Independent Inquiry into the issues raised by the David Fuller Case publishes final report

15 July 2025: Immediate release

- Inquiry concludes that current arrangements in England for the regulation and oversight of the care of people after death are partial, ineffective and, in significant areas, completely lacking.
- Inquiry concludes that it is possible that offences such as those committed by David Fuller could happen again, particularly in those sectors that lack any form of statutory regulation.
- Report makes a total of 75 recommendations. Its 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 Independent Inquiry into the issues raised by the David Fuller case is today publishing its Phase 2 Report.

In November 2021, the Secretary of State for Health and Social Care announced an independent inquiry into the issues raised by the actions of David Fuller, an electrical maintenance supervisor. Over the course of 15 years, Fuller committed sexual offences against at least 100 deceased women and girls in the mortuaries of the Kent and Sussex Hospital and the Tunbridge Wells Hospital. His victims ranged in age from nine to 100.

This phase of the Inquiry has looked at the broader national picture and considered if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

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

Based on what the Inquiry has found in its Phase 2 work, it concludes that it is currently possible that offences such as those committed by David Fuller could happen again, particularly in those sectors that lack any form of statutory regulation.

The 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.

A total of 75 recommendations are made within the report, some of which are relevant to specific sectors, with others having wider relevance. They are interconnected and must be implemented collectively to ensure that deceased people are protected.

Sir Jonathan Michael, Chair of the Inquiry, said:

"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 – across 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. This is the first time that the security and dignity of people after death has been reviewed so comprehensively.

"Inadequate management, governance and processes helped create the environment in which David Fuller was able to offend for so long. These weaknesses are not confined to Maidstone and Tunbridge Wells NHS Trust. I found examples in other hospital and non-hospital settings across the country. The security and dignity of people after death, do not feature in the governance arrangements of many organisations which are caring for the deceased.

"I have therefore come to the conclusion that the current arrangements for the regulation and oversight of the care of people after death are partial, ineffective and, in significant areas, completely absent.

"I have asked myself whether there could be a recurrence of the appalling crimes committed by David Fuller. - I have concluded that yes, it is entirely possible that such offences could be repeated, particularly in those sectors that lack any form of statutory regulation.

"During the Inquiry, I came across a number of recurring themes:

- *Firstly, abuse of deceased people can be deliberate, or can result from neglect or incompetence.*
- *Secondly, organisations and individuals tend to view any threat to deceased people as most likely to come from outside their organisation rather than internally.*
- *Thirdly, there is an over-reliance on trust and long periods of employment as a mechanism for internal governance and control.*
- *Lastly. many organisations are failing 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 as vulnerable as the living. They are worthy of the same level of protection. The harm inflicted on David Fuller's victims and the hurt and trauma experienced by their families must never be repeated. At present, I cannot give that assurance.

"The recommendations I am making today are designed to protect the security and dignity of people after death. Most of these recommendations are to specific sectors, some have wider relevance and are addressed to the Government and to existing regulators. They all need to be implemented to ensure that deceased people are properly protected.

"My overarching recommendation to the Government, is that there must be statutory regulation in place to protect the security and dignity of people after death, whichever setting or institution they are in.

"My recommendations are necessary and, as a society, we owe it to everybody to ensure that they and their loved ones are cared for securely, and with dignity, after their death.

"I would like to thank 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.

"It is essential that the recommendations I make today, and in my interim report on the funeral sector, are implemented without delay."

ENDS

Notes to Editors

The Phase 2 report is available at https://fuller.independent-inquiry.uk/report/

For media inquiries please email fullerinquiry@luther.co.uk or telephone 020 7618 9110.

Further background on David Fuller

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 mortuary offences under the Sexual Offences Act 2003*, at the same time as his conviction for the murders of Wendy and Caroline.

Further background on the Inquiry's work

The Inquiry was established in two phases. Phase 1 was to examine the events at Maidstone and Tunbridge Wells NHS Trust and establish how David Fuller was able to commit his appalling offences and remain undetected for so long. The Phase 1 Report was published in November 2023.2

The Inquiry expedited its work on the funeral sector following reports of cases of neglect of the deceased in some funeral homes and the growing calls for regulation of the sector. An Interim Report on the funeral sector was published in October 2024.

Phase 2, the final phase of the Inquiry, has explored the wider picture of care of the deceased in England. The aim was to assess the effectiveness of systems and processes designed to ensure the security and dignity of the deceased across all

sectors where they may be cared for, and thus prevent such awful crimes being committed again in the future.

Following the publication of its Phase 2 Report, the Inquiry has fulfilled its Terms of Reference and will cease to operate. It is for the UK government to respond to the Report and its recommendations.

*The Crime and Policing Bill, currently before Parliament, contains a provision (Clause 58 when introduced in February 2025) which would replace the existing offence of sexual penetration of a corpse under the Sexual Offences Act 2003 with a wider offence of sexual activity with a corpse and a stronger custodial penalty.