Independent Inquiry
into the issues raised by
the David Fuller case

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.

When I was asked by the then Secretary of State for Health and Social Care, the Rt Hon. Sir Sajid Javid, to chair this Independent Inquiry it was clear that the responsibility was significant, as the safety and dignity of the deceased is a matter of relevance to us all. Despite the lack of legal status for the deceased, we all expect our loved ones, and indeed ourselves, to be treated with the same dignity and security after death as when alive.

David Fuller's crimes shocked me when I first heard about them and continued to appal me as I led this Inquiry's work. These crimes showed that the arrangements to protect the security and dignity of the deceased in the hospitals where Fuller worked were inadequate.

The Inquiry considered how Fuller was able to offend undetected for so long in the mortuaries in hospitals in Tunbridge Wells, in Phase 1, and reported our findings in November 2023. I made 17 recommendations to Maidstone and Tunbridge Wells NHS Trust and Kent and East Sussex County Councils to prevent anything similar happening there again.

I was also asked to review the arrangements in place to protect the security and dignity of deceased people in other hospital and non-hospital settings across the country. The Phase 2 Report which is published today, gives my assessment of the current situation and makes wide ranging recommendations for changes that I believe are necessary to provide the safety and dignity for the deceased that we all expect

In addition to the wider NHS across England, the Inquiry has reviewed local authority mortuaries and body stores, hospices, NHS ambulance services, centres for medical education and training and independent healthcare providers. I have also reviewed the current oversight and regulation of services providing care of deceased people. My findings and recommendations for the funeral sector were published in an interim report in October of last year.

In conducting Phase 2 of the Inquiry, it has become obvious to me that the arrangements for the care of deceased people are both complex and interconnected. There are multiple organisations, with different governance and operating models in each of the sectors that we reviewed in Phase 2. The sectors I have considered are large – for example, in England, there are around 4,500 funeral directors, 204 NHS trusts, 317 local authorities, over 200 hospices and more than 14,000 residential and nursing homes. I believe that this is the first time that the security and dignity of people after death in England has been reviewed comprehensively.

The inadequate management, governance and processes that helped create the environment in which David Fuller was able to offend are unfortunately not confined to the Maidstone and Tunbridge Wells NHS Trust. I found examples in other hospital and non-hospital settings across the country. I found that the security and dignity of people after death did not feature in the governance arrangements of many of the organisations caring for the deceased, that we reviewed in the Inquiry.

My overall conclusion is that the current arrangements for the regulation and oversight of the care of people after death in England are partial, ineffective and, in significant areas, completely lacking.

Most importantly I have asked myself if there could be a recurrence of the appalling crimes committed by David Fuller. Based on what I have found in Phase 2 of the Inquiry, I believe it is currently entirely possible that such offences could happen again, particularly in those sectors that lack any form of statutory regulation.

During its work the Inquiry came across a number of recurring themes: Abuse of deceased people can be deliberate, or it can be the result of neglect or incompetence.

- Organisations and individuals tend to view any threat to deceased people as most likely to come from outside the organisation rather than internally.
- There is an over-reliance on trust and long periods of employment as a mechanism for internal governance and control.
- There is a reluctance for organisations to explore systemic risks or to ‘think the unthinkable’.

I urge all those involved in the care of people after death to challenge themselves on these issues; to question whether they uphold the same standards in caring for someone after death, as they would if that person were alive. The deceased are at least as vulnerable as the living and worthy of the same level of protection. The type of harm inflicted on David Fuller’s victims and the hurt and trauma experienced by their families must never be repeated. At present, I am not assured of this.

In this Report I make a number of recommendations to protect the security and dignity of people after death. Some of my recommendations are to specific sectors, some have wider relevance. My overarching recommendation is that there should be statutory regulation in place to protect the security and dignity of people after death, whichever setting or institution they are in. The recommendations I make work together. They all need to be implemented to ensure that deceased people are protected.

I urge the government to begin work on implementing my recommendations, from both this Phase 2 Report and my Interim Report on the Funeral Sector. They are necessary and, as a society, we owe it to everybody to ensure that they and their loved ones are cared for safely and with dignity after their death.

I would like to end by thanking everyone who has contributed to the work of this Inquiry, especially the families of Fuller's victims, who bravely shared their experiences with us in Phase 1. Those experiences have continued to be a driving force behind this Inquiry throughout Phase 2.