Media statement

Good morning. My name is Jonathan Michael and I am Chair of the Independent Inquiry into the issues raised by the David Fuller case.

In December 2021, David Fuller, an electrical maintenance supervisor with Maidstone and Tunbridge Wells NHS Trust, was convicted of the murders of Wendy Knell and Caroline Pierce in 1987. On his arrest, police officers conducted a search of his home address. This search uncovered printed photographs and video images, held on hidden computer hard drives of Fuller performing sexual acts on deceased people. The subsequent police investigation found that Fuller had sexually abused at least 100 deceased women and girls in the mortuaries of the hospitals in which he had worked. His victims' ages ranged from 9 to 100 years old. His offences took place between 2005 and 2020. Fuller was convicted of the mortuary offences under the Sexual Offences Act 2003, at the same time as his conviction for the murders of Wendy and Caroline.

Today, the Inquiry is publishing its Phase 1 Report. This phase of the Inquiry has been to establish what happened in the Maidstone and Tunbridge Wells NHS Trust to allow Fuller to commit such awful crimes and to understand how his offending remained undetected for so long.

When the then Secretary of State for Health, the Right Honourable Sajid Javid MP, asked me to chair this independent Inquiry, I was conscious of the responsibility of the role, as Fuller's crimes had caused shock and horror across our country and beyond.

As a former NHS hospital consultant and Chief Executive, I hoped that I could help provide answers to the families of Fuller's victims by identifying what went wrong to allow the creation of an environment, where Fuller was able to offend undetected for so long.

I also wanted to help the Trust and all organisations charged with the oversight of the Trust and its mortuary services, to understand, to acknowledge and to learn from what went wrong and to take steps to ensure that nothing similar could ever happen again.

The offences that Fuller committed were truly shocking, and he will never be released from prison. Failures of management, of governance, of regulation, failure to follow standard policies and procedures, together with a persistent lack of curiosity, all contributed to the creation of the environment in which he was able to offend, and to do so for 15 years without ever being suspected or caught.

This is not solely the story of a rogue electrical supervisor. Fuller's victims and their relatives were repeatedly let down by those at all levels whose responsibility it was to ensure that they were appropriately cared for and protected in the mortuary.

Over the years, there were missed opportunities to question Fuller's working practices.

He routinely worked beyond his contracted hours, undertaking tasks in the mortuary that were not necessary or which should not have been carried out by someone with his chronic back problems. This was never properly questioned.

There was little regard given to who was accessing the mortuary. Fuller entered the mortuary 444 times in a single year and this went unnoticed and unchecked.

Mortuary staff were mostly unsupervised and left to their own devices. They frequently did not follow policies and standard operating procedures. We heard that deceased people were left out of fridges in the post-mortem room both overnight, and during working hours when Fuller was carrying out maintenance tasks. He was not accompanied or supervised by mortuary staff at these times. Fuller sexually abused the deceased in the mortuary on 12 occasions during working hours, when mortuary staff should have been on duty. On their intermittent assessments, those responsible for regulation of the mortuary often did not detect these systemic procedural failings.

Despite the fact that the mortuary was one of a limited number of designated restricted areas in the hospital, it was in this uncontrolled environment that Fuller was able to offend undetected. The senior management of the Trust had been aware of problems with the running of the mortuary from as early as 2008. But there is little evidence that effective action was taken to remedy these issues or that the Trust Board paid any attention to the mortuary. Requests for CCTV to be installed in the mortuary were not actioned for over a decade.

Had his colleagues, managers and senior leaders been more curious, it is likely that he would have had less opportunity to offend.

In January 2023 we received an allegation that an electrician had been sexually abusing the deceased in the mortuary at the Kent and Sussex Hospital in the late 1990s. I referred this allegation to Kent Police in line with our terms of reference. We were able to investigate it once the Police had completed their enquiries. This uncovered a further allegation that bodies of the deceased were scalded in the mortuary in the late 1990s. We have not been able to confirm events behind these allegations. However, they illustrate that there were concerns about inappropriate behaviour in the mortuary at one of the predecessor organisations to Maidstone and Tunbridge Wells NHS Trust some seven years before Fuller is known to have sexually abused deceased women and girls in the mortuary.

Although the failures took place over many years and during various management and regulatory regimes, I expect the current leadership of the Maidstone and Tunbridge Wells NHS Trust and those outside the Trust charged with oversight and regulation, to reflect seriously and carefully on their responsibility for the weaknesses and failings that I have identified in this Report and to implement my recommendations.

The Report makes 17 recommendations with the aim of preventing any similar atrocities happening again in the Trust. The recommendations follow from the evidence that we have heard and reviewed in the course of our work. We have held interviews with over 200 witnesses and reviewed more than 3,700 documents. I am satisfied that our detailed work and the co-operation we received from the Trust and other interested parties has enabled the Inquiry to reach robust and evidence-based conclusions.

My recommendations include:

- Recommending that the Trust ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs. [Recommendation 1]

- I recommend that the Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen. [Recommendation 2]

- I recommend that the Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary. [Recommendation 6]

- I recommend that CCTV cameras are installed in the mortuary and the post mortem room and that the footage is reviewed regularly, alongside records of who is accessing the mortuary and how often. [Recommendations 9 and 10]

- And I recommend that the Trust Board must review its governance structures to make sure that the Board has greater oversight and assurance of legally regulated activity in the mortuary. Alongside this, the Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients. [Recommendations 13, 14 and 17]

Had these, and other measures that I am recommending, been in place when Fuller was working at the Trust, I firmly believe his offending could have been prevented.

I note that the Trust has improved its overall performance in recent years. Only this year, it was moved into the highest category in the NHS England performance monitoring system.

The findings of this Inquiry are in sharp contrast with that.

Fuller committed 52 per cent of his offences between the beginning of 2018 and his arrest in December 2020, the same time period during which the Trust has seen rapid improvement in other areas of performance. This serves as a stark reminder that there may be serious hidden issues found in organisations that are apparently performing well.

The fact that the Trust was apparently improving its overall performance does not in any way excuse the failings that allowed Fuller to offend. The thousands of staff who worked hard to provide high-quality care for patients across the Trust, and had nothing to do with the running, management and oversight of the mortuary, will be justified in feeling let down by their colleagues who held those responsibilities.

As the Inquiry has been preparing and finalising this Phase 1 Report, we have also begun our Phase 2 work, looking at the broader national picture to understand the procedures and practices across the country which are in place to protect the deceased, not just in hospital mortuaries but in other settings too. Central to this is understanding whether we can be confident that offending such as Fuller's couldn't take place in other locations where the bodies of the deceased are kept.

Finally, I would like again to reiterate my sincere thanks to the families of Fuller's victims, for bravely sharing their feelings and experiences with us, and for their patience as we undertook the process of reviewing evidence and drafting this Report.

Thank you.