DF's actions.

Assurances of the mortuary

14. In conducting its work the Inquiry will have due regard to inspection reports of the Trust and its mortuary facilities by the HTA, other regulators and other relevant reviews.

Assurances of the Trust

15. Reviewing the Trust Board's response to the issues raised by DF's mortuary offences. In particular, this will focus on the steps taken to identify failures to protect and safeguard the deceased in the Trust's mortuary facilities, when these steps were taken and whether they were sufficient. The Inquiry will seek to review all relevant materials relating to the Trust Board's decision making, including correspondence, meeting minutes and other materials.

Arrangements for transfer of the deceased

16. Reviewing the arrangements made between the Trust's mortuary facilities and other organisations involved in the storage and transfer of a body, for example, local funeral directors, to ascertain if there were any concerns raised or missed opportunities to identify DF's offending. The focus will be on the period 2005 to 2020.

Other relevant Inquiries

17. In conducting its work the Inquiry will have due regard to the findings of other relevant inquiries that have taken place in a healthcare context.

Recommendations

18. The Inquiry will make recommendations on matters arising from what is known and identified about the wider circumstances of the mortuary offences, any other relevant inappropriate conduct that is identified and the failures to prevent and stop DF's actions. The aim of the recommendations will be to outline steps that can be taken by NHS Trusts and other organisations with mortuary facilities to prevent similar offences occurring again in the future.

Gathering evidence

19. The Inquiry places great value on affording the families of those affected by DF's offending the opportunity to have their accounts heard by the Inquiry. It welcomes the opportunity to speak to family members to gather information regarding how they have been affected by DF's actions. Meetings with the families will be set up to accommodate this.

20. The Inquiry will be seeking information and evidence from those who work or worked for Maidstone and Tunbridge Wells NHS Trust and its predecessors, relevant regulatory bodies such as the Human Tissue Authority, and subject

matter experts in the field of pathology. As part of this, the Inquiry will publish a policy on its interview process and will ensure the process is fair and those providing evidence feel adequately supported. A list of the categories of witnesses the Inquiry will seek evidence from is at annex A of this note.

Updates

21. The Inquiry will provide regular written updates to the families of victims of DF and, as appropriate, other stakeholders to provide a summary of the progress of the Inquiry and its work. This will include notifying family members of the Inquiry's findings immediately in advance of publication of the Inquiry's report. The Inquiry wishes to maintain an open dialogue with family members so that they are able to come forward and continue to provide information to the Inquiry when they wish to.

The standard of proof

22. The Inquiry will adopt a flexible standard of proof when determining any factual issues. A variable and flexible approach has been used in many other inquiries, considering the standards adopted in both the civil and criminal courts. Some findings may not be subject to a standard of proof but judgements will be made by the Inquiry Chair on the basis of facts found during the Inquiry's work. This may relate to findings of behaviour by DF which whilst not necessarily unlawful, would be deemed inappropriate by colleagues or those who observed it.

Witness accounts **Annex A**

During phase 1, the Inquiry will gather witness accounts from a range of interested parties/witnesses whom the Inquiry believes will have information that is relevant to its terms of reference. This will include, but is not limited to, the following:

- Families of David Fuller's victims
- Chief Executive Officer of Maidstone and Tunbridge Wells NHS Trust
- Past and present members of the Maidstone and Tunbridge Wells NHS Trust board
- Past and present members of the Maidstone and Tunbridge Wells NHS Trust leadership team with oversight of mortuary management, security, swipe card access or oversight of contracted staff.
- Senior leaders from Interserve (and later Mitie) who had oversight of Disclosure and Barring Service checks for staff, security, swipe card access and responsibility for the supervision of David Fuller.
- Staff who worked in or who regularly visited the mortuary at Tunbridge Wells Hospital past and present.
- Staff who worked with David Fuller.
- Staff who can provide an overview of the CCTV and security systems for the hospital and mortuary.
- Staff who feel they have information to share which may be of interest to the inquiry.
- Portering staff at Maidstone and Tunbridge Wells NHS Trust
- Cleaning and domestic staff at Maidstone and Tunbridge Wells NHS Trust
- Pathologists who worked at the Maidstone and Tunbridge Wells NHS Trust
- Coronial staff
- Local funeral directors
- Senior leaders from national regulatory bodies relevant to the inquiry, for example, the Human Tissue Authority

It is possible that others with relevant information are identified through the Inquiry's investigations. They too will be contacted to provide witness accounts to the Inquiry.