Independent Inquiry
into the issues raised by
the David Fuller case

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Progress update

May 2022

Purpose of this report

The purpose of this report is to provide an update on the progress of the Independent Inquiry.

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Introduction

David Fuller, 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 2005.

In January 2021, Fuller 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. On 15 December 2021, Mrs Justice Cheema-Grubb sentenced him to a whole life term for the murders and imposed determinate sentences amounting to a total of 12 years' imprisonment for the mortuary offences, to be served concurrently to the life sentences. In her sentencing of Fuller, she remarked that his violations go against everything right and humane and described his crimes as incomprehensible.

In February 2021, the Board of Maidstone and Tunbridge Wells NHS Trust commissioned an investigation, independently chaired by Sir Jonathan Michael, to consider how the mortuary offences could take place without detection, what lessons the Trust could learn and to address the most likely questions of the victims' families and key stakeholders. The investigation was limited to a desktop review because of constraints that had necessarily been imposed by Kent Police and the ongoing criminal trial.

On 8 November 2021, the Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care, announced that given the scale and nature of Fuller's sexual offences, he was replacing the Trust-commissioned investigation with an Independent Inquiry, chaired by Sir Jonathan. The Secretary of State explained that the new Inquiry would build on the work already done by the Trust-commissioned investigation to look into the circumstances of the mortuary offences and the wider national picture.

The Inquiry is a non-statutory investigation with two phases. The first stage is focussing on Fuller's activities in the Kent and Sussex Hospital and the Tunbridge Wells Hospital at Pembury. The second phase will be to look at the implications of Fuller's activities and the issues identified in phase one for the country as a whole, in order to safeguard the dignity of the deceased and ensure that Fuller's horrendous activity cannot be repeated elsewhere. The Secretary of State has committed that the the findings and recommendations of the Inquiry will be published.

Background

History of Kent and Sussex Hospital and Maidstone and Tunbridge Wells NHS Trust

Tunbridge Wells Health Authority operated the Kent and Sussex Hospital from 1982 until February 1994. The Kent and Sussex Weald NHS Trust operated the Kent and Sussex Hospital from February 1994 (when it was formerly established as a legal entity) to February 2000. Kent and Sussex Weald NHS Trust was dissolved as a legal entity in April 2000.

Maidstone and Tunbridge Wells NHS Trust was formerly established as a legal entity in February 2000 and took over the operation of the Kent and Sussex Hospital and Maidstone Hospital. The Tunbridge Wells Hospital at Pembury, a private finance initiative hospital, was opened in January 2010. Kent and Sussex Hospital was decommissioned in 2011, leaving Maidstone and Tunbridge Wells NHS Trust to operate Maidstone Hospital and the Tunbridge Wells Hospital at Pembury.

History of David Fuller's employment

David Fuller successfully applied for the role of electrical maintenance craftsman at the Kent and Sussex Hospital in November 1988. He began working at the Hospital in 1989, first as a temporary worker, and was then made permanent in March 1989. In 2002 Fuller successfully applied for the role of maintenance supervisor at what was then Maidstone and Tunbridge Wells Trust, working at the Kent and Sussex Hospital. He continued to work at the Kent and Sussex Hospital until it was decommissioned in 2011, when he was transferred to the newly built Tunbridge Wells Hospital at Pembury. At that time, in line with maintenance at the hospital being contracted out to a private supplier, Fuller was transferred from the Trust to Interserve Group Ltd as an employee, then in 2020, his employment was transferred from Interserve to Mitie Group PLC which had taken over the provision of maintenance services to the Trust. Fuller remained in the same role until his arrest for the murders in December 2020.

Investigation by Maidstone and Tunbridge Wells NHS Trust

In February 2021, the Trust Board commissioned an investigation into the alleged activities (at that time) of David Fuller arising from the Kent Police investigation. The investigation was overseen by Sir Jonathan Michael as independent Chair. The Chair was supported by a senior investigating officer. It was intended that the findings of the investigation were to be made available to the Trust, NHS England/Improvement, the Human Tissue Authority, the Care Quality Commission and Kent Police.

The investigation was limited to a desktop review because of constraints that had necessarily been imposed by the ongoing police investigation and the criminal trial. At that time, Kent Police were still investigating the two murders and the mortuary offences, which had been subject to a court order restricting reporting in any detail. This meant that the investigation team had to give ongoing police investigations primacy. In addition, there were a very limited number of individuals who were aware of the mortuary offences within the Trust. These factors limited the investigation team's ability to interview and take evidence from employees and executives of the Trust, Interserve Group Ltd, Mitie Group PLC and others until the police investigation had concluded and Fuller had been sentenced.

The desktop review considered the following areas:

- review of relevant Trust and Mitie policies and procedures,
- review of Human Tissue Authority (HTA) documentation including Regulations and Standards, required role descriptions, reports of inspections of the mortuaries at Kent and Sussex Hospital and Tunbridge Wells Hospital and the associated Trust action plans,
- analysis of relevant documents including but not limited to, job descriptions, staff appraisals, mortuary governance meeting minutes, mortuary audit plans and planned and reactive mortuary maintenance records,
- review of records of police interviews with staff,
- review of Fuller's personnel files,
- interrogation of mortuary floorplan with CCTV locations and mortuary site visit,
- review of risks, incidents and complaints related to the mortuary, and
- review and interrogation of swipe card data of Fuller's access to hospital areas.

The investigation team also met with the police to understand Fuller's behaviour and how he offended.

The desktop review identified key lines of enquiry and identified individuals who the investigation team believed would have information that was relevant to the case. In addition, the desktop review identified a range of additional information relevant to the investigation which was held by Interserve Group Ltd and later Mitie Group PLC (which took over responsibility for facilities management at the Trust in 2020), Kent Police, regulators and other interested parties. However, it was not possible for the investigation team to take first-hand evidence or request this additional information due to the necessary constraints of the criminal and judicial processes.

Collecting first-hand evidence and requesting and analysing additional documentary information alongside the material from the desk top review, is being taken forward by the Independent Inquiry.

Areas of concern flagged to NHS England

Although the investigation team could not interview individuals and take first-hand evidence, it identified high level themes and areas of concern that Sir Jonathan, in his role as independent Chair, deemed could not wait to be acted on until the police investigation had concluded and the criminal proceedings against Fuller had been conducted. These themes were shared with the Trust in August 2021 and subsequently with NHS England/Improvement and are as follows:

Responsibilities between NHS Trusts and contractors/ subcontractors

This related to the expectations between a Trust and the contractors/subcontractors they employ and set out that consideration should be given to detailing in policy what the expectation is for sub-contractors with regards to disclosing the findings of disclosure and barring checks (DBS) of their employees. If this is deemed necessary, consider how this will be done to ensure practice is aligned with policy; and also, how adherence to policy can be tested and evidenced. If this approach is not deemed necessary, consider how contractual arrangements with sub-contractors detail expectations regarding the rigour of policy/procedure related to people management.

Security and access

This covered access to high-risk areas and how this is monitored and set out that consideration should be given to reviewing which areas of organisations would be classed as sensitive or high-risk, in line with regulatory requirements. This would include reviewing who requires access to high-risk areas.

Consideration should be given to monitoring access, involving a review of CCTV and swipe card use. The audit could consist of each restricted area auditing swipe card access records and CCTV footage intermittently, to identify anomalous activity. This should include any external or temporary buildings or units to main hospital sites. This would need to be a proportionate and measured response to the investigation findings to date.

Policies and procedures versus practice

This theme is twofold. The first part relates to the assurance that practice is aligned with policy. The second part is that local policy must be aligned with Trust-wide policy and include the necessary stakeholders during its development and consultation.

Oversight of regulated activities

The independent investigation recommended that all NHS providers are clear what specific statutory and regulated activities and responsibilities they have as organisations and that compliance with all such requirements are subject to routine monitoring and report. There should be a designated/nominated individual who has responsibility for the oversight of these in order to provide assurance to Trust Boards that these requirements are being met, for example, Board level Director of Assurance.

Management of areas and services not covered by regulation

There is a risk that areas not covered by regulation or accreditation may not be afforded the same security considerations as those that are.

Consideration should be given to the security and management of areas not covered by regulation or accreditation, in order for the organisation to assure itself that they are maintained and secured to the appropriate level.

NHS England/Improvement subsequently wrote to all NHS Trusts on 12 October 2021, requiring all Trusts with either a mortuary or body store to urgently review their practices and seeking confirmation that they had done so by 16 November 2021.

The Independent Inquiry and high-level plans

Although the Independent Inquiry was announced by the Secretary of State for Health and Social Care on 8 November 2021, it was not able to begin its work until the New Year. This was because no substantive work could begin until after Fuller was sentenced. This happened on 15 December 2021. The Chair felt that it would not be appropriate to contact the families of Fuller's victims immediately after his sentencing and in the weeks prior to and over the Christmas and New Year period. The Inquiry did not have any contact details for the families and thus were unable to contact them until the Police had confirmed that they had consented for their details to be passed to the Inquiry. This information started to be shared with the Inquiry in January 2022. In the meantime, the Inquiry put the foundations in place for its work, including recruiting the Inquiry team, setting up its website and IT systems and putting emotional support in place.

Chair's statement

The Chair issued a statement on 18 January 2022. In his statement, Sir Jonathan set out that understanding how Fuller's offences took place in hospital settings without detection over such a long period of time, will require a focused and detailed approach. He also spoke of his determination that he and his team will be objective and thorough in their work, and equally determined to provide an opportunity for those families and staff who have been directly affected by the actions of David Fuller, to share their experiences and information with the Inquiry in ways that are sensitive and supportive.

Terms of reference – views and publication

On his appointment as Chair, Sir Jonathan made the commitment that he would seek the views of the families affected by Fuller's actions on the Inquiry's draft terms of reference. Sir Jonathan contacted families who had consented for their details to be shared with Inquiry, inviting their views on the draft terms of reference. He gave assurance that the Inquiry would preserve the anonymity and protect the dignity of their loved ones throughout its work.

Organisations that had an interest in the work of the Inquiry were also contacted and invited to share their views on the draft terms of reference.

After careful review and consideration of the comments the Inquiry received, common themes that emerged from families and other interested parties that expressed a view included:

- the level of Fuller's supervision and what mechanisms were in place to check his working practices,
- employment checks and whether there were earlier offences,
- whether the Trust should perform additional checks for staff with mortuary access,
- the Trust's arrangements for post-mortem examinations
- whether there was a process for places receiving the deceased from the Trust, for example, funeral directors, to raise concerns,
- the Trust's policies for access to restricted areas, including monitoring of swipe card access and CCTV,
- recommendations from relevant inquiries and investigations, for example the investigations into Jimmy Savile,
- the role of the Human Tissue Authority,
- procedures and practices of mortuaries in non-hospital settings,
- the interactions between private contractors and the NHS,
- pre-employment checks for locum mortuary staff, and
- the application of safeguarding legislation to the deceased.

Amendments were made to the Inquiry's terms of reference to reflect these common themes. The terms of reference were published on 23 February 2022. A copy of the terms of reference is at appendix 1.

Next Steps

Following publication of the terms of reference, the Inquiry was able to begin its work to collect evidence and information.

The Inquiry is in contact with those families of the victims of Fuller who have consented for their details to be shared with it, and those who have approached the Inquiry directly. It is offering families the opportunity to share their experiences and the impact of Fuller's abuse with the Inquiry. The Inquiry is also asking families what they think needs to change to prevent anything similar from happening again. Most of these individual, private family sessions are taking place at the Inquiry's office or online, if preferred, with two members of the Inquiry team present. However, where possible, the Inquiry is offering a choice about how, where and when families share their information. The Inquiry is offering emotional support provided by professional counsellors to families whilst they are speaking with it and is taking care to protect the anonymity of families and their loved ones. Anonymised summaries of the information that families share with the Inquiry will be published, with their consent, as part of the Inquiry's report. The information the Inquiry receives from families about the impact of Fuller's dreadful actions will help the Inquiry illustrate why any recommendations it might make to prevent similar abuse from happening again, are important and necessary. The Inquiry will keep in regular touch with families of victims to provide updates on its progress.

The Inquiry will hear first-hand evidence from employees and former employees of the Trust, Interserve, Mitie and others, for example those with corporate responsibility for the Trust and regulators. Witnesses the Inquiry is planning to hear evidence from include those who can explain the practices and procedures in the mortuary, security at the Trust and others who have knowledge of David Fuller and his presence at Tunbridge Wells Hospital. From the Inquiry's engagement with witnesses so far, it has experienced a high degree of co-operation and expects this to continue.

The Inquiry is not currently planning to hold public hearings, in order to protect the dignity and anonymity of the deceased. Witnesses will be invited to meet members of the Inquiry and will be provided in advance with an outline of the topics they will be asked about. These interviews with the Inquiry will be recorded and the subsequent transcripts analysed. Careful consideration is being given to the timetable and sequencing of the interviews to make sure that no stone is left unturned. The desktop review that was carried out by the original independent investigation has been used to inform lines of enquiry for these evidence sessions. Further lines of enquiry are being identified and developed by the Inquiry. This first-hand evidence will be considered and analysed alongside the information from the independent investigation's desk-top review, the areas of concern that were identified by the investigation and raised with the Trust and NHS England, and additional information that is being supplied by the Trust, Kent Police and Mitie amongst others. The Inquiry does not plan to provide disclosure of all the materials it receives because of the time that will take to review materials for redaction, the distressing content and the need to ensure that swift progress is made, given the serious issues involved,

The Inquiry is supported in its work by two Independent Advisors, who have been appointed as subject matter experts to provide specialist advice to Sir Jonathan and his team. Professor Mike Osborn is President of the Royal College of Pathologists. John Pitchers is Chair of the Association of Anatomical Pathology Technology. Professor Osborn and Mr Pitchers will make sure that the Inquiry is informed about previous and current best practice in the management of mortuaries and care of the deceased. They will also support the Inquiry to identify lines of enquiry and identify organisations to contact for information that are relevant to the Inquiry's terms of reference.

The Inquiry continues to liaise with Kent Police to ensure that if it identifies possible criminal conduct, this is referred swiftly for further investigation, in line with the Inquiry's terms of reference.

Conclusion

The first phase of the Independent Inquiry, focussing on Fuller's activities in the Kent and Sussex Hospital and the Tunbridge Wells Hospital at Pembury, is firmly under way, with families of Fuller's victims having the opportunity to share their experiences with the Inquiry from March. The collection of first-hand evidence is starting and analysis of material from both the original Trust-commissioned investigation and additional material that has been supplied to the Inquiry by relevant organisations, including the Trust, Mitie and Kent Police is underway.

Work has begun to further scope and plan for the second phase of the Inquiry, to look at the implications of Fuller's activities and the issues identified in phase one, for the country as a whole in order to safeguard the deceased and ensure that this activity cannot be repeated elsewhere.

The Inquiry is aiming to publish its initial report, on matters relating to Maidstone and Tunbridge Wells NHS Trust, as soon as possible to ensure that any urgent safeguarding issues and lessons learned are identified. Because the Inquiry has already received a greater volume of evidence than had been expected, the initial report is now expected to be published later in 2022 rather than in the middle of the year as anticipated. The Inquiry is aiming to publish its final report, looking at the broader national picture and the wider lessons for the NHS and for other settings, in 2023.

The Chair is determined that he and his team and will be objective and thorough in all their work to uncover how such acts could take place undetected in hospitals for such a long time, and to make recommendations that would reduce the chance of such offending being possible in the future

Appendix 1

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

Phase 1

- 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.

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