

Independent Inquiry
into the issues raised by
the David Fuller case

Return to an Address of the Honourable the
House of Commons dated 28 November 2023 for

**Independent Inquiry into the issues
raised by the David Fuller case**

Phase 1 Report

Ordered by the House of Commons to be printed
on 28 November 2023



© Crown copyright 2023

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us at contact@fuller.independent-inquiry.uk

ISBN 978-1-5286-4528-7

E02731932 11/23

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Chair's introduction

When I was asked by the then Secretary of State for Health and Social Care, the Rt Hon. Sajid Javid MP, to chair the Independent Inquiry into the issues raised by the David Fuller case, I was fully aware of the significant responsibility of the role. David Fuller's crimes caused shock and horror across our country and beyond. I felt duty-bound to play any part I could to help provide answers for the families of David Fuller's victims, and to ensure that no families would ever have to suffer the same ordeal, the impact of which the victims' families are still living with today.

My formal responsibility is to conduct a truly independent inquiry and to report my findings and recommendations to the Secretary of State for Health and Social Care. My responsibility has been to discover how David Fuller was able to commit so many offences, over such a long period of time, without ever being suspected or discovered. In doing this, I have sought to identify what went wrong. This includes looking at how those charged with oversight and regulation of mortuary services at Maidstone and Tunbridge Wells NHS Trust (the Trust) had allowed the development of an environment in which David Fuller was able to offend with impunity.

In identifying where governance, systems and processes have failed, I am able to inform the Trust, the NHS and the regulators of my findings and to recommend what corrective action is required. Where the Inquiry has found significant failings, I have a responsibility to identify and hold to account those individuals and organisations responsible. While it is important to understand the past failings that enabled David Fuller to offend, it is equally important to make recommendations that would help prevent such events from happening ever again.

When the Secretary of State announced the Inquiry, he stated that it would involve two phases. Phase 1 of the Inquiry would examine what happened at Maidstone and Tunbridge Wells NHS Trust. This Report covers the findings from this first phase. As the Terms of Reference for Phase 1 are focused solely on what happened at Maidstone and Tunbridge Wells NHS Trust, we have made no comparison with the management and assurance of mortuaries in other NHS trusts. This is being explored in Phase 2, as part of our work to look at the broader national picture, to understand the procedures and practices across the country that are in place to protect the deceased.

For Phase 1, we heard evidence from 200 witnesses who participated in the Inquiry. Three people refused to give evidence when asked. By refusing to cooperate, they demonstrated a disappointing lack of social conscience or support for the Inquiry's work. I was clear from the outset that I would name all those who refused to cooperate with the Inquiry without good reason, and therefore I have named these three individuals in Appendix 4. However, with the contributions of the 200 other witnesses, through interviews and written evidence, I believe that we have produced a robust and comprehensive picture of what happened at the Trust.

The offences that David Fuller committed were truly shocking, and he will never be released from prison. However, the failures of management, governance, regulation and processes, and a persistent lack of curiosity, all contributed to the creation of the environment in which he was able to offend. This is not solely the story of a rogue electrical maintenance supervisor. David Fuller's victims and their relatives were repeatedly let down by those at all levels whose job it was to protect and care for them.

I make a number of recommendations to help prevent such events from happening again. I urge the Trust and others to act quickly and decisively on these recommendations. I also expect the Trust and others to reflect on their responsibility for the weaknesses and failings over many years that are identified in this Report.

Maidstone and Tunbridge Wells NHS Trust has improved the overall performance of many of its services in recent years. In 2023, the Trust was moved into the highest category in the NHS England overall performance monitoring system. The findings of this Inquiry sharply contrast with that. David Fuller committed 52 per cent of his offences at Tunbridge Wells Hospital between 2018 and his arrest in December 2020, the same time period during which the Trust has seen rapid improvement in other areas. We found evidence that poor practice in the mortuary continued beyond David Fuller's arrest in December 2020. In January 2021, the Trust discovered that the deceased were still being stored unrefrigerated overnight prior to post-mortem examination, a matter which it was required to report as a serious incident to the Human Tissue Authority. 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 justify the failings that allowed David Fuller to offend. The thousands of staff who worked hard to provide high-quality care for patients, 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 did hold those responsibilities.

When, during the work of the Inquiry, I became aware of current issues and practices that could compromise the security and dignity of the deceased, I took immediate action to raise these with the relevant authorities in line with the Inquiry's Terms of Reference. I had to do this on two occasions. In my former role, chairing the internal investigation into David Fuller's crimes at Maidstone and Tunbridge Wells NHS Trust, I had previously notified the Trust and NHS England of a number of procedural weaknesses that I had identified which required immediate attention.

Many families told the Inquiry that they considered the sentences that David Fuller received for abusing their relatives too lenient. This has added to the emotional trauma they are suffering. It is not within the Inquiry's Terms of Reference to examine the sentences he received, but I was moved by the strength of feeling among the families. Consequently, I have written to the Ministry of Justice and asked that the experiences and feelings of the families of David Fuller's victims are taken into account in any review of sentencing.

I would like to end this Introduction by recognising those who have contributed to its findings, particularly when it has been difficult for them to do so. Above all, I would like to thank the families for bravely sharing their feelings and experiences with us, and for their patience as we undertook the lengthy process of reviewing evidence and drafting this Report. I know it may make for difficult reading, but I hope they feel it gives them the answers they deserve.

Finally, although the responsibility for the findings and recommendations of the Inquiry lies firmly with me, I could not have done this work alone. I would like to acknowledge the commitment, hard work and advice of all members of the Inquiry's Secretariat. I would also like to acknowledge the assistance and advice of the Independent Advisers to the Inquiry. The names of all who have assisted me are listed in Appendix 3.

Sir Jonathan Michael
Chair

Contents

Chair's introduction	iii
Background	1
Chapter 1: Family accounts	8
Chapter 2: David Fuller's offending	48
Chapter 3: David Fuller's employment and working practices	67
Chapter 4: Mortuary management and oversight	118
Chapter 5: Security arrangements at Maidstone and Tunbridge Wells NHS Trust	151
Chapter 6: The wider system	177
Chapter 7: Governance and accountability within Maidstone and Tunbridge Wells NHS Trust of matters relating to David Fuller	207
Chapter 8: Allegations of inappropriate conduct in the mortuaries at Kent and Sussex Weald NHS Trust in the late 1990s	234
Chapter 9: Culture	249
Chapter 10: Conclusions and recommendations	262
Appendix 1: How we did our work	271
Appendix 2: Terms of Reference	278
Appendix 3: Team members	282
Appendix 4: Witnesses	284
Appendix 5: Glossary of terms	286
Appendix 6: Governance structures	292

List of figures

Figure 1: Mortuary floorplan	49
Figure 2: Offences by day of week	50
Figure 3: Offences by time of day	50
Figure 4: Offences by year	51
Figure 5: Lines of accountability from mortuary staff to Chief Executive, 2005 to 2020	122
Figure 6: Appendix I, Assurance Framework and Risk Register	217
Figure 7: Trust governance structure, April 2009	292
Figure 8: Trust Board committee structure, September 2017	293

List of tables

Table 1: Serious Untoward Incidents in the mortuary, 2009	126
Table 2: Human Tissue Authority identified shortfalls, 2015 and 2018 inspections, Maidstone and Tunbridge Wells NHS Trust	183
Table 3: Kent County Council contracts for provision of post-mortem services at Maidstone and Tunbridge Wells NHS Trust	198

Background

This Report presents the findings and recommendations of the Independent Inquiry into the issues raised by the case of David Fuller. Throughout this Report, the terms 'the Inquiry' and 'we' are used interchangeably. However, the findings in this Report have been decided by the Chair of the Inquiry. A description of the Inquiry's methodology can be found in Appendix 1.

The Inquiry's Report contains information that is distressing and difficult to read. Readers should also be aware that the Inquiry interviewed David Fuller in the course of its work and that this Report includes extracts from these interviews.

In this Report, we will refer to the deceased and deceased people, rather than bodies, to preserve the dignity of those against whom David Fuller offended.

We begin the Report with this brief introduction to the case of David Fuller, the setting up of the Independent Inquiry, and the context regarding Maidstone and Tunbridge Wells NHS Trust (the Trust), NHS oversight during the time of the offending, and the role of mortuaries in the NHS.

The Inquiry's findings are in Chapters 2 to 9, followed by the conclusions and recommendations to prevent the risk of anything similar happening in Chapter 10.

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 for the murders of Wendy and Caroline, in December 2020, police officers conducted a search of his home address. This search uncovered video images, held on several hidden computer hard drives, together with printed photographs of David Fuller performing sexual acts on deceased people. The subsequent police investigation identified that David Fuller had sexually abused deceased people in the mortuaries of the hospitals in which he had worked. David 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. He received two whole-life sentences for the murders of Wendy and Caroline and a 12-year prison sentence for the mortuary offences, which will run concurrently with the life sentences.

When sentencing David Fuller for the murders of Wendy and Caroline, Mrs Justice Cheema-Grubb remarked on the brutality of the murders. She noted that David Fuller attacked and murdered 25-year-old Wendy in her own home, with a blunt instrument, and asphyxiated her. Mrs Justice Cheema-Grubb noted that David Fuller attacked 20-year-old Caroline outside her home as she was returning from a night out with friends. Caroline's screams were heard by her neighbours. Her brutalised body was found in a water-filled dyke some distance from Tunbridge Wells. She had also been struck around the head with a heavy object and asphyxiated by David Fuller. Mrs Justice Cheema-Grubb remarked that both women had been sexually assaulted and that she considered this sexual conduct was most likely to have occurred after

their deaths. It is of central relevance to this Inquiry that Mrs Justice Cheema-Grubb considered the motivation for the murders of Wendy and Caroline to be sexual, to gratify David Fuller's interest in sexual intercourse with the deceased.

The available evidence identified that David Fuller had committed the mortuary offences from 2005 until the time of his arrest in December 2020. During this time, he had been working initially at Kent and Sussex Hospital and later at Tunbridge Wells Hospital. The evidence used to convict David Fuller of the mortuary offences indicated that he had committed the offences against at least 100 women and girls. It was his arrest for the murders of Wendy and Caroline that brought his criminal offending in the mortuaries to an end.

In December 2022, following the identification of a further 13 victims, David Fuller was sentenced to an additional four-year prison sentence. Ten victims remain unidentified.

The background of David Fuller

David Fuller was born in Portsmouth in 1954. Between 1972 and 1976, he undertook a four-year City & Guilds Electrical Technician apprenticeship at Her Majesty's Dockyard at Portsmouth. He moved to Kent in the late 1970s and held several jobs in west Kent, all within his specialism in electronics. David Fuller began his first NHS role as an electrical maintenance craftsman at Kent and Sussex Hospital in 1989. This was less than two years after he had murdered Wendy Knell and Caroline Pierce. The criminal background check for his appointment to the role of electrical maintenance craftsman will be discussed in detail in Chapter 3.

In March 2002, David Fuller successfully applied for a supervisory position, in the Maintenance department at Kent and Sussex Hospital. The vetting process for this appointment will also be discussed in detail in Chapter 3. In May 2011, David Fuller transferred to the newly built Tunbridge Wells Hospital. On transferring to the new Tunbridge Wells Hospital, David Fuller became an employee of the private facilities provider Interserve (Facilities Management) Ltd. This was because the new Tunbridge Wells Hospital had been built under a Private Finance Initiative (PFI), which will be discussed in more detail later in this chapter.

Initial response to David Fuller's crimes by the NHS

In February 2021, the Board of Maidstone and Tunbridge Wells NHS Trust commissioned an internal 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 proceedings.

NHS England is the national body that leads the NHS in England. In October 2021, after receiving an initial briefing from the internal investigation, NHS England contacted all NHS trusts that provided either mortuaries or body stores and asked them to ensure

compliance with existing guidance from the Human Tissue Authority (HTA) and ensure implementation of the following actions:

- (1) To review security arrangements and ensure that access points to mortuaries are controlled by swipe card security wherever possible and, if not possible, that sufficient mitigations are in place to ensure facilities are secure and access is auditable;
- (2) That effective CCTV coverage of 'mortuary areas' must be in place and reviewed systematically;
- (3) To undertake a risk assessment of the operation, security and construction of the mortuary or body store; and
- (4) Ensure that there is consistent application of the appropriate levels of Disclosure and Barring Service checks for all trust and contracted employees.

NHS England requested that NHS trust boards formally reviewed the evidence of compliance with these requirements, that they assured themselves that they had reviewed the evidence in response to each action, and that they confirm to NHS England, by 16 November 2021, that they were satisfied that the appropriate response had been taken.

The Independent Inquiry into the issues raised by the David Fuller case

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

The Inquiry was established as a non-statutory inquiry and is being conducted in two phases. The first phase investigates how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries of NHS hospitals in Kent and why this activity went unnoticed. The second phase will consider the broader national picture and the wider implications for the NHS and for other settings where the deceased are cared for before burial or cremation. The second phase will also review the adequacy and effectiveness of the regulatory arrangements for the care of the deceased. The findings and recommendations of the Inquiry for both phases will be published.

This Report presents the first phase of the Inquiry. It sets out the Inquiry's methodology, findings and recommendations. It also describes the impact that David Fuller's offending has had upon the relatives of his victims. The impact of David Fuller's offences upon the victims' relatives is captured in Chapter 1. We are grateful to them for their courage in coming forward. We recognise how difficult it was for families to engage with the Inquiry, given the distressing nature of the offences committed against their loved ones. These family accounts make for uncomfortable reading. However, we urge all to

read them, as it is important to understand the harm that has been caused to so many families by David Fuller's appalling crimes against their loved ones.

The recommendations of the first phase of the Inquiry are set out in Chapter 10. The recommendations from Phase 2 of the Inquiry will be published separately.

History of Maidstone and Tunbridge Wells NHS Trust

Tunbridge Wells Health Authority operated Kent and Sussex Hospital from 1982 until February 1994. Kent and Sussex Weald NHS Trust operated 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 formally established as a legal entity in February 2000 and took over the operation of Kent and Sussex Hospital and Maidstone Hospital. Tunbridge Wells Hospital was opened in January 2010 at Pembury. Kent and Sussex Hospital closed in 2011, leaving Maidstone and Tunbridge Wells NHS Trust to operate Maidstone Hospital and Tunbridge Wells Hospital. The Maintenance department from Kent and Sussex Hospital was transferred to Tunbridge Wells Hospital in May 2011, and the mortuary service was transferred to this new hospital in September 2011. Tunbridge Wells Hospital was built under a PFI. This is an important factor in this Inquiry as, because of the PFI arrangements, David Fuller's employment transferred from the NHS to the facilities provider, Interserve (Facilities Management) Ltd. However, even though his employment status changed, David Fuller continued to work at Tunbridge Wells Hospital, as an electrical maintenance supervisor, until his arrest in December 2020.

The move to Tunbridge Wells Hospital, a Private Finance Initiative building

Between May and September 2011, all services at Kent and Sussex Hospital moved to the new hospital build at the Tunbridge Wells site. The maintenance service, including David Fuller, moved to the new hospital in May 2011 and the mortuary service moved in September 2011. The new hospital was built under a PFI. Under the PFI arrangement, the hospital was funded and built by a private sector consortium and then leased to the NHS Trust for a defined period of 34 years, at the end of which time the NHS will take ownership of the hospital. Hospitals built under a PFI arrangement have complex contractual and management arrangements to ensure that all parties are fulfilling their contractual obligations. A third-party company was established to design, build and operate the new premises. This company is called the Kent and East Sussex Weald Hospital Ltd. This company is termed a Special Purpose Vehicle (SPV) and we will refer to it as such from this point. The SPV subcontracted a private sector facilities management company called Interserve (Facilities Management) Ltd (Interserve) to provide the 'hard' facilities management services, which included maintenance of the buildings and equipment. 'Soft' facilities maintenance services, such as portering, cleaning and catering, remained the responsibility of the NHS Trust. As part of the PFI arrangements, the mechanical and electrical maintenance staff at Kent and Sussex Hospital, including David Fuller, became employees of Interserve when they

transferred to the new Tunbridge Wells Hospital. The staffing and the management of the mortuary remained the responsibility of the Trust.

NHS trusts, oversight, accountability and scrutiny arrangements

The oversight, accountability and scrutiny arrangements for NHS organisations changed significantly during the period 2005 to 2020. In the early 2000s, the NHS experienced a period of significant organisational change under the NHS Plan. The first NHS trusts were established and, in 2002, regional and district health authorities were abolished, and replaced by 28 strategic health authorities (SHAs). Primary care trusts (PCTs) took responsibility for the commissioning and delivery of acute and mental health NHS services for a local population. The SHAs provided oversight of the performance of the NHS in their area. The SHAs reported to the NHS Executive and then to the Department of Health.

Kent and Medway SHA was responsible for the oversight of Maidstone and Tunbridge Wells NHS Trust. Although the local PCT would have had an oversight role in relation to the Trust's contract performance, the Trust was not directly accountable to the local PCT.

The Health and Social Care Act 2012 abolished SHAs and PCTs, replacing them with clinical commissioning groups. At a national level, the performance of NHS trusts, such as Maidstone and Tunbridge Wells NHS Trust, was undertaken by the Trust Development Authority (TDA). In 2016, the TDA was merged with another NHS oversight organisation, Monitor, to form NHS Improvement. NHS Improvement was then responsible for the regulation and oversight of the Trust and its remit was to ensure that NHS trusts were able to deliver agreed levels of planned and emergency care safely and were clinically and financially sustainable.

NHS Improvement formally merged with NHS England in 2022. However, the two organisations had been working together as a single organisation since 2019 to provide oversight and leadership of the NHS. Maidstone and Tunbridge Wells NHS Trust reported to the regional office of NHS England, and the Executives of both organisations had regular meetings to review performance.

Mortuaries and post-mortem examinations on NHS premises

In England, mortuaries where post-mortem examinations (PMEs) are undertaken can be situated in NHS hospitals or alternatively on local authority premises. Mortuaries only used for the safe storage of the deceased until burial or cremation can be found in a variety of locations. The Inquiry will consider mortuaries in other locations during Phase 2 of the Inquiry. This Phase 1 Report will focus on the mortuaries at Maidstone and Tunbridge Wells NHS Trust.

The Tunbridge Wells Hospital mortuary provides both storage of the deceased and a PME service, as did the mortuary at the former Kent and Sussex Hospital prior to the move to the Tunbridge Wells Hospital site. Since 2007, the mortuary at Maidstone Hospital has only been used for the storage of the deceased. In this Report, we use the term 'mortuary' to mean its purpose as both a body store and a PME service at Tunbridge Wells Hospital, and as a body store only (from 2007) at Maidstone Hospital.

Mortuaries on NHS premises provide an important service within a community. In addition to providing safe and secure storage for the deceased, many will also be where PMEs are undertaken. The aim of a PME is to identify the cause of death or to learn other information about the death, and disease or pathology suffered by the deceased, or, consent permitting, to obtain material for research. PMEs are almost always carried out by specialist doctors known as pathologists. They are assisted by qualified mortuary staff called anatomical pathology technologists (APTs). APTs are responsible for the management and running of the mortuary, often with the help of pathologists and other staff. They also prepare the deceased for PME if one is to be conducted and assist the pathologist. They arrange for the viewing of the deceased by relatives and liaise with funeral directors for the transportation of the deceased in preparation for cremation or burial. Where there is a reasonable suspicion that the deceased died a violent or unnatural death, where the cause of death is unknown, or if the death occurred while in custody or state detention, an investigation into the death is commenced by HM Coroner. In these cases, the deceased will be moved to a hospital or local authority mortuary. HM Coroner then has legal control of the body, and the deceased will be cared for in a mortuary until the coroner's investigation, which often includes a PME, has been concluded.

The activities and premises of mortuaries are regulated by the HTA following its establishment in 2005 under the Human Tissue Act 2004. The HTA is an arm's-length body of the Department of Health and Social Care, but it is independent of this Department. The HTA will be discussed in more detail in Chapter 6. The HTA Codes of Practice and standards supporting the regulation of mortuaries require that there must be a system of governance for all the decisions made regarding the deceased such as consent for a PME or the storage of human tissue from the deceased.¹ The Codes of Practice and standards also require the deceased to be stored in secure premises that are well maintained and safeguard the dignity of the deceased.²

NHS mortuaries receive the deceased from hospital wards and in many circumstances also from the wider community. The deceased are received from the community under a range of circumstances, including where deaths have happened at home, in road traffic incidents, or when someone has died in circumstances where there is a suspicion that they have taken their own life. If someone has died in circumstances where the police consider the death may have happened as a result of criminal activity, a forensic PME will be undertaken by a specialist forensic pathologist, registered with the Home Office.³

1 HTA Codes of Practice, see HTA website.

2 HTA Code of Practice, *Post-mortem examination licensing standards and guidance*, p. 19.

3 Royal College of Pathologists, 'What happens during a post-mortem?'; see Royal College of Pathologists website.

Adult coronial, forensic and hospital consented PME are conducted at the Tunbridge Wells Hospital mortuary.⁴

Many NHS hospitals and some other organisations have mortuaries or facilities that act as 'body stores'. Body stores are facilities that receive and care for the deceased until released to funeral directors for cremation or burial. PME are not undertaken on premises that are solely body stores. As PME are not undertaken in these facilities, body stores are not subject to regulation by the HTA, unless human tissue is stored for a scheduled purpose.⁵

4 HTA Inspection Report, 2018, p. 3.

5 Scheduled purposes as set out in the Human Tissue Act 2004, Schedule 1, Scheduled purposes, Part 1 and Part 2.

Chapter 1:

Family accounts

1.1 Introduction

Since its establishment, the Inquiry has been committed to listening to the families affected by David Fuller's terrible actions and to ensuring they were at the heart of our work. It is important that the Inquiry's work to prevent anything like this happening again is informed by the families' experiences and the impact David Fuller's crimes has had on them. The Inquiry's work began with the families of David Fuller's victims.

Kent Police's Operation Sandpiper investigated the offences committed by David Fuller at Maidstone and Tunbridge Wells NHS Trust mortuaries. The Kent Police Family Liaison team informed the affected families about the Inquiry and asked if they wished to be contacted. Everyone who agreed was asked by the police to complete a consent form, giving permission for the Inquiry to contact them.

The Inquiry is in touch with 111 individual family members who gave consent for us to contact them. They represent 72 of the 91 identified victims of David Fuller; that is, 79 per cent of the victims. The Chair has regularly written to the families who have agreed that the Inquiry can contact them, updating them on our progress. Some families did not want to engage with the Inquiry. We understand this and respect their decision.

On his appointment, the Chair made the commitment that he would seek the views of the families affected by David Fuller's actions on the Inquiry's draft Terms of Reference. We contacted the families who had given consent for their details to be shared with the Inquiry, inviting their views on the draft Terms of Reference. Common themes that emerged from the families and other interested parties who expressed a view included:

- the level of David Fuller's supervision and what mechanisms were in place to check his working practices;
- employment checks and whether there were earlier offences;
- whether Maidstone and Tunbridge Wells NHS Trust (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 those 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.

After careful review and consideration of the responses we received, we were able to incorporate the issues that were important to families into our final Terms of Reference.

Following publication of the Inquiry's Terms of Reference, families were invited to speak with the Inquiry in private, to share their experiences of finding out what had happened to their relatives and the impact that this had had on them. These sessions took place either at our confidential office location, their home, an alternative location or online. The Inquiry offered emotional support (provided by professional counsellors) to families while they spoke to us, and had robust processes to protect the anonymity of them and their loved ones. All the family members we spoke to were sent a verbatim transcript of their session and given the opportunity to comment on those transcripts. The Inquiry has spoken to 54 family members, representing 33 of David Fuller's victims.

With the consent of the families who so bravely spoke with us, or instead sent a statement, summaries of what they told us are presented in this chapter. Some of the families told us they were not concerned about remaining anonymous. However, to ensure that the identities and dignity of all the victims and their families are protected, all the summaries have been anonymised.

Many who came forward to speak to the Inquiry told us that they were doing so in order to help prevent anything similar happening to anyone else.

In trying to comprehend what David Fuller did, it is important to take the time to read these accounts to understand how his actions have affected these families.

1.2 The families' experiences

Family member F1

F1's wife was a victim of David Fuller. He told us that he had been contacted by Kent Police, who asked to speak to him in person. He praised the police, acknowledging that delivering shocking and upsetting news was a difficult thing for the officers to do. *"And yeah, they were extremely professional and I can't fault them at all. So, the police side of it has been brilliant."*

However, F1 was not as impressed with how the Trust contacted him, and spoke of how he was telephoned by a doctor on behalf of the Trust. The call came with no warning, while he was at work, and felt insincere to him. *"I also had a telephone call from a doctor, who, I would imagine, worked at Tunbridge Hospital. That wasn't so good ... he was extremely insincere and half-hearted. So completely unimpressed with Tunbridge Hospital."*

F1 went on to say that, in contrast to the police's direct and personal approach, he was disappointed that the Trust had only contacted him via telephone, followed up by letters. He said that he would have preferred to speak with someone in person:

"[O]ne insincere phone call has just left me with a very bad taste in my mouth and I want nothing to do with Tunbridge NHS Trust. I think that what I would've actually preferred would have been a face-to-face meeting. You know, not necessarily with the chief executive, but with somebody at the hospital who would've been able to sit down like we are at the moment and explain why it happened."

In order to protect his wider family, F1 decided not to inform them of what David Fuller had done, feeling it would taint the memory of their loved one:

"[T]he impact on my family has been non-existent, because they don't know. The impact on me, it's basically robbed me of 25 years of happy memories ... Anything that reminds me of my wife also reminds me of what David Fuller did to her."

F1 spoke of how the Trust had a responsibility to care for his wife in the same way it would look after and protect the living in its care. He said that *"the hospital has a duty of care, not only to the living, but also to the deceased whilst they're in the hospital's premises, and there's no escaping that"*. He felt that things could have been done, and policies put in place by the Trust, to prevent what had happened. These included the installation of CCTV, not allowing technicians to enter and work in the mortuary alone, and carrying out correct employment checks. Where such procedures were not in place or adhered to, he felt that the Trust should be held accountable.

F1 went on to say that he felt the events at the Trust were not the fault of Trust staff:

"[T]he staff of the NHS are fantastic. We all know that they're doing a fantastic job with the resources that they've got. Don't blame the foot soldiers, blame the generals. Blame the leaders. Blame the people who have put the procedures into place."

Family member F2

F2 and her husband found out about David Fuller abusing their daughter when police officers came to their home. She spoke about the confusion and anxiety of unexpected contact with the police, but also told us that the police were very supportive and helpful:

"[O]ne Friday evening, we had a knock on the door and my husband went to answer it, and it was two support officers ... we sat in the garden, and he started going on about the two murders of the young girls, and I was thinking, 'What's this got to do with [her daughter]' ... and then he said that while [her daughter] was in Pembury Hospital [Tunbridge Wells Hospital], she was abused ... I couldn't get my head round how that could happen."

F2 said she was given an information folder by the police, which included a letter of apology from the Trust. The Trust later called her with further details of what had happened to her daughter, but she felt it was inappropriate for the Trust to share this information with her: *"They phoned me a couple of times ... That sent me quite in a panic attack ... I didn't feel that she should've told me these details. It was for the police to tell me when I was ready."*

Finding out what had happened had an impact on F2's mental health, and meant she was unable to work for months, suffering from anxiety and panic attacks. She was prescribed sleeping pills, as nightmares were preventing her from sleeping. She said:

"I went back to work and even when I went back to work, it was hard. My anxiety was playing me up, my breathing gets out of control. I could only do a few hours at work and then I'd have to go home again ... I'm back to work normal now ... I still have funny days ... I couldn't sleep, and your mind doesn't shut up. It just goes over and over and things ... your brain starts going over about him wheeling her about, just crazy."

F2 told us:

"I can't understand how he could keep going in there, multiple times a week. I assume he had a zap card to get in there and it didn't get picked up that he was going in there, possibly out of his hours. That needs to be questioned, I think. How someone worked there and did this over 12 years, and no-one was suspicious."

She spoke of her concerns for other families, and how she wanted the Inquiry to help prevent such dreadful things from happening again: *"I just want you to put something in place that guarantees, as much as you can, that this never happens to anybody, because it's devastating and changed our life."*

Family member F3

F3 was first told of David Fuller's offences against her sister by the police:

"[M]y doorbell went, I opened the door and there were two Met Police officers there ... I first of all, I thought that they were Jehovah's witnesses, and then they showed me their warrants."

She praised the support she received from the police, who were *"So lovely to me all weekend ... I wrote to their chief constable to say how amazing they were, 'cause they were fantastic."*

The Trust also contacted F3:

"[T]hey were the last ones to get in touch out of everyone who was going to get in touch ... they'd allocated me a doctor, who then phoned ... she sounded absolutely terrified, quite frankly ... I felt really sorry for her, but she had been given her lines to take ... it was the one part of the way that this has been handled that really irritated me actually, because it started off with an excuse ... and that was the last thing I wanted to hear right then."

F3 decided not to tell her immediate family. She spoke about the impact that this has had on her and of her fear that the family would find out:

"[T]here's this constant, constant reminder of it, that's not necessarily in my control ... I'm sort of at this height, this pitch of readiness the whole time to have an excuse at hand ... a constant state of readiness trying to anticipate what's going to happen next and how to organise it so that it doesn't hurt everyone else."

When asked what she thought needed to change at the Trust to prevent anything similar from happening again, F3 questioned how the Trust conducted staff vetting, saying, *“clearly, employment checks weren’t enough”*. She thought that security at the Trust, CCTV and the monitoring and auditing of access via swipe cards needed to be improved:

“I got given a load of old flannel by the Trust about that we were protecting the dignity of the deceased. Bullshit. You did exactly the opposite. You allowed her dignity to be whipped away, by not having CCTV. But these methods are only as good as the people behind them who are operating these systems. And they need to be given the time, the money, and the ability to do these checks.”

Family member F4

F4 told us that the police visited him at his home to tell him about David Fuller’s offences against his mother: *“I had no understanding then until the two police officers came to my house, very respectfully I’ve got to say.”* Weeks later, he was contacted by the Trust: *“I received a letter which was from the trust. The head of the trust. Just kind of recognising, you know, what had happened ... I didn’t have any verbal contact with anybody except this letter.”*

F4 described himself as a rational person but spoke of his difficulty in coming to terms with his mother’s death, and how learning, years after her death, of the abuse of his mother took him back to that time of grief:

“I do not mean to say that I’m insensitive. Of course I’m not. But my mother had passed away already so ... when I found this out, it kind of took me back ... back into the moment well back into that time ... It kind of just sort of almost frozen me into that point.”

He told us how David Fuller’s actions have affected how he remembers his mother, and that this happens *“whenever my mum’s memory comes up, you see a picture, or you see a memory. You don’t think of her, I don’t think of her, I think of this.”*

F4 told us how he could not understand why security at the Trust was not better: *“I was kind of thinking, how in this day and age you can’t walk down a street without 30 cameras on you anywhere. Why would you have a situation where somebody could just come and go?”*

Family member F5

F5 is the daughter of one of David Fuller’s victims. The police contacted her family to let them know of her mother’s abuse by David Fuller, and her family then informed F5 and other family members of what had happened. She spoke about how difficult it was for her family to break the news to her and how she did not want them to carry the weight of this information without her support:

"I found out via my younger brother ... which I really feel for him ... to have that responsibility. To have to tell us ... it's such abhorrent information ... they [her family] were sort of half hoping that maybe they could shield or protect us, and both myself and my older brother were very much in agreement that you can't burden this alone. So, it's obviously the worst conversation we've had. It was one of those conversations that you can't quite believe it's true. I remember sitting there and watching my brothers on screen. Erm, my, erm, older brother pretty much breaking down like I'm doing right now. Not an image I ever want to see again."

F5 told us about the impact of learning of David Fuller's abuse, just as she and her family were beginning to come out of a period of mourning for her mother: *"We were just starting to get over the rawness of losing her so suddenly anyway, and then to hear this was just, erm, like nothing else really."*

The knowledge of what David Fuller had done affected F5's physical and mental health:

"I become anxious. I've never been anxious in my life before. Er, brain fog, I mean, just, yeah, er, physically shattered, emotionally drawn, shattered. Nausea. I mean I lost probably a good stone in weight ... I would say 'it's rocked us' is just such an understatement. I really, honestly can't give you the words to describe how this has affected us."

She told us:

"[T]hese people are vulnerable individuals. I know they're not alive, but they are vulnerable individuals. They haven't got their ways and means of being able to obviously stick up for themselves or defend people off. So why on earth is someone who's a subcontractor being allowed to go in and out of that building at all times a day without having some form of supervision? I just ... I find that an absolute disgraceful trust loss there."

F5 described her disbelief that David Fuller's actions were not discovered earlier:

"I really struggle to believe that there weren't glaring signs that should've been picked up upon and followed ... When does someone not turn round and go ... 'Are we having that many problems with our refrigerators that, you know, that this ... their man needs to come in at all different hours of the day?' Not one person has turned round and thought, 'Oh, that's a bit odd?'"

She spoke of her disappointment in the sentencing of David Fuller:

"[W]e haven't got justice ... This man ... was put away for double murder ... He got 12 years for the extent of his abuse to every single individual ... in the morgue in that timeframe ... Twelve years. I assure you that does not feel like justice at all ... If that was your mother that had been abused in that horrific way, you would be sitting here and you would also be just as bloody angry ... because, you know, rape's rape whether you're alive or dead to me."

Family member F6

F6's sister was a victim of David Fuller. The police contacted her parents to inform them of what David Fuller had done to her sister. She told us that *"the police went to my parents' house to tell them ... and they invited us, like my siblings round one by one to tell us"*.

F6 said: *"It's just sort of changed everything, like I don't think my family will really be the same, my parents definitely not."* She told us of how, after years of grieving, being told what David Fuller had done to her sister had changed how she thought of and remembered her:

"[I]t's just, like you already lose someone that's close to you and then like ... years after ... it's like you're going back through it again but this time it's sort of changing your memories because now when I think of her ... I just think of what happened ... It's made her like this permanent victim and it's not the way you really want to remember your sister ... people die and you think about all the nice things and the good times that you had ... this is just the very last thing that happened to her and that's how like my memories are going to be now."

F6 spoke of how she felt she could not access bereavement support, because she could not and did not want to speak to people about the things that had happened to her sister, and how that made her feel:

"[Y]ou think well it's like lonely grieving, but at least everyone you know has like lost someone that's close to them ... everyone can like know how that feels. But ... I found it to be so isolating because I didn't want to talk about it, and I didn't want to hear more about it."

What happened to her sister is always on her mind: *"When you wake up in morning it's like the first thing you think about and you're like 'good, we get to do this again'"* She spoke of her disbelief at the access and freedom David Fuller had to commit his crimes:

"Well I would have thought that the security card, the fact that he could have gone anywhere, they would have done more thorough checks on them or had cameras ... it's difficult to believe that he could go in and out with his security card so many times and there not be a record of that to flag up that it's an issue ... I just guess that with the awareness that people have of it now, something would have to change because it clearly happens, and it probably isn't the only place it's happened."

Family member F7

The police visited F7 to tell her that her mother was a victim of David Fuller:

"It was all too much to take in ... I felt, once the police had left, absolutely shellshocked both trying to process the events and crimes but most alarmingly in the short-term trying to understand if my mum's identity was going to be revealed ... At no point in this initial meeting was I assured that her name and details would remain totally anonymous ... I was racked with worry all weekend that ... my family and friends and those of my mum would find out through the media."

F7 told us that she could not fully describe the impact of David Fuller's crimes, as she was only just beginning to process what had happened:

"[T]he crimes are so unspeakable and relate to someone that I so dearly loved that I know that it will take me the rest of my life to get over this ... I am now being forced to carry the heavy weight of a dark secret on my shoulders for the rest of my life, in order to preserve my mum's name and to protect other members of my family."

She said:

"I have lost any trust in the NHS. The fact that in a very new and hi-tech hospital such as this one ... [David Fuller] was able repeatedly to carry out these heinous crimes ... that his time and whereabouts were clearly not recorded ... that he was able to use his mobile phone/recording devices in the mortuary ... that there was no CCTV ... that his CRB [Criminal Records Bureau] checks were not adequate ... so much needs to be done to ensure that the dead and vulnerable are never made victims like this again."

F7 told us: *"If some good can come out of this I know that my mum would be happy and proud of me in some small way for being involved in effecting some positive change ... For the victims of this crime, it won't be forgotten for decades to come."*

Family member F8

F8 is the brother of one of David Fuller's victims. He and his wife spoke to the Inquiry. He found out what had happened to his sister when police officers called at his home:

"And knock at the door and there were two police officers standing there, because of the sort of the Covid and bits going on I opened the window rather than the door ... and I said well can you tell me what it's about, they said 'no we'd rather not stand out here in public explaining this can we come in?' So, they came in and that's when the bombshell hit ... it was just absolutely shocking I mean you couldn't really take it in to be honest, yeah it was just dreadful. I mean we didn't sleep did we that night at all really."

The news of David Fuller's crimes made F8 feel like he was reliving his sister's death:

"We both felt we were at long last able to move on from our painful grief. After receiving the awful news that evening, I was instantly transported back as if it was yesterday to the worst day of my life ... All the events that dreadful day returned instantly and vividly and the pain and grief too. This time more intense with the additional horror and thoughts and emotions of David Fuller's actions in the mortuary."

F8 spoke of feelings of guilt – *"we just don't feel we kept her safe in death"* – and of how he and his family thought they were leaving their loved one with people who would protect her:

"She had her dignity stolen from her in the very place she should've been at peace and safe. And that is the awful thing now because it's, it's been impacted with so many other things so it's worse than the original grief to be honest because there's all this other guilt and awfulness that you're dealing with."

F8's health has suffered. He said that *"it has affected us both tremendously. I have now sleep anxiety and I don't sleep very well so I've got insomnia as well. I can't actually say that it's all because of this but it's a big factor is for sure."*

He spoke of constant reminders – whether in the media or because of work colleagues discussing the case and the trial – and of how he will never again be able to remember his sister without thinking of David Fuller:

"He has distorted and stolen our hopes of happy memories, I can't tell you how much I despise him ... because of his sickening actions every thought of her is irrevocably scarred. It's like having a beautiful photograph of her which is damaged in some way."

F8 questioned how it could have happened, querying *"the fact he was in there in and out by the sound of it all the time over this great big, long period how did nobody think, why is he always going in that mortuary? You know this just seems unbelievable to us."*

Family members F9

F9 are the mother and stepfather of one of David Fuller's victims. They were anxious when contacted by the police, not knowing what this was about:

"I had a phone call from the police saying that they wanted to come and see me. Quite worrying actually, but he told me it wasn't anything to worry about, but you don't have the police at your door for no reason."

The couple spoke about how the police broke the news to them. They said that they were kind and considerate, but their kindness could not soften the impact of what they were saying:

"[T]wo very nice police officers ... they started off by giving us background to ... they started with, the murders that had happened in ... And just gave us a progression of how they managed to catch up with Fuller and all his ghastly crimes ... There's not really a great deal that I can say about the police visit, because once they had said ... given us the background, erm, I was numb I just couldn't believe it, couldn't comprehend it."

They both spoke about how they felt they had not been supported, but how they understood the difficulty in helping someone through an incomprehensible and horrible situation: *"I suppose there's a limit to what anyone can do. I just wish we all had wands, you know. Magic wands. Wouldn't life be nice then?"*

The impact of the events has led to the couple being reluctant to go to a hospital. They are not able to stop thinking about what happened:

"[I]t just is constantly on my mind. I wake up thinking about it. Just how and why ... it's a nightmare, living nightmare to think ... Dread forbid any other loved one needs to go into a mortuary ... I would do my utmost to prevent them having to go into a hospital mortuary ... it's not the way we should depart this world ... there was no dignity ... Privacy. And surely that is so, so wrong."

F9 also spoke of how they felt families had been brave to speak up, but that they wanted to protect their identity:

"Yeah. There's people that have been a bit more outgoing than we have ... we've seen it on the news and, er, especially during the court case, there was some horrific bits came out, you know. People were really brave to actually stand up. We've just felt that we wanted ... To be anonymous."

They said:

"[H]e had a captive audience for as long as he wanted ... That he was allowed to be in there on his own. I understand there was CCTV cameras around, but either they didn't work, or somebody didn't look at them ... How was he accessing the mortuary? Why was no-one picking up? The fact that he went in so often. I mean, as I said to the doctor that called me, 'Surely those refrigerators don't break down that often.'"

F9 thought that the issue of security and access to the mortuary could be managed by ensuring no technician was allowed to enter the mortuary unaccompanied: *"Maybe a buddy system. You know, for ... a person who's not employed actually in the mortuary can't go in there on his own after hours."*

The couple spoke about the impact that David Fuller's sentencing had on them:

"I know it's not part of the inquiry as such, but we were really disgusted with the sentence that he got. Really. And that has really impacted on us ... Three months for this, four months for that ... I mean, if he hadn't have gone down for life, we reckon ... He'd have got 12 years ... He would've been out in six. It was nothing ... And we were saying that, more or less now that, erm, a corpse doesn't have any rights ... I mean, that corpse was a person ... And the poor thing wasn't given a chance to say yes or no ... It's unthinkable, isn't it?"

Family member F10

F10's stepdaughter was a victim of David Fuller. F10 was at home with his wife, the mother of the victim, when two police officers came to visit them: *"Just a knock at the door, two women there, asking to speak to my wife. Wouldn't speak to me, strictly only to my wife."*

What the officers told F10 and his wife had a devastating effect: *"And then to find out what that bastard did, it's literally ripped my soul out."*

F10 was devoted to keeping his stepdaughter safe in life. He said: *"Literally, I spent my life looking after my daughter, protecting her ... that's what we did, that was my job in life, and I thought I'd done it and then they tell me I haven't."*

The knowledge that in death their daughter was not safe or protected while in the mortuary's care had a devastating impact on the couple and their mental health:

"Last thing we said to them was 'look after her' ... And then to find all this out, you know, my wife literally, those, that last month, she was agoraphobic, just starting to go out. Just starting, life was just coming back together and then bang, gone, all the way back to square one ... I've wanted to commit suicide ... It's the impact, is just unbelievable, you can't fathom it, you can't."

F10 told the Inquiry of the difficulties of trying to come to terms with what had happened, and how constant reminders in the media made this an impossible task:

"[I]t's just so hard and it's just going on and on and on. We're never going to draw a line under it ... we've got another few more years counselling, trying to get back to life. You know, we don't see anyone anymore, we don't go out, we don't socialise ... Every day you know, his face pops up in the paper, a comment on the TV. It's just, there's no relenting of it ... It's in here, it's always. I've never felt pain like it, and I never will."

He spoke about feeling shame and not wanting to talk about what had happened, to protect the dignity and memory of his stepdaughter:

"[Y]ou got to believe the shame that comes with this. And it's not our shame, but it is. The shame that is attached to this. It's, breaking us ... don't want the shame attached to the family. And it's a misguided shame, it is, but it is shame. It shouldn't be. You know, losing the child, that was hard, that was hard enough. I've lost her twice."

F10 told us that the actions of David Fuller had tarnished the memory of his stepdaughter. He and his wife want to remember her for who she was, and not as a victim of David Fuller's abuse:

"We've had to take photos down of my daughter because we can't look at them ... I can't tell the others, I don't want her remembered for that and that's what it will be. She'll always be the girl that was raped by the monster ... not my daughter anymore."

F10 feels the mortuary crimes are not being given the same importance as the murders David Fuller committed: *"Literally, we've just been left out. We're collateral for this, this is all about the murders ... that shows in the sentencing. It's all about getting him for the murders, not about what he did to our daughter."*

When asked what needs to change to prevent such things from happening again, F10 said that no person should ever be unaccompanied in the mortuary, and monitored CCTV needs to be in place. Because of his previous crimes, David Fuller should not have had access to restricted areas:

"We know he was a burglar, we know he had background checks ... and still he had free access to the hospital. Now to me, that's stupidity. Fair play, give someone another chance but don't give them free run of the place."

Family member F11

F11 is the stepfather of one of David Fuller's victims. He was on holiday in another part of the UK when the police contacted him and his wife: *"We were just getting ready to go out for dinner. Phone call from the police. Which was obviously quite shocking. Because they couldn't explain what it was about."*

The police could not give F11 details of what had happened over the phone, and travelled hours in order to speak with him and his wife in person:

"But there was obviously some urgency, insofar as they wanted to come down and see [his wife] and I that night ... And when they arrived, and they were ... superb ... the way they relayed the information and what had happened was a lot to take in."

F11 told us that finding out what had happened took him and his wife back to the time of their daughter's death, just as they were beginning to come to terms with it. He said that he was *"not saying that you ever get over that sort of grief, the passing of a child. Heaven forbid. But [his wife] just had seemed to get into a relaxed – a more relaxed way."*

F11 explained how, at that time, he did not feel it was right for him to seek professional counselling, but that he needed to tell someone close to him in the strictest confidence:

"But trying to actually deal with that and not telling anybody is when it comes back down to the counselling side, etc. And for whatever reason, for whatever reason, I didn't go for counselling ... don't get me wrong, I think counselling is absolutely imperative. But counselling's about timing. And whether you feel that at the time."

He told us that knowing what had happened to their daughter, and trying to deal with their feelings in different ways, had put a strain on the relationship between him and his wife. He said: *"[W]hat has been the impact on me? The impact directly is the relationship, my relationship with [his wife]. And vice versa ... I really really struggled with this of not being able to tell anybody."*

F11 spoke of how, if it were not for the murders, David Fuller might never have been caught for his crimes in the mortuary:

"[W]here was the security? Why wasn't he checked out? ... That's just about a DNA database, which is what I understand, is how he got caught for the murders ... he could have gone on and on and on. Nobody would have known anything about it."

When asked what he thinks should change, F11 said he thought that installing CCTV and carrying out employment checks would help. However, he also questioned *"what can change in the future? Well, one, yes, put CCTV in. Okay. But two, you can't legislate for people. This guy had the perfect credentials, didn't he?"*

Family member F12

F12 was not at home when police came to her house to inform her of what David Fuller had done to her daughter:

"[Her relative] called me '... there's police at your house', and I think it's just human nature to go 'shit, what have I done?' And I was like, 'it's probably something ... someone's died' ... I arrived, and there was a tall gentleman and a lady, and I think I was quite panicked to be fair, so I just said, 'please tell me you're not here to inform me someone's died!'"

F12 said that the Trust had contacted her to discuss what had happened. As part of that conversation, she was told how they had taken steps to prevent such things from happening again:

"[They] just rang up to say how sorry they are ... and almost ... not to worry, 'we've got an extra camera in there now. No one's allowed to walk down there alone.' And I just thought 'alright, thanks'. But it wasn't that lady's fault on the phone, course it wasn't ... it's no one's ... that's the hardest bit ... I don't have anyone to blame."

She spoke about how respectful, caring and helpful the Trust mortuary staff had been when she visited her daughter in the mortuary. However, she was later disappointed by the way the Trust had communicated with her about what David Fuller had done:

"He [mortuary staff member], honestly, he helped me every day ... I'm so grateful that I had that time with her there ... it gave me a little bit of a reason to get up in the morning, and go and see her ... So, when they rang me and was like, 'we're very sorry'; it didn't feel good enough."

Living with the knowledge of what David Fuller did to her daughter has affected F12's mental health and her ability to lead a normal life:

"I have about 4 or 5 panic attacks a day. I'm learning little things to help me not do it, like, I stare into space, or I say my name ... I can't sit down and actually rest. I can't watch telly, or ... just do anything, without ... as crude as it is, I just see him putting her in sexual positions, and ... it's, I can't get it out of my head, and I do try."

F12 told us of her struggle to come to terms with what had happened to her daughter, and of how she would never understand how anyone could do what David Fuller had done. She said that *"a problem with the heart causes the body to die. I get that. But how am I meant to get this? I rack my brains for a reason, not ... even if he [David Fuller] did give me one, it wouldn't be good enough."*

She described the support and care she receives from her family – *"a little safety net almost"* – but also how she knows they struggle, not knowing what to say or do. She said that *"they don't look at me the same anymore. And it's not, again, not out of hate or disgust of anything. It's just the pity, and I don't like being pitied."*

When asked what she felt needed to change, F12 spoke of being upset and angry about the sentencing of David Fuller for his mortuary crimes:

"I know he got two life orders, he's never coming out ... but he got 3 months for what he did to her ... had she been breathing, he would have got up to 15 years ... but because she had died, it's almost ... a lesser thing."

F12 told us how very difficult it was to speak with the Inquiry, but that she felt compelled to do so:

"I don't want anyone to know, but at the same time, I'm so proud of her, and I'm not shameful ... There's nothing else I can do ... I can't change his sentence. I can't change the law ... so today was an only step I could take for her. Because I didn't want to come today. If there's an ounce of standing up for her or helping ... Then I'm all in ... regardless of how I feel, so, I thought about it, and I thought 'I'll just go and I'll just be honest', because there is no shame on my part or [hers] ... And do you know what, if she was alive, and it happened, and she was alive, she would have told you guys. She would have. She would have done everything to help. So, I've got to do that instead."

Family member F13

F13's mother was a victim of David Fuller. Police visited her at home: *"Two police officers had come to my door ... They had knocked my door and told me what had happened to my mum."* F13 told us that someone from the Trust had called her, offering to answer any questions she had, but that they were unable to answer her queries fully.

F13 told the Inquiry that she had existing mental health issues, and that hearing the news about her mother had made these worse, requiring her to be prescribed medication. She told us that *"now [I] have been diagnosed with PTSD ... I was stable. I'm not stable anymore. I'm up and down like a yo-yo."*

F13 expressed her disbelief that David Fuller's crimes went unnoticed:

"Well, it looks like the man was able to run around and do what he likes ... how was he allowed to spend so much time in the morgue and nobody noticed ... how come nobody had noticed the bodies would have been different ... How come nobody had noticed something wrong with these bodies?"

She told us she could not understand why David Fuller was given access to restricted areas of the Trust. She had heard that he had Disclosure and Barring Service (DBS) checks showing he had committed crimes in the past.

F13 feels the Trust is responsible for allowing this to happen: *"Even though I love the NHS, I blame them for this. Well, that particular hospital I blame for this ... They need to sack the CEO, as I can't believe he's still in the hospital."*

Family member F14

F14's wife was a victim of David Fuller. He spoke about how the police came to his home to break the news of what had happened:

"[T]wo officers came to the front door, and I was unsure at first. You know, I don't let anyone in the house ... I let them through. And then they came out with it, 'There's been an assault in Pembury Hospital [Tunbridge Wells Hospital] on the so and so date ... by a certain person called so and so' ... I didn't know what to say."

F14 was later contacted by the Trust: *"Well, the hospital themselves, they contacted me a few days after that."*

He told us how David Fuller's crimes have affected his life:

"David Fuller did his sickening, inhumane, degrading act on my dearly beloved wife's body in the mortuary at Pembury Hospital [Tunbridge Wells Hospital] ... I was first shocked and sickened for weeks ... So, Christmas doesn't mean anything anymore, not the same."

F14's health has been affected by what happened:

"Raised blood pressure it won't go down. I mean, you've got this anger, but you shouldn't express it. But it's there. It's not an anger, it's like ... it's hard to ... you're not just sick and unwell, it's something else. It's like there on a permanent basis, it won't go away."

Speaking about how David Fuller got away with his crimes for so long, F14 said:

"[I]s it possible others knew of David Fuller at the hospital to cover up for him? ... All those years, you know? I thought perhaps there are others who are like minded, who may be not carrying out the action but watching in glee at the videos received by him, you never know? They say they will protect him."

F14 also spoke of his disquiet at what had happened:

"This has a sinister ring to it to me. There's something not right about it. To allow him to ... no one found out, over all that time. All them people coming and going in the hospital in that time scale."

David Fuller's crimes have affected how F14 remembers his wife:

"I've got photos of my wife at home, and I look at them ... and you must be careful about thinking too much, or you might start something off ... The problem is, she looks a lot younger than her age, and she's got a lovely face. She had a lovely face."

He feels the Trust did not provide the protection his wife deserved:

"[W]hen anyone comes into hospital and has to go for a post-mortem, or their body has to be seen to, it should be in a private and safe environment. And if that hasn't been the case in Pembury [Tunbridge Wells Hospital], why? ... Why was it allowed to be going on, how long, eleven years or twelve years?"

Family member F15

F15's sister was a victim of David Fuller. He was working away from home when his family contacted him about his sister. He said that *"my mum had sent me some texts saying that she had some rather nasty news for me, and would she like to ... take me aside to tell me"*.

All the information F15 received about what had happened was via his family:

"I've not had any contact or communications from the Trust ... Or from the police. Yeah, I would like to know exactly what he did to my sister, you know, so I may well approach the police and ask for that information."

He told us that knowing what David Fuller had done has affected both his work and his relationships. He said that *"it's put a strain on my marriage. Erm, yeah, it's been really difficult."*

F15 cannot understand how David Fuller was able to offend in the mortuary for so long:

"I'm very disappointed that this has been allowed to happen ... he can't have managed this, to do all these crimes completely undetected for as long as he did ... and he must've, you know, let information slip ... there must've been red flags waved, been waving for a while ... whistles being blown. There must've been."

F15 told us how he feels that the Trust is at fault:

"You know, to smear it on the NHS. I mean, it's got enough problems of its own ... It's not the organisation as a whole ... but erm, yeah, it's disappointing that the local Trust here, erm, so poorly managed ... They just run as a business ... They don't care about people's, you know, impacts ... I don't think. It's just a machine, isn't it? They have no, erm, no feelings as such."

He went on to say of David Fuller that *"he's handed us all life sentences that none of us asked for"*.

Family members F16

F16 are relatives of one of David Fuller's victims and spoke to the Inquiry together. They learned of David Fuller's crimes via a meeting with the police:

"They ... sat us down, we're all sitting, all shaking, not knowing what's going on ... They just told us. And everyone obviously just kind of broke down ... didn't believe it, almost, it was like something out of a horror film or something."

They told us that trying to deal with what David Fuller had done had put a strain on family relationships: *"I think it's drove a bit of a wedge between me and my [relative]. As you can imagine, a difficult time."*

Knowing what David Fuller did has caused one of them to be anxious and to worry about the safety and protection of his wife when she passed away. He said: *"It puts things in my head now. Is she safe? ... I said I want assurances that my wife is going to be safe. Because I didn't want the same thing."*

Another family member told us of how she became frightened for herself and her family: *"Just gave me so much anxiety and nightmares ... And even it sounds stupid, but I was scared of anything if I died. I was scared that it would happen to me."*

The family felt that security should be tightened: *"Not have an all-access pass ... And if you're in a morgue, you should not be on your own."* They questioned David Fuller's frequent visits to the mortuary: *"How do they not see how many times he's used his card to go in and out?"*

When talking about what measures they felt could be put in place to make sure something like this never happens again, the family told us: *"Well after Jimmy Savile, why weren't these things put in place? ... They should have been put in place from day one, not after something's happened ... It's locking the door after the horse has bolted."*

Family member F17

F17 found out about what David Fuller had done to his daughter when the police came to visit him:

"[T]hey gave me the news about it. But up until then I didn't know a thing about ... he was just about to be charged, so they came ... just before the, it was come on the telly. They came to let me know. I think it was getting released that night actually. So, yeah, police came and told me about it."

F17 spoke of how he could not comprehend what had happened: *"I struggle to believe somebody can do that ... it's just so sick and so unreal ... Why would somebody do that?"*

The impact of what happened has affected his mental health:

"I feel like I'm in a dark place. I feel, I struggle to hold me thoughts together and to comprehend things ... feel sick in the stomach ... I can't sleep right at night. I think about this guy nearly every night."

It has also badly affected his ability to concentrate:

"I'd be watching a programme and then 10 minutes later I'd think, what's just happened there? I can't read because I read a couple of pages and then what, what's going on in this story. I can't watch a film. That's it, I'm watching a film and I, I'll drift out. I'll not know what's going on."

F17 feels more should have been done to limit David Fuller's access to restricted areas:

"A bit of bloody common sense really and what a fellow like that's doing around the morgue. How, how could somebody just come in and out of a mortuary at will and do what he wants. With such comfort and with such ease that he's taking photographs of it or he's filming it. He's, he's totally secure in his head that he's gonna get away with doing what he's doing because nobody's confronting him."

F17 told us how he feels the deceased should have been kept safe at the hospital: *"These are where people go when they die. You feel a bit of security ... A bit of pride ... some dignity ... They've died. There should be a bit of respect for them and that."*

He described the ongoing impact that David Fuller's crimes have had on his life:

"I sort of just drift through my day one thing to the next ... I'm just existing. I'm just forcing through life. I've got no meaning to it, I've got nothing now. I just can't get me head around what this man's done to my daughter, and I feel so disrespected by it. I just feel so sorry for her ... I wish I could have done something for her, something that could be done for her."

When asked what he thinks needs to happen in the future, F17 told us:

"I want to have something ... done about it to be honest ... I want to know it's not just been forgotten and, and he's away and that's it. It's dealt with because for, for me it's, it's how has he done it and why, how has he been able to do it? Yeah, that's the end of life ... You think you're safe ... This isn't something that should be going on or it shouldn't even be able to be going on."

Family member F18

F18 was the long-term partner of one of David Fuller's victims. He was not at home when the police came to speak with him:

"I actually got a phone call, erm, saying it was the police at my door ... told me they needed to speak to me urgently face to face. It took me, like, 45 minutes to get home, and the whole way home, I'm thinking, 'What's going on?' You know, 'Who's died?'"

He told us that the Trust had also contacted him: *"He said he was the head of the Trust ... they was just bending over backwards to offer support, help. He kept apologising, you know. Obviously, he didn't do it. It's not his fault."* In addition, he was given support by the Kent Police Family Liaison team and Victim Support, which he found a great help.

F18 did not want to tell people about what had happened:

"I didn't want no-one else to know, because I was kind of embarrassed for [his partner] ... You don't want people knowing your business like that, you know. It's something you need to deal with, but you don't want people knowing."

He did tell some close family members, but was very anxious about doing so: *"I spoke to them then and I said to them, 'Look, did I do the right thing?' And they went, 'Absolutely.' Didn't wanna know, but you've gotta know."*

F18 told us that he thought David Fuller's sentencing for the abuse of the deceased was too lenient:

"[H]e got two life sentences, four life sentences, for the murders, which is brilliant. Amazing for the families [of the murdered victims]. For the hospital stuff, he got minimum sentence for everything ... we just felt ... we just felt robbed ... if you broke down the 12 years over the 103 victims that are known of, it worked out to ... er, I think it was one and a half months each. Something stupid like that."

F18 cannot understand why no one questioned how often David Fuller visited the mortuary:

"He was not mortuary staff. All right, he's an electrician, but how many times does a light bulb need changing, you know? The man's going in there hundreds of times. He's going in there at night-time, when he's not on shift. When he's not even in work, he's going there ... surely there should be some kind of flag?"

He spoke of the long-lasting impact these events have had on him: *"And the thing is, people say, 'Don't worry, it gets better.' I'm looking for the better."*

Family member F19

F19 described how her father broke the news to her that her mother was a victim of David Fuller:

"[H]e just asked me if I'd seen any of the news ... I hadn't really been watching any news ... and he said he had a knock on the door ... two police officers ... they had wanted to speak to him about my mum, now my mum passed away [some time ago]"

so obviously when he was telling me this I was thinking this doesn't make sense, that was ages ago mum passed and why would the police want to talk about her now."

F19 told us that her father had explained what the police had told him. She said that *"it was obviously very hard for dad to break the news to me"*. He had not been able to tell her sooner, as he had been told by the police not to discuss the matter: *"So, he'd kept that to himself."*

F19 contacted the police family liaison officer to discuss what had happened. She wanted to understand *"everything that was going round in my head so I could get a list of questions, things that she [the liaison officer] may or may not be able to answer to get that ball rolling really"*.

She spoke of her need to know more details:

"[A]s soon as dad told me that this person had interfered with mum after she had passed, I just had so many visions and you know probably went to the darkest place I've ever been in my own mind as to what had happened to her. So, for me, I needed to know what had happened."

Finding out what had happened to her mother has exacerbated an existing medical condition – *"it's really affected me"* – and she has been unable to work, the impact of David Fuller's crimes causing feelings of guilt:

"[E]motionally it's been horrendous, it has, it's been really awful, and I think for me, for a number of reasons, I think for the first obviously I felt very guilty about mum dying, and I know it's not my fault, I know it's something that happened ... it's oh, could I have done anything differently, could I have stopped that happening? If I had stopped that happening then this [David Fuller's crimes] wouldn't have happened, so there's been a lot of arguments in my own mind about things. I know there's nothing I could have done ... it's all those sorts of intrusive thoughts that go round in my mind really."

F19 requested that the Trust contact her to discuss what had happened. She told us of her frustration that this took quite some time:

"I was cross because I said actually, I said to my family liaison officer actually I specifically asked that they call me and you know, 7, 8 weeks down the line isn't appropriate ... I know they're busy ... But actually this, to me this was important."

A doctor from the Trust did eventually contact F19. When asked if she was given an apology during the conversation, F19 told us: *"No, there was a 'I'm sorry we're having to have this phone call' apology ... there was an apology in the conversation but not a more in-depth apology as such."*

When asked what she felt could be done to prevent this ever happening again, F19 told us: *"One of my questions to the hospital was, why was it never picked up on the vast, vast amount of times that this person was going into the mortuary? ... Out of hours and everything."* She also questioned how people accessed the mortuary and how employment checks were carried out:

"[N]obody should be alone in the mortuary at one time. So, for me that would be the most sensible thing ... to have access to the mortuary that you would have to go in pairs ... he would have had to have kept having those DBS checks so how was it, how was it missed?"

F19 feels the Trust was at fault for what happened to her mother:

"I held the trust responsible because for me, mum wasn't safeguarded ... It doesn't matter whether she was alive or dead, she was in the Trust premises and she should have been given the respect ... that should never have happened, you know, and that care in death should have been there as if it was alive, when she was alive."

Family member F20

F20's daughter was one of David Fuller's victims. She spoke to the Inquiry with her husband:

"Police came to our home ... and I thought, oh my god! What have I done? Or who's died? ... I couldn't quite believe what they were saying. It was just like something out of a horror movie ... and then we're sitting there and we're listening and not believing it. We thought how in God's name can this happen? And the more they went on and on and on about how long it had been going on the most disbelief was there because you think, how?"

F20 told us of the impact this has had: *"It makes you feel like you failed all over again ... you have only anger to deal with and it shouldn't. Angry with yourself. Angry with the services. Angry with the doctors. There's so much I've learnt about depression."*

Her husband became seriously ill, which he believes was a result of the shock: *"What he had done ... I was rushed to hospital."*

F20 said:

"We don't really have much of a life anyway. You don't when you lose a child. We don't do lots of things ... we don't sleep well. Everything in life that you should start to try and enjoy is barred by this ... We used to be very sociable people, but we don't socialise now very much ... it's just how it's become."

She spoke of being unable to believe that no one suspected anything about David Fuller: *"I find it unbelievable that nobody found him creepy or anything ... I can't understand in all these years why if someone's like that, someone didn't have any inkling whatsoever."* She also questioned the unrestricted access David Fuller had to the mortuary:

"Well, you don't give someone a, a swipe card so they can get in anywhere unless you know that they're going somewhere with someone else ... If you're going to go into a mortuary, you shouldn't have anything like a phone or recording equipment ... Beggars belief that someone could just go in and out willy-nilly, take your tool bag. Nobody questions it."

F20 wishes she had never been told about David Fuller's abuse:

"[M]y real opinion is I wish someone had never come to my door ... if we didn't know, we wouldn't be going through that pain ... Because once you know, you can't un-know. However hard you try, you know. You just, it's there. It doesn't go away."

She went on to say:

"I know people say the dead are dead. They're just bits of tissue but that's not the point. The least when you've gone and you're dead, you're safe. You've got that peace. Nobody is going to be bothering or playing about with you, or, touching you."

Family members F21

F21 spoke to the Inquiry about the impact David Fuller's offending has had on them. One family member explained how he found out about what had happened to his mother, and how he had to relay that information to his family:

"[I]t was me that was originally told. I'd just finished work, sat down to sort out the housework and whatnot. Knock on the door, two police officers asking to speak to me ... they told me what was going on, I immediately rang my brother as soon as I found out all the information. Then he came round."

He wanted to tell his brother face to face what had happened. His brother said:

"[H]e messaged me on Facebook saying you have to come round the police are here it's about mum's body and then obviously, I didn't think it was anything like this, I thought maybe we'd just cremated the wrong person. So, I phoned dad straight away saying 'oh something's happening the police are at [X's] house I'll let you know as soon as we find out' ... we updated him and then we arranged to meet him with the police on the following Sunday. And then dad was present there that's when he got the full story."

Mr Miles Scott, Trust Chief Executive, did speak to the family, but when asked what he told them, they said: *"Nothing really that we didn't know, it was just, it felt more like a check-up."*

One member of the family told us that he had had to contact the Trust directly: *"But I had to ask for my own separate apology because obviously they didn't have my details like."*

When discussing the impact the offending had had, the family told us that *"it's there every day I mean it's never far from waking thoughts to the you know the minute you wake up till you go to sleep it's always gonna creep in somewhere that's the thing."*

They explained how they had found coverage and discussion of the David Fuller case on social media very upsetting and distressing to them as a family: *"Yeah, we've, well I reported it to Kent Online and all sorts and I know we can't do nothing about it we can't delete comments and obviously Facebook don't find nothing offensive about anything."*

They could not understand how David Fuller got away with his crimes for so long:

"It's just so many questions build up and it's just things that I feel like could've been addressed a long time ago for someone to find out about it and then there's the stuff"

about the videos where the police told us there's one where he almost gets caught. So, I just don't understand how no one knew ... Because I personally think someone at the hospital must know."

One family member said he no longer trusts doctors and that David Fuller's crimes have affected how he feels about getting medical treatment:

"Oh, God yeah. I've got things wrong with me and refuse to go to a doctor now ... just in case they send me to one of them places. And I don't know what's gonna come up in my head if I do go to a hospital, so I just stay away ... I had no problem going to the doctors before that and now, no. Just no trust for them whatsoever ... I know it's not the doctors, but it was in their hands."

When asked what they thought needed to change to stop such a thing happening again, the family mentioned the need for more cameras and security. However, they also added that *"they could throw all the money they want at it, put security cameras inside the morgues with the bodies, I don't think it would deter anyone ... I think it will happen again at some point."*

They feel anger towards the Trust, saying they are *"quite angry that they're trying to, like say it wasn't their fault ... Yeah, they're blaming it on the contractor. Yeah, and but it was in their hospital at the end of the day and they let it happen for so long."*

They also told us how they felt David Fuller's sentencing for the abuse was too lenient: *"Yeah. It's like three months for what he did to mum, and we know pretty much everything he did to her and we know he recorded it and there's multiple videos. Treated her like a trophy basically."*

Family members F22

F22 are two family members whose sister was a victim of David Fuller. A relative contacted one of them to explain what had happened:

"[My relative] actually rung me to say could I go round there, and I thought he was going to tell me that he was maybe a little bit unwell 'cos he sounded serious ... And then he told me what had happened ... and it was just like [her sister] had died all over again."

They told us of trying to understand what they were being told:

"I'm thinking how did that happen ... it just didn't make sense ... the only thing I could think of was that, you know, you got something so, so precious in your life and you put them somewhere safe and it's not safe, and then you realise nothing's safe like in the world ... we just feel like, she's just let down."

They said they felt shame for what had happened to their sister:

"[A]t the beginning it was like we, I felt ashamed for some reason. I felt embarrassed and I couldn't, I didn't know why but, and it's taken me a little while to realise that the shame, it shouldn't be shame that I carry round. And I shouldn't be feeling shamed for ... my sister ... But I did, and I probably still do. And I think that's hard because we've had to keep this secret."

They were concerned about the details of David Fuller's crimes being in the press, so decided to tell their wider family themselves. At that point, they said: *"[W]e had to make a decision ... We done it as a family, as a decision. We told them all at, on the same night but all in our homes. Which was awful."*

One of the family members said:

"I've spent so long now just battling away dark horrible thoughts creeping into my head. And I, and from the beginning I knew that they shouldn't be there, you know, I don't want them there because once they get in, I know I've got to fight harder."

The frequency with which David Fuller visited the mortuary and the fact that this was not questioned was something both of them told us they could not understand: *"You must have a serious problem in that morgue with electrics ... the amount of times he was in there ... why has no-one picked up on that? You know, that is what I don't understand."* They told us: *"I'm like there's no point putting a lock on the door if everyone's got a key."*

Family member F23

F23's sister was a victim of David Fuller. She came with her husband to speak with the Inquiry. She told us that the police had informed her of what had happened: *"It was a call from the police. They came up the driveway one afternoon ... when you see plain clothes police coming for a reason you haven't ... expected, you automatically think something awful has happened."*

She said that finding out about David Fuller's crimes had caused her to relive the grief of her sister's death:

"So that was ... so on the day when we found out from the police, it was all the feelings you'd expect of shock. I felt sick. I felt like I was gonna faint ... I was shaking ... just took me back ... it was all those same feelings all over again ... We kind of started grieving all over again, didn't we? It just brought it all back again."

F23 spoke of how she and her husband had to work the day after being told, and that they were not allowed to mention what had happened:

"It was just like she'd just died all over again ... we had to work the next day ... and, of course, we'd been told we weren't allowed to tell anybody, so it was a really strange thing, because we felt awful ... but we didn't want anybody else to know we felt awful ... it was incredibly difficult to keep that information quiet."

F23 was offered a meeting with the CEO of the Trust:

"Yeah, Miles Scott. So, I've actually personally spoken with him ... a very nice lady phoned me from the hospital first and offered me their sincere apologies and then said that I could have this meeting with Miles Scott if I wanted to, which I did, and he and I had a chat for about 40 minutes."

F23's husband spoke of his surprise at how David Fuller was able to offend: *"I mean, they ... well, they appeared to run a very tight ship there, you know ... it did look like a sort of safe, you know, safe place."*

When discussing her ongoing feelings as a result of David Fuller's actions, F23 told us:

"I just felt intense, intense rage. I felt absolutely cheated, because my sister had ... well, and I have had an incredibly difficult life ... we thought she was finally at peace and then this came up, and it just rocked us ... it was as though he'd robbed me of that peace."

Family member F24

F24 was visited at home by the police, who informed her of David Fuller's crimes against her mother: *"I felt completely overwhelmed and panicked by their sudden and very unexpected appearance ... What the officers actually told me that late afternoon was unimaginable and has affected every part of my life."*

The police told F24 that everybody has the right to be treated with dignity and respect, and that unfortunately her deceased mother was not:

"My mind raced, I was thinking about organs being taken without consent, her body not being correctly stored, everything seemed a blur ... My imagination went into overdrive. Every time I was not busy or tried to sit quietly, my mind would produce the most shocking, terror filled images of David Fuller in the mortuary."

She was subsequently contacted by the Trust:

"I was able to sit down and have a conversation with Miles Scott, Chief Executive ... it was good to speak to him. He obviously recognised that there had been errors within the hospital, but I did feel that he didn't excuse anything, he seemed quite lax about the whole thing as well really ... he admitted that the swipe card data had never been checked. And then tried to excuse that by saying how many staff there were in the hospital. That's not good enough for me. That's not good enough for anybody."

F24 spoke about the effects David Fuller's actions have had on her life:

"The ongoing impact has been felt by all those close to myself and my family. The initial feelings were intense grief, as if my mother had died all over again. I had to process a new layer of grief that rips the healing I had previously been doing open once more ... Extreme fear and anxiety, with total lack of trust, mainly directed at older men like David Fuller. I've struggled with sleep, nightmares and paranoid thoughts."

She has had to leave work: *"The effect that these crimes had on me meant that I could no longer do that job. Every time I tried to study or focus quietly, my mind wandered to such dark and horrendous places."*

F24 told us how she copes with the distress:

"I find that when I'm really struggling, I do things that cause me some level of pain that I am in control of and that I can take the blame for ... I will find that I will just smoke 20 cigarettes, because it's something that I'm disgusted with ... I will go out with my friends, but I won't just have a few drinks, I'll make sure I get really drunk, so that the next two days, I can feel really awful about myself and my choices that I have made. Because it's a control ... a pain that I can control."

As a result of what happened to her mother while in the care of the Trust, F24 no longer has confidence in the NHS:

"The extreme fear and terror I feel at the thought of a loved one having to visit or stay at an NHS site makes me feel sick ... I for now, and maybe even forever, have little faith in an organisation that showed such a lax attitude and unprofessional manner in how their Trust was run and who they employed."

F24 feels that no one should be able to access a mortuary without a mortuary staff member being present, and that refrigeration units should be locked at all times:

"I would like to see things like that in place nationwide, because this isn't an isolated event ... there have been queries into other people, I think quite famously Jimmy Savile doing similar things ... I think that if we don't put the procedures in place to stop this from happening or to make it a lot more difficult to happen, you would just see history repeating itself again and again. Because there will always be people with those depraved fantasies in the world."

F24 told us:

"When you go into hospital, whether you're visiting somebody or whether you're a patient yourself, you are at your most vulnerable. We're there at the mercy of others, we have to completely trust the people around us ... If you're aware that an organisation that big isn't looking after you and their security processes in place aren't there to protect you, nobody's checking on that, how can you go in there in your most vulnerable state and feel safe? You can't."

Family member F25

F25's sister was a victim of David Fuller, and he and his partner spoke with the Inquiry.

The police travelled to speak with him about what had happened: *"They were so lovely, you know, and I actually felt quite mean for making them drive all the way down there ... they explained it and I thought, oh this is terrible. This is just awful."*

F25 told the Inquiry that before learning of David Fuller's crimes he was generally a happy, positive person:

"I couldn't wait in the mornings to get up and start my day but now it's just total upset. The only time I have peace is when I dream and you know, it's just like a holiday, you know. I'm not in control of trying to keep all these thoughts in."

He spoke of how he is unable to stop thinking about what David Fuller did:

"[E]very night, every night, you know, I just, I wouldn't sleep ... I wouldn't say no, get out my head, you know ... thought about him ... he can come in my head any time he likes. He just wanders in and, you know, anything could just trigger, just like that."

The trauma has prevented F25 from being able to focus:

"I can't concentrate ... I can't relax ... Before I used to sort of sit down and watch a film or read a book, but I can't do any of that now ... it's just consumed me ... at any time just comes in my head and ... I just forget what I'm doing."

He explained to the Inquiry how hard it has been to process and manage what he knows, *“just like juggling a hot potato, no, hot coals ... and they are always going to be there. How long can I keep juggling these hot coals for? I don’t know.”*

When asked what he thought needed to change, he said: *“[O]ne question I did ask was it post-mortem ... if they are doing a post-mortem, would there be some signs, I don’t know ... and that CCTV needs to be in every area.”*

F25 spoke of wishing he had never been told of David Fuller’s crimes:

“I didn’t want to be told in the first place ... if I could go back and not hear it ... I just wish, you know, there was somebody can give me an answer ... I just cannot comprehend this thing ... I want an answer to fix me, to fix me.”

Family member F26

F26’s wife was one of David Fuller’s victims. He and his partner spoke with the Inquiry:

“Had a knock on the door ... two police officers, who were in plainclothes, erm, came to the door saying, ‘I need to speak to you about something to do with [his wife’s] death’ ... at that point, I pretty much broke down ... and it was just bringing it all back home.”

F26 was contacted by the Trust, and his partner told us how she asked the Trust for more information:

“I did speak with the Trust ... there were questions that I asked that they didn’t have the answers to, and the person I was speaking to was going to find out and get back to me, and they never did ... so from that perspective, I don’t think that’s very good, because those questions are still left unanswered.”

F26 told us that he and his partner have processed the information in different ways, and that this has had an impact on their relationship:

“I guess my way of processing it is very different. I’m not the sort of person that needs to know answers to questions. I don’t need to know detail ... [his partner] does need to know detail ... So, it has caused, I wouldn’t say conflict is the right word, but it’s caused tension, certainly.”

He told us that he thinks the use and monitoring of swipe cards needs to change:

“How many times does a light bulb need changing? Erm, I don’t understand why there wasn’t something ... in this day and age, when computer systems can flag all sorts of things, why on earth there wasn’t a flag to say how often this key code was being swiped and the times of day it was being swiped.”

F26 spoke of how he feels the deceased should be just as well protected as other patients:

“And in a hospital baby unit, you’ve got alarms on the door, you’ve got people watching out. Those babies can’t protect themselves ... Why is it so different for deceased? They are in a position where they cannot protect themselves and there should’ve been better security around that, of protecting the people who cannot protect themselves.”

He feels the Trust needs to take responsibility for what has happened:

"[O]kay, he was really clever. He was really crafty. People that sort of con people and scam people into believing that they're somebody else or whatever, they're very good at it and he had everyone fooled. And I do, I do understand that part of it, but there is also a part that it just shouldn't have been open to be possible for it to happen in any way."

Family members F27

F27 are siblings whose mother was one of David Fuller's victims. Police contacted one of them to break the news of what had happened:

"It was me that was told. I'd come home and there was two police officers in my house ... I was absolutely devastated and gobsmacked when I found out it was about my mum. And then trying to find the words to tell my two [siblings] as well. It's not been easy."

They told us of the effects the knowledge of David Fuller's crimes has had on them:

"Yeah, not sleeping properly. Not eating ... I really want to just hide away. But ... I can't ... I might fall off to sleep straight away, but then I can only be asleep two hours. And then I'm awake and you're laying there, and it just goes through your mind all the time ... I've been suffering with really bad headaches, tension headaches ... To bring back up the grief. You know, I think it's brought back up mum dying again."

One of the siblings told us of how they now feel more vulnerable: *"I felt alright before. You know, I felt alright ... I used to walk down the road at gone midnight. And it's a dark lane. But didn't bother me ... And that's changed now."*

Not being able to speak about what has happened has also been difficult for them:

"[Y]ou're guarded with what you say ... you're frightened that you're going to blurt something out. And you get emotional and ... you have to hold it in ... Because you don't want anyone to know ... and you're just like crying inside because you can't let anything out."

They told us of their disbelief that, in all that time, no one saw anything out of place:

"And what I don't understand is that no one noticed ... That anyone had been moved ... Because obviously he'd been in and moved them ... it just all plays in your head ... because you just think surely someone, someone must have noticed. You know?"

Access to the mortuary and employment checks were things the family thought needed to be looked at:

"I know ... they work certain hours and they go in after hours, but then again, you should maybe go in in pairs then, and not singly ... If there's a problem, they should have known that he'd got a criminal record, three burglaries."

Speaking of the wider impact David Fuller's actions have had, one of the siblings told us:

"I just feel ... I don't even know how to say it ... It's a void there all the time. It's trying to put into words ... devastated ... the words out there are not enough ... devastated that this has actually happened ... that somebody could actually do such a heinous crime."

Family member F28

Police came to F28's home to tell her about David Fuller's crimes against her daughter:

"They didn't actually introduce themselves. They were telling me to sit down in my own home, and I'm going, 'what's going on?' ... because I'd already lived through that experience of two police officers coming to my home to tell me my daughter had died ... So, your mind is kind of playing games with you, what is there to tell you about someone who's already dead ... that's how I found out about the horrendous things that went on in the mortuary."

The Trust also contacted F28: *"Oh, they were useless. Useless. Useless."* She met with Mr Scott, Chief Executive of the Trust, telling us that *"the man gets out ... a piece of paper, and reads, 'we are very sorry, I mean, huh?'"*

F28 believes the Trust, its CEO and its staff failed to protect her daughter:

"[P]eople who failed in their duty to monitor the access cards, the security, the whole line of management responsibility there has been failings ... There are many people who should be held accountable really, and you pay the price for failing. We all pay the price for failing."

She went on to say:

"[L]essons learnt' is not good enough ... because lessons are never learnt ... We just minimise the risk of them happening again, they always happen again ... it's this holistic 'lessons learnt' and no one is held accountable, and that is my biggest problem."

F28 told us that she would like to see the law changed, *"to make sure that this offence is given the correct tariff of punishment to protect the dead ... I would like a law that's correct and just, that people respect the dead ... I mean it's a mockery."*

She told us that *"it's hard enough losing your ... child ... but then to find out what happened, that's the bit I can't get over, because it was allowed to happen"*.

Family member F29

F29's daughter was a victim of David Fuller. She was on holiday with her husband when police contacted her:

"I explained where I was and obviously went into panic mode ... they said they couldn't speak to me over the telephone ... but I think because I was so distressed ... they were able to let me know that it was to do with [her daughter] who had died ... And so they travelled ... to give me the news ... we had a four and a half hour wait to know ... all sorts of things going through my mind."

F29 told us that she and her husband were dealing with their feelings in different ways, and that this had put some strain on their relationship: *"I found that really difficult to discuss that with my husband ... it's because we are trying to keep this to ourselves."*

She said how important it was to her to protect her family from knowing about what David Fuller did:

"I've become really lonely I think. Trying to deal with this without other people knowing ... I removed myself to protect myself ... to protect the people I don't want to know ... I've got a good network and there's people from all walks of life that I know I could talk to. And I know it would be helpful, but I'm not brave enough yet."

What has happened has affected how she thinks of the hospital: *"I never want to step foot in that place."*

F29 has also removed herself from situations where the David Fuller case might be discussed:

"It's affected my socialising ... I decided I didn't really want to meet with people ... I was petrified that somebody was going to say something when I was in a group, or just start talking about it ... it happened ... I was able to get out of the room ... they were men talking about it ... which was worse really ... that's another worry I have that ... these situation[s], awful situation, sometimes fun is made of things, I just couldn't have dealt with that."

F29 has developed coping mechanisms to try and deal with what has happened:

"I have tried to stop my brain thinking about what happened ... that's why I'm frightened of reading anything ... if it goes beyond what I can cope with, erm, I'm not sure how I'll be ... one did happen, just briefly and I oh, and I was like, oh no, so right open your eyes, get up, go and have a cup of tea and off you go again. So yes, it affects me. Of course, it does ... but I feel safe here."

She told us that *"it happened and I can't, no one can take that back ... They're dead. My daughter was dead. I just expected respect ... I just thought she was, you know, safe in that space but obviously, she wasn't."*

Family member F30

F30's mother was one of David Fuller's victims. He got a call from his family telling him that Kent Police had been in touch and wanted to speak to them: *"I'd got in the car and went down there ... my [relative] had got there, and he was in a state ... my [other relative] was in there who was all over the place."*

Knowing what David Fuller had done to his mother deeply affected him:

"I didn't know if I was coming or going, and I still haven't to this day ... you know, I'm holding down my job but, I just drift off ... I was getting up and walking around the bloody streets at midnight. You know, aimlessly."

F30 described to us the lasting effect this has had:

"[E]veryone's got a mum ... Most of us think that they were the best person in their life ... think of your dead mother being raped on a stainless-steel morgue table ... Because that's what happens in my eyes when I close my eyes at night."

For F30, the Trust Board should be accountable:

"You know, what should he have done, in my opinion, the CEO? That's simple. He should have resigned. In actual fact, the whole board ... and if he wouldn't resign, the Secretary of State for Health ... in my opinion, should have dismissed the whole lot of the ... Was it his fault that Fuller carried out those crimes? No, of course it's not. But he is responsible, as the top person, to make sure that the systems and the practices and the procedures within that Trust are being adhered to."

F30 questioned how employment checks were done: *"[H]e had a criminal record. Was that ever checked out? ... it's for the Tunbridge Wells Health Trust to be vetting ... they were employing these people ... they're not working in a cake factory; they're working with vulnerable people."*

He said of the sentencing of David Fuller:

"[I]f he hadn't done the double murder, you know, necrophilia you get maximum two years ... what did he get? ... eight or ten years ... it was pathetic ... Has my mother got justice? No. My mother will never get justice. He's locked away. He's got it, but he got it for the crimes of those horrendous murders ... he must be the single worst sexual offender in British criminal history."

F30 told us how David Fuller has altered the way he remembers his mother:

"It's ... when I got to my mum's grave, I now know that in her time, on top of a sudden awful death that in my opinion come too early ... I've got to know that she was sexually assaulted in what I would have wished ... believed was a safe place ... my beloved mother would always be the victim of that individual. There's nothing we can do about that."

Family member F31

F31's wife was a victim of David Fuller, and he and his two daughters came to speak to the Inquiry. He said: *"So, as you can imagine this has been really hard for me and my family and the last six months have been some of the toughest months of our lives."*

The family told us:

"[S]he was at peace or so we thought. That same evening of her passing she was violated. When a loved one dies in hospital you expect them to be kept safe, dead or alive. My wife was in hospital's care, she should have been safe ... years on and this one person has caused us so much heartache with the hospital playing a big part in this along with the external facility companies that had the contract for the hospitals. How they let it go on for so long without noticing something was wrong I do not know and those people who allowed this to go on should be made accountable."

The events have had a lasting impact on the family:

"[W]hen we all heard this we were devastated, it's changed our lives and our lives will never be the same again ... cannot sleep properly, cannot function properly, for a long time we couldn't see even our mum in the same way because we just can't get past the fact of someone interfering with her when she should have been at peace."

One of F31's daughters described the effect this has had: *"I mean personally I literally feel scared of everything. I feel like someone's gonna break into our house, I don't feel safe at night, I look at everyone differently, you know."*

The family were disappointed with the sentencing of David Fuller:

"We did hope the sentencing would help us feel better but we are heartbroken, shocked and angry that such a small sentence of 12 years in total was given to someone that had violated over a hundred victims ... the law and the NHS Trust seem to not see them as people anymore."

They spoke of their disbelief that the crimes were not uncovered sooner, explaining *"what shocked us was that no one noticed and we don't believe no one noticed ... he was going in so many times ... we just don't believe that no one noticed or he was doing this alone"*.

When asked what needs to change, the family told us: *"[N]o one should be allowed to go in those areas without anyone else, you know ... you know actually what is the point of having CCTV, swipe cards if no one's actually looking at it."*

They said:

"And you know it's changed each one of us as people, we just, you know we were happy before and we're not now, we're just traumatised and you know just feel completely different. And the worst part is, it's happened to our mum and we can't ask her and speak to her and ask her how she is."

Family member F32

F32 was at home when the police visited her to inform her of David Fuller's crimes against her mother: *"I woke up to police knocking on my door."*

She spoke about how the offences had hindered her coming to terms with her mother's death:

"[S]ince I lost my mum ... it's been probably the hardest ... years of my life and I've worked really, really hard to even be able to just semi function like a normal human being ... And all of that's been taken away from me ... I just feel like I've been living in a nightmare ... it's so hard to, you know, to stay positive and see anything like good in the world."

The Trust has also contacted F32: *"I did feel a little bit with the letters that I got on sort of behalf of Miles Scott the CEO ... it just felt like lip service and that it's sort of a PR move more than anything."*

F32 told us of her disbelief at the length of time David Fuller offended without raising people's suspicions:

"I just can't believe that in what ... twenty odd years that he worked for the NHS not one single person thought there was either something not quite right with him ... there's got to be some sort of negligence somewhere ... I just find it so hard to believe that ... not a single person he interacted with at that hospital saw anything at all?"

She told us that employment checks and lone access to the mortuary are issues she feels need to be improved:

"[E]ven if you're just picking up the rubbish on the playground ... you have to go through ... a DBS check ... why isn't there that same sort of hierarchy ... when dealing with people in, in the moment when they not just need, but deserve the most respect ... it can't be that just one person has access to it and they can go in on their own volition and you know it needs to be that either it's two people at a time, there's always someone with them ... more CCTV."

F32 was angry that David Fuller gave poor mental health as a reason for his behaviour:

"I know he tried to say that he was mentally unwell and that, which also really, really made me angry because you know my mum really, really struggled with mental health ... I feel like I'm fighting every single day to be here, but I don't go around doing things like that ... he knew what he was doing was wrong otherwise he wouldn't have gone to such lengths to hide it ... there's no excuse ... it's just yet another slap in the face. Because I just think how fucking dare you, how dare you?"

She said:

"[I]t's not a victimless crime ... in fact there's even more victims because it's every single person in like in their families and their partners and their children ... They now not only have lost that loved one ... now they've got to do that grieving process all over again."

F32 asked us:

"[H]ow am I as a young woman ever meant to trust any authority ... it's already hard enough if I walk in the dark, I'm always looking over my shoulder ... but it's like now I have to be scared of that for when I die. It's meant to be like the one time you get peace."

Family member F33

F33 is the father of one of David Fuller's victims. He and his wife were at home when police came to tell them what had happened:

"[W]e had two ladies knock on the door ... there were two of them ... and they frightened me actually frightened both of us ... they told us there was a court order in place and therefore some of the things that they may tell us we wouldn't be able to divulge."

He told us: *"[T]hat's what I found really hard ... Not being able to talk about it because we were frightened to talk about it because they'd told us not to. And that I found very distressing."*

F33 asked the police if they were certain his daughter had been one of the victims:

"I think I asked them the question 'well how can you be sure?' ... they said that Kent Police had done a number of checks and verification ... so there was no doubt ... subsequent to his arrest further offences or what appeared to be further offences have been found or details of [them] in the form of discs and pictures, images."

He has also questioned whether he should have been informed or not:

"[T]o be told ... what had happened it did come as a terrible, terrible bit of news and something that has troubled me ... I've asked myself a number of occasions afterwards, 'would I have wanted to know?' ... I would just have happy memories ... I can never undo what I've been told and that will be with me for the rest of my life, that's what I find really distressing."

F33 wanted to protect his family from that distress:

"[T]he impact on me is that I had images coming into my mind ... I found them very traumatic to deal with and I did not actually wish to share or give the opportunity for other members of the family to actually have that. I didn't want them to have any of their visions ... in good times to be sullied."

He told us: *"I'm not looking to sort of go round and scatter blame ... I feel there's only one person responsible for what's happened."* However, he did say:

"I found it peculiar there was unsupervised access to sensitive areas ... I gather that David Fuller took pictures of the people concerned but also backed this up at a later date with information from the mortuary logbook ... I found it hard to believe that the logbook and other sensitive information would be left unattended ... I find it very difficult to understand how these offences and the nature of these offences remained undetected for so long."

When discussing what he felt needed to change, F33 told us: *"I would like to think that whatever weaknesses come to light there are counter measures put in place and lessons learned for the future. So, no one else has to suffer like we have."*

Family members F34

F34 told us how police came to their home to break the news of what had happened to their daughter:

"It was quite a shock to suddenly have these two police in front of me ... They started talking about David Fuller and we thought 'but that was years ago?' I was listening to everything they said ... it was such a shock."

What the police told them has meant that the grieving process has started all over again for them:

"I was starting to get over the loss ... I was starting to think well actually I'm feeling a lot better about it now ... And this just landed on us ... It was like she'd died all over again."

The Trust has also been in contact: *“There was a letter in the end ... from Mike [Miles] Scott ... he wrote that letter saying how sorry he was and how he was going to make sure everything was properly sorted out.”*

The couple spoke of the impact David Fuller’s crimes have had on them:

“What he did makes me shudder with disgust ... I’m just disgusted that someone could be such a pervert ... We’ve both become incredibly anxious ... my anxiety is, goes through the roof sometimes ... because it’s so disgusting, such a disgusting subject, you can’t talk to your family and friends about it ... Since [we found out] I have not slept a full night’s sleep ... and I am exhausted ... I think it’s destroyed us all.”

F34 feel that tighter security and more robust employment checks should be in place. They cannot understand how David Fuller could have offended for so long unnoticed:

“They should be monitoring the swipe cards for a start ... He joined the NHS in 1989 and he worked for them until he was arrested in 2020 ... all that time the NHS was funding him, his activities whether they knew it or not ... I would like to know how on earth this could happen ... no one was suspicious ... Nobody works late every night. Not every night.”

They also believe someone needs to be held accountable: *“I mean I really think someone should lose their job over this because his crime was so serious ... this is like the worst one-man crime wave I can remember in my lifetime.”*

F34 told us that what happened will affect them for ever:

“[Y]ou think when someone’s in a hospital mortuary, they are at rest, they are safe, no one can do anything more to them ... That is what we really believed at the time ... you’re trapped with this horrible information for the rest of your life.”

Family member F35

Police visited F35 at his home to break the news of David Fuller’s crimes against his wife. He was stunned and horrified by what the police told him: *“And I had to make ‘em tell me three times before I could even comprehend what they were saying to me ... just shock ... it’s just worst, the worst horror story you can even think of.”*

He told us that the Trust had written to him: *“Miles Scott, I think it was wrote to me. And I found it a bit insulting ... I thought ... I don’t even want to read ... I can’t even read that. Couldn’t read it ... It was condescending.”*

He also had a phone call from the Trust:

“And I said, to be honest ... I don’t know what you want from me ... I can understand you’re apologising, but ... it just didn’t mean anything to me ... so I ended up saying I don’t want them to contact me anymore.”

F35 told us how David Fuller's actions have made him and his family feel:

"[S]ick to the stomach, drained of life, numb, shocked, horror, disgust, mentally and physically drained, violated, betrayed, contaminated, distraught, depressed, sadness, angry, lack of trust and beyond grief ... How dare he think that he can do this to our loved one, a wife, a mum, the sister, sister-in-law, aunty, daughter-in-law and a cousin. We couldn't, she couldn't defend herself. Who gives him that right? We are so angry."

He spoke of his lack of faith in the Trust and its security systems:

"I didn't want anything to do with the hospital ... the trust has gone completely ... you must now have a swipe card to enter whatever building. Okay ... we'll tick that box, put the machine in. But if no one monitors that, then it's a complete waste of time."

F35 described the impact David Fuller's actions continue to have on him and his family:

"We are distraught trying to find our way through this horrific nightmare ... It doesn't feel real. And we are grieving all over again and have gone back to the day that our loved one passed. It's constantly on our minds ... It's literally overtaken my, my life."

Family member F36

F36 was distraught when police told him of David Fuller's crimes against his wife:

"When that monster did what he did to [his wife], it broke me, I'll be really, really honest it's taken [many] years, to build myself back up to nearly where I was as a human being since losing the love of my life ... when the police officers told me what he did I was, I was sobbing. Even the anniversary of her death or our wedding anniversary I haven't sobbed like that I mean, howled with crying."

The news took him back to the pain he felt when his wife died:

"[T]he enormity of it, the depravity of it and then the numbness that overtook me and it was the same ... the worst thing that you could imagine has happened to your wife, feeling sick, crying, smoking a lot, feeling numb, lapses in memory. They are exactly the same for both days."

F36 spoke of how he could not comprehend what had happened:

"[T]here is no way I can ever understand why somebody would do that to another human being, and I used the term human being, I know there are differences between when somebody is alive, and somebody is dead, but [his wife] was a human being."

He told us of the wonderful support he has had from his family, but how seeing him in pain has impacted them: *"How has this affected my family? They've seen me go through, the hardest ... years of my life and for me to build it back up and then they've seen me go right back down to where I was."*

F36 spoke of his feelings of guilt at not being there to protect his wife:

"And then I thought ... it's not me that should have had to protect her in the morgue ... She should've been protected, and she wasn't ... it felt like I'd failed her as a husband ... and I couldn't be there and that, that's been heart-breaking for me."

He feels access to the mortuary was poorly monitored:

"[H]ow that monster was allowed to gain access to the morgue, mortuary so many times without somebody in the mortuary thinking 'he's in here so many times why is he here, we can't have that many electrical faults' ... who checks the swipe card logs? ... It doesn't make any sense for an electrician to go into a room that often."

F36 told us that *"the hospital have clearly, clearly failed her. There is no doubt in my mind that things should've been done better ... the actions that took place should have been prevented. Full stop."*

Family member F37

F37's partner was one of David Fuller's victims. Police contacted him by phone, explaining that they could give no details and needed to speak with him in person:

"[T]hat in itself was quite an excruciating experience ... it was actually nearer two hours because they got lost on the way ... and I spent that time absolutely wound up ... the police only contact you in circumstances like that if there's a death, an accident ... that was an extremely painful two hours ... It was literally, it was hell because we honestly thought somebody had died ... So, they turned up ... they were very pleasant both of them ... Cut to the chase pretty quickly ... you know I think a bit of a shock ... it [his partner's death] happened [many] years ago. I've moved on with my life, it doesn't, it doesn't diminish the fact you have feelings for a person."

F37 told us of the impact of further conversations with the police:

"I had a sleepless night after every time they called me ... I said this to the police, actually I'd have preferred not to know, to be honest with you. Because it's in my past, what good has it done? None."

The Trust also made contact with F37. He said: *"[W]e did have a meeting with Miles Scott ... He was very subservient almost, you know very apologetic, listened to what we had to say."*

F37 feels that security and employment checks need to be improved to prevent anything like this happening again:

"[A] DBS check was done on him, what is the point of doing these checks if they go to the person being investigated rather than the person that is actually doing the employing ... completely idiotic ... Why that information was not passed onto the NHS Trust ... why it wasn't investigated? ... I understand that the Trust have changed the angles of their CCTV cameras and they've got swipe cards ... How are we going to ensure that they are properly monitored, the entries and the exits into the mortuary? And that any pattern is brought out. Really important."

He told us of the lasting impact of David Fuller's actions:

"It can be very upsetting ... this is something you could think about for the rest of your life as to the injustice to the victim. The victim will never get justice and you could say well it doesn't matter they're dead. It taints the memory of the victim."

Family members F38

F38 are the mother and stepfather of one of David Fuller's victims. The police came to their home to break the news to them about David Fuller's crimes against their daughter. They said that they *"came home and there were two men waiting for me, plain clothes ... and they told us"*.

Up until that point, the couple were unaware that their daughter was at the hospital where David Fuller worked:

"[Y]ou grieve a child, you always carry it with you, but I felt as though I had gone back to that time. But it was worse, the thought of someone abusing her ... I didn't even know that [her daughter] was at Pembury [Tunbridge Wells Hospital] ... so that was kind of a shock ... I think if ... it would have come out in the news, we would never have made the connection."

To protect their daughter, and the feelings of others, they have not shared what has happened with family or friends: *"[W]e don't want to upset people ... We're guarded, we're containing a secret which is horrible ... one that we can't release."*

F38 received letters from the Trust about the compensation scheme, and also a telephone call. They said: *"[W]e were quite angry and were questioning things ... we looked at the Jimmy Savile inquiry, we'd looked at, the human tissue authority had done an investigation into Pembury [Tunbridge Wells Hospital]"*.

They told us of how they had looked at previous reports and guidance:

"When we heard, the first thing I thought was Jimmy Savile, because as far as I'm concerned there are no lessons for the Trust to learn because they have been learnt in the past ... where someone's asking what lessons can be learnt, it really makes me angry because those lessons came out, at the very least in the Jimmy Savile inquiry."

F38 said:

"It makes you question that ... when people die, that duty of care was different ... this is a system failure ... he was doing it for a long period of time. This isn't just a one off, or a year, this is a long, long period of time."

Family member F39

F39's aunt was a victim of David Fuller. She told us that, when the police officers came to tell her what had happened, it took some time to take in what they were saying.

She told us that the seriousness and abhorrence of this crime is something that none of the family can comprehend, and that it felt like they were mourning her aunt all over again.

She said that *“to have this disgusting individual abuse her in such a monstrous way is beyond comprehension ... I cannot even say or see that name without feeling a sense of disgust and nausea.”*

Family member F40

F40's daughter was a victim of David Fuller. He described the police arriving to explain what had happened. He referred to the moment he was told as *“an unbelievable shock”*, stating that he was glad that his wife had died prior to this, as she *“would have gone to pieces really”*.

F40 stated that he had seen the case on television: *“I mean we heard the case on the TV thinking kind of, what a beast, or animal. Or even, not even an animal.”*

F40 describes not being able to sleep at night and wishing sometimes that he had never been told: *“I haven't slept at night. I keep waking up thinking about it. And some of me thinks, in a way, I wish I wasn't told. Then I wouldn't have known, would I?”*

F40 said that he had told some family members. He described having to make the decision about whether or not to tell people as *“all quite horrendous really ... I've tried not to tell too many people about it. But sometimes I think well, perhaps I should. I don't know. Honestly, I don't know the right way of doing it really.”*

F40 questioned why autopsies had not uncovered any of David Fuller's crimes. He said he *“still find[s] it amazing that it went on for so long and so many people and so wide a range”*, and expressed a belief that the NHS has *“slipped up ... slipped up on that really badly”*.

F40 explained to the Inquiry the difficulty of moving on:

“And I haven't slept that well, I mean I've been to the doctors, and I got sleeping pills. And I don't see why, I can't make out why I can't move on. Whether it's the fact that it's a double barrel. That I've lost my wife as well.”

When asked what he thought should change as a result of David Fuller's crimes, F40 said: *“Well, obviously some form of security's got to come in.”*

F40 described the support that he had received from the police and Victim Support, stating that the police still call fairly regularly, and that Victim Support has been *“brilliant”*. He went on to say that the support and counselling had been very good, but that counselling was difficult, as it *“does bring it back every time”*. F40 further explained this: *“Cause you're talking and you see, you see, I see my daughter in the morgue, which I really don't want to see. I want to see her as she was ... so that's ... altered my life.”*

1.3 Summary

Sharing their experience of the impact that David Fuller's crimes has had on them required tremendous courage on the part of families. We appreciate that the decision to speak to the Inquiry was difficult for many. Almost half (45 per cent) of families who spoke to the Inquiry told us that they felt compelled to share what had happened to them so that it might help prevent another person from experiencing what they had been through.

Most families we spoke to (89 per cent) were informed of David Fuller's crimes by the police, with many praising the support of the police family liaison officers. The remaining families were told by other family members. Nearly all the families told us that they had received a letter from the Trust via police family liaison officers as part of an information pack, with 60 per cent saying that they were telephoned directly by the Trust.

All the families of the victims told us of the shock of finding out what had happened, and of not understanding how such events could ever have taken place. In total, 92 per cent spoke of their disbelief that David Fuller's mortuary crimes went undetected for so long. The majority of relatives we spoke to, 79 per cent, told us how they had kept the information to themselves, carrying the burden of this secret alone.

We heard about the impact on people's daily lives, with 92 per cent of families describing the harm to their physical and mental health. People told us of the damage done to their social, emotional and sexual relationships and behavioural patterns, as well as the consequences for their families and others. Almost a quarter explained how trying to deal with their feelings has put a strain on their relationships.

Being told of David Fuller's actions has brought back painful memories, with 66 per cent of families telling us that it caused them to relive the pain and grief of losing their loved one. One-fifth of families spoke of feelings of guilt that they could not do more to protect their loved one in death.

Around 50 per cent of families described how David Fuller had tainted the memory of their loved one. They told us of not being able to look at photos and of not being able to remember happier times.

Over half of families told us they no longer trust Maidstone and Tunbridge Wells NHS Trust or the wider NHS. We have also heard anger, with 60 per cent believing the fault is with the Trust for failing to protect those most dear to them when they were at their most vulnerable.

When asked what they felt must change, 89 per cent of families spoke of their disbelief at the open access David Fuller had to the mortuary. Over half spoke of the need for more, or improved, CCTV. The sentencing of David Fuller for his mortuary crimes was also an issue for families, with 32 per cent voicing their concern about what they felt to be a lenient sentence.

In discussing the work of the Inquiry, 13 per cent of families voiced concerns about the independence of the Inquiry from the NHS. Some were concerned that the Inquiry did not have legal powers to compel witnesses to come forward, and that this might reduce the effectiveness of the Inquiry.

The families of David Fuller's victims trusted the Trust to take care of their loved ones after death, as well as in life. They had every expectation that the mortuary would be a place of safety, peace and protection for the deceased. Unfortunately, as the families discovered, this was not the case. The Inquiry is charged with identifying the failures that allowed David Fuller to offend undetected for so long, and recommending actions that need to be taken to prevent such crimes in the future.

It has been important for the Inquiry to hear and acknowledge the enduring impact that David Fuller's crimes have had on the families of his victims. We thank them for their courage and candour in coming forward and sharing their experiences.

Chapter 2:

David Fuller's offending

Please note that this chapter contains details of the offences committed by David Fuller. Only relevant and necessary information is included, but, nonetheless, the material may be distressing to read.

In this chapter, we consider David Fuller's offences at Maidstone and Tunbridge Wells NHS Trust (the Trust).

The essential role that mortuaries play in a hospital and the wider community is set out in the Background chapter. A mortuary should be a place of dignity and security for the deceased.

David Fuller is known to have sexually abused the bodies of deceased women and girls in the mortuary at Kent and Sussex Hospital and then in the mortuary at the new Tunbridge Wells Hospital on 140 occasions between August 2005 and November 2020. He offended on 22 occasions at Kent and Sussex Hospital and on 117 occasions at Tunbridge Wells Hospital. On one occasion it is not possible to be certain in which of the hospital mortuaries the offence was committed. There were 101 victims; the youngest was nine years old and the oldest was over 100. The only evidence of David Fuller's offending comes from his own records, which were dated between 2005 and 2020. His crimes were discovered because he kept photographic and video evidence of the offences.¹

David Fuller carefully catalogued his sexual abuse of the deceased. He filmed and photographed himself committing a range of sexual assaults. This included David Fuller penetrating the mouths, anuses and vaginas of his victims with his penis, tongue and fingers. In other cases, he masturbated while assaulting his victims and sucked the breasts of some. Fuller abused some victims more than once. Some he moved around the mortuary, placing them on the floor, on a chair and in different positions.²

Information about the times and dates of David Fuller's crimes is taken from his own records, including the digital time and date stamp from his photographs and videos. The accuracy of this information is therefore reliant on him having correctly set the time and date on his camera. Where Kent Police have been able to check these details against other sources of data – for example, CCTV footage of the corridor outside the mortuary from 2020 – they have found them to be accurate.

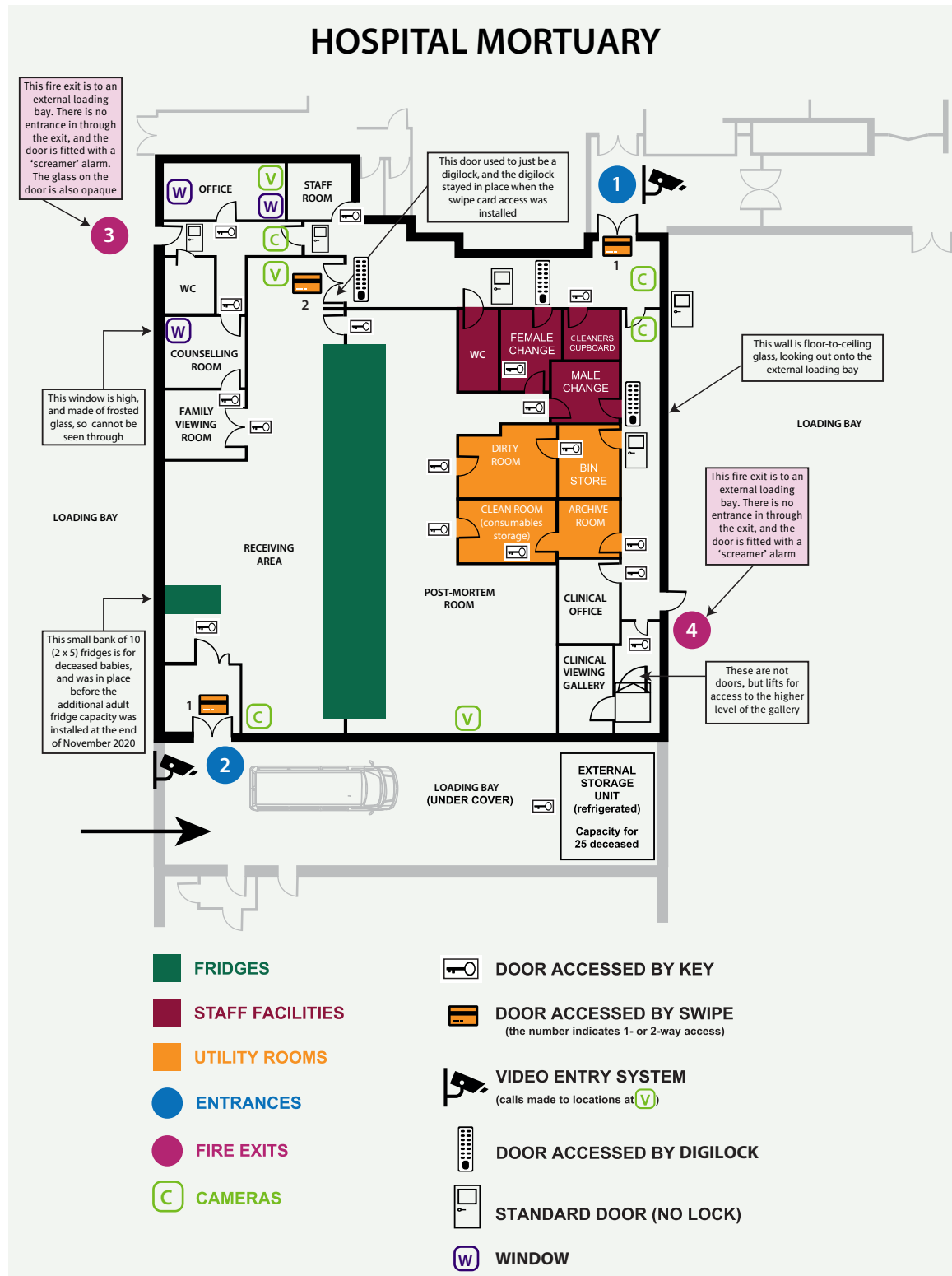
It appears that David Fuller most often abused his victims in the post-mortem rooms at Kent and Sussex Hospital and the new Tunbridge Wells Hospital, although we are aware of at least one instance when he offended in the receiving room at the mortuary

1 Offending data provided by Kent Police.

2 Sentencing remarks of Mrs Justice Cheema-Grubb, 7 December 2022.

at Tunbridge Wells Hospital.³ At Tunbridge Wells Hospital, the Interserve (Facilities Management) Ltd (Interserve) offices, where David Fuller was based, were on the same corridor as the mortuary, in the basement of the hospital. See Figure 1.

Figure 1: Mortuary floorplan

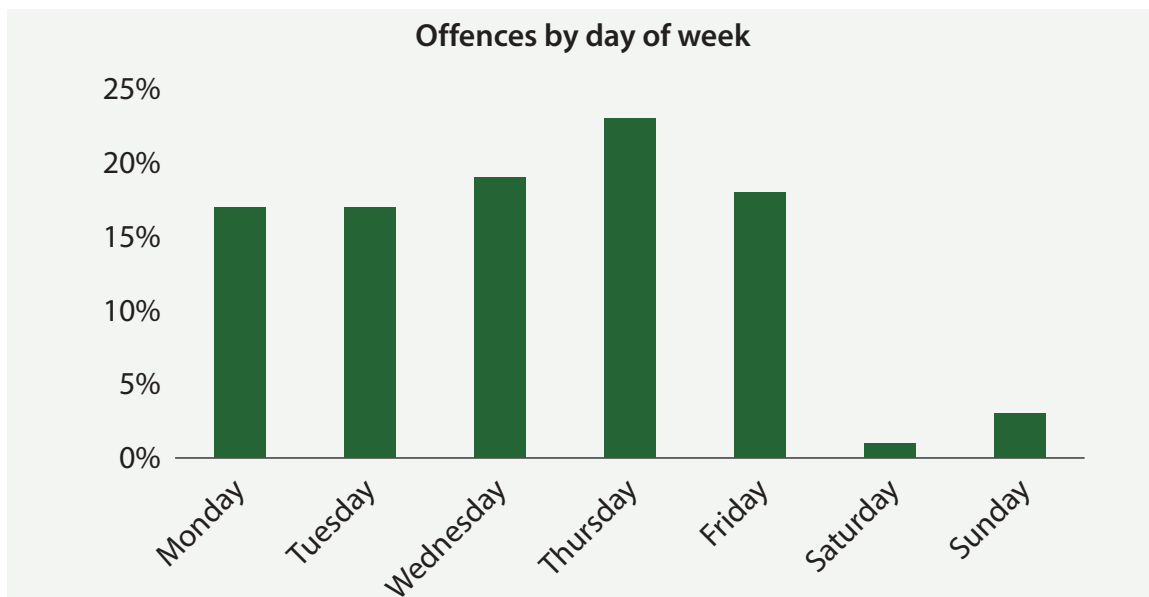


Source: Maidstone and Tunbridge Wells NHS Trust.

3 Offending data provided by Kent Police.

Other than there being little evidence of David Fuller offending at the weekend, there appears to be no pattern to his offending by day of the week or whether post-mortem examinations (PMEs) were being carried out on a particular day (see Figure 2). David Fuller offended before a PME was undertaken on 33 occasions between 2014 and 2020. In Chapter 6, we consider if this presented missed opportunities to detect his crimes.

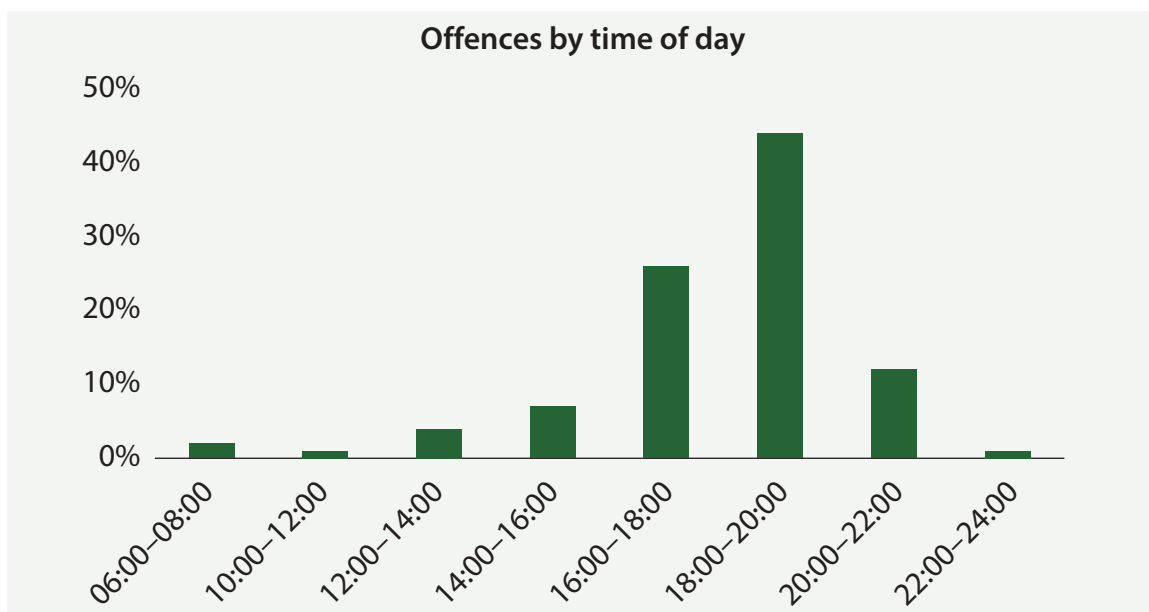
Figure 2: Offences by day of week



Source: Kent Police.

Mortuary working hours at the Trust were 8am until 4pm. The majority of David Fuller’s offences occurred outside mortuary working hours. He was most likely to offend between 6pm and 8pm, and second most likely to offend between 4pm and 6pm (see Figure 3). David Fuller offended during mortuary working hours on 12 occasions, and this is considered later in this chapter.

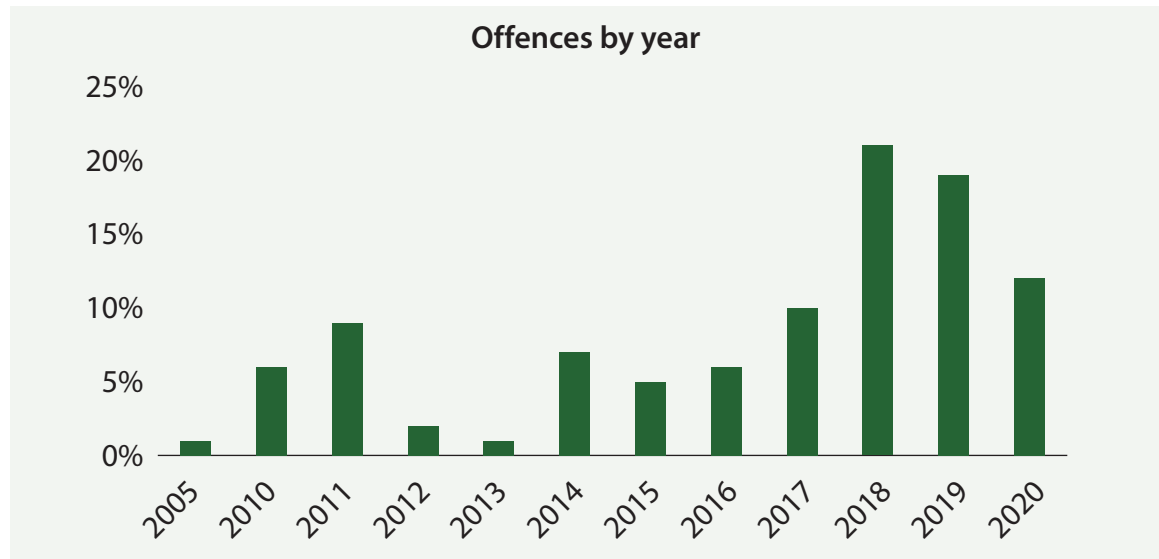
Figure 3: Offences by time of day



Source: Kent Police.

David Fuller's offending increased in 2018 and 2019, with 40 per cent of his known offences happening in these two years alone (see Figure 4).

Figure 4: Offences by year



Source: Kent Police.

When questioned about why his offending increased in 2018 and 2019, David Fuller responded that he *“was getting progressively worse, yeah”* but could offer no explanation as to how he was able to commit a greater number of crimes during these years and told us that the mortuary was no easier to access during those years than it had been before. The Inquiry was told that there was a change in how Interserve engineers accessed the mortuary around this time, with a move away from access on individual swipe cards to the use of a shared card.⁴ This did not affect how David Fuller was able to access the mortuary, as we learned that he retained access on his personal swipe card, but it may have increased his confidence that he would not be disturbed in his offending. Access to the mortuary is considered in Chapter 5.

The Inquiry found no explanation as to why David Fuller did not offend in some years. When asked, David Fuller told us that he was experiencing physical health problems between 2006 and 2009, caused by an injury he sustained at work in 2004. The only records of his offences are David Fuller's own records: video recordings and photographs.

2.1 Offending prior to post-mortem examination

In 2020, there was a marked increase in David Fuller's offending the day before the victim had a PME. Seven of the nine identified victims sexually assaulted by David Fuller in 2020 were abused the day before their PME took place.

The Inquiry heard from the three anatomical pathology technologists (APTs) who worked in the Tunbridge Wells Hospital mortuary that there was a practice of placing

⁴ Witness transcripts of Interserve employees N126, N127, N128, N133, N147, N153, N158, N160, N164, N169, N407, N408, N409, N410, N505 and N551.

the deceased in the post-mortem room the day before their PME. One APT told us this practice began in 2018:

*"We, not routinely, but we would get the patients out that were due for post-mortem the next morning, out before we left home, and leave them in the post-mortem room ... It was to ... of benefit of us and the patient. So, obviously, people are very, very cold and the patient wouldn't be as ... I don't know the right word, but manoeuvrable to eviscerate, so it was more for ease of for us."*⁵

Leaving deceased people out of fridges overnight in this way does not safeguard the dignity and security of the deceased. This practice is considered in more detail in Chapters 3 and 4.

David Fuller told us that he noticed deceased people being left out in this way sometime towards the end of 2019 or in 2020. David Fuller also told us that he knew the days that PMEs were to take place, as this information was required for Interserve to schedule maintenance:

"But there were occasions, which were discussed with Ken and the staff, when we had the emergencies with the pod system [located in the post-mortem room ceiling] and the blockages ... the peak times for breakdowns for that system was between 4 and 6 pm ... nearly every day ... And so, you would go in there to be able to, to be able to dislodge that, me or anyone else, and that's when I noticed that patients were being left out at that time. When I discussed that with Ken he said, 'well, if you don't mind doing it at those times:'"

David Fuller told the Inquiry that, at the Kent and Sussex Hospital mortuary, the deceased were also left out overnight prior to their PME the following day – *"they probably were left out every time there was, was there for a post-mortem to happen"* – and that there had been occasions when he had been asked to make electrical repairs while deceased people were laid out in the post-mortem room.

David Fuller told the Inquiry that he offended against deceased people left out in the post-mortem room at the Tunbridge Wells Hospital mortuary on one occasion, and at the Kent and Sussex Hospital mortuary on two occasions:

Q: *Were there occasions when you offended against the bodies that were left outside the fridge?*

A: *Towards the end I have to say yes, because that was, that was in my recording to show that that's what the case was, yes.*

Q: *And what about at Kent and Sussex?*

A: *[O]ne night there were two patients left out ready for post-mortem examination the following morning, when there was a problem with an alarm ...*

Q: *And did you offend against those patients at the Kent and Sussex that were left out?*

A: *Yes, I did."*

5 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

- It is clear to the Inquiry that leaving the deceased out, overnight, in the post-mortem room, prior to their PME the following day, was a practice both at Kent and Sussex Hospital and at Tunbridge Wells Hospital and may have provided greater opportunities for David Fuller to offend, which he did on at least the three occasions to which he has admitted.

2.2 Offending during mortuary working hours

David Fuller sexually assaulted the bodies of deceased women in the mortuary at Tunbridge Wells Hospital on 12 occasions during mortuary working hours between June 2015 and June 2017.⁶ These offences happened between 12 noon and 4pm, when mortuary staff should have been on duty:

- two offences began between 12 noon and 1pm;
- two offences between 1pm and 2pm;
- four offences between 2pm and 3pm; and
- four offences between 3pm and 4pm.

The offences during working hours all took place in the post-mortem room in the mortuary, which is separate to the receiving room where the deceased are brought into the mortuary and released to funeral directors (see Figure 1). There is a lockable door between the two areas. The refrigerated units (referred to as 'fridges') containing the deceased are double-ended and accessible from both the post-mortem room and the receiving room. While the receiving room is open to porters and others, access to the post-mortem room should have been restricted. David Fuller's access to the post-mortem room is considered later in this chapter and in Chapter 5.

When asked about his offending during mortuary working hours, David Fuller maintained that he had only offended outside working hours, when mortuary staff would not have been on duty. The times and dates of his offending are taken from David Fuller's own records, including the automatic time stamp on his camera. He offered the explanation that, if the battery in his camera was flat, the camera would default to the original factory settings, which could have given an inaccurate time reading. However, when questioned further, David Fuller accepted that this would also have amended the date in addition to the time.

The accuracy of the data on the date and time of David Fuller's offences is reliant on him having correctly set the time and date on his camera, including making adjustments for British Summer Time. Where Kent Police have verified the offending data against other evidence, as they were able to do for offences in 2020 from CCTV footage and swipe card access, they have found them to be accurate. Given this, and the methodical nature of David Fuller's recording and cataloguing of his offending, the Inquiry is of the view that, on balance, the data is likely to be accurate.

6 Offending data provided by Kent Police.

The Inquiry asked the three APTs who were on duty at various times when David Fuller offended during mortuary working hours if they had any idea how this could have happened. Their respective responses were:

*"None at all."*⁷

*"Yeah, how exactly did it happen when we are there? Knowing that we're working in an office or around in the area and he come in and offended when we were there ... We pretty much on a non post-mortem day we're pretty much office bound, unless he came in and fixed the pod system [system for delivering samples around the hospital; maintenance access to this was above the post-mortem room ceiling]. We used to have the pod system overhead in the post-mortem room erm, and he just knocked on the doors and say 'right, I'm going to be in the PM room, doing the pod system'. We'd say, 'yeah okay then', cos he did repair the pod system. We would pretty much leave him to it cos he come in to say he was doing a job. We'd leave him to it."*⁸

*"I can't get my head, because it makes me feel responsible now, you know. Like before I felt like, you know, if I'm not at work, I can't – but now I feel like I'm, you know, got questions to answer and I can't answer them. Sorry. Just feel like I can't answer how that could even happen, just can't wrap my head round it because he was – you know, it wasn't just wandering round the department. When he did come, he did let himself in, but he would always report to us in the office and say, 'I'm here. What you doing? I've got this job to do'. 'How long you are going to be?', 'Ten minutes', '15 minutes', and he go and do it. No, I wouldn't necessarily follow him and watch him because I just didn't have the time to do that."*⁹

In statements to the Inquiry, all three APTs said that they *"can offer no explanation as to how DF was able to carry out offences on the dates and times listed"*.¹⁰

The Inquiry was told by the Trust that there were no training events or meetings that would have required staff to be away from the mortuary when the offences took place.¹¹ The mortuary staff provided statements to the Inquiry indicating where they were at the dates and times of the offences. In none of the 12 offences were there fewer than two staff members on duty.

In their statements and when interviewed, the three APTs set out reasons why they might have been absent from the mortuary for periods of time, or why they might have been occupied and therefore not aware of what David Fuller was doing. These included being away from the mortuary for lunch; releasing the deceased to funeral directors; doing tasks that involved them leaving the mortuary to go to other areas of the hospital for limited periods of time; and taking time off in lieu for additional hours they had worked. The Inquiry has noted these explanations but does not find them credible.

7 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

8 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

9 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

10 Written statements of N131; N130; Mr Kenneth Crossley, January 2023.

11 Email, Mr Kevin Rowan (Trust Secretary since 2013) to Inquiry, 31 October 2022.

The Inquiry found that there were two instances of offending during the mortuary lunchtime, 12.30pm to 1.30pm, when we have been told the mortuary is sometimes left unstaffed. However, there is no way of knowing if this was the case on these occasions.

There are no records of the time that mortuary staff took off in lieu for working additional hours for the period in question. In any case, we heard from the three APTs that they would not take time off in lieu if this meant that the mortuary was not staffed. The APTs' taking time off in lieu is discussed further in Chapter 4. In addition, N131 stated that they had never taken time away from the mortuary without notifying the Lead APT or Mortuary Manager.¹²

The Inquiry heard that mortuary staff would at times leave work at 3.30pm if they had begun their working day early. This could have provided David Fuller with the opportunity to offend undisturbed. However, eight of the 12 crimes he committed during mortuary working hours happened before 3pm, and in the absence of records it is not possible to confirm if mortuary staff had left early on the four occasions he offended between 3pm and 4pm.

The Inquiry has considered whether it was possible that David Fuller offended while mortuary staff were present but elsewhere in the mortuary.

Detailed investigation of the offences committed by David Fuller was the role of Kent Police and the criminal courts, not the Inquiry. However, the Chair and the Independent Advisers to the Inquiry considered it was important to the Inquiry's work to review a sample of the materials relied on by the Kent Police investigation relating to David Fuller's offending (the offending material) to assist their understanding of the circumstances in which offences were committed. The sample was selected by the Independent Advisers to include those cases where they considered David Fuller was most likely to have injured the deceased in his offending. There was also a particular focus on the 12 occasions when David Fuller offended during normal mortuary working hours. This was particularly important to understand whether there were missed opportunities to detect the offending when it was happening. The offending material was considered by the Chair and Independent Advisers under controlled conditions at Kent Police premises. Examination of offending material was not available to, shared with or undertaken by the wider Inquiry team. The material is of great sensitivity and was only reviewed as far as was strictly necessary to advance the Inquiry's work.

Examination of the offending material of the 12 in-hours offences revealed that David Fuller offended confidently and brazenly and in a manner that was completely incongruous with his presence in an area that could have been accessed at any time, without warning. He did not appear to be concerned that he was behaving in a way that could not have been explained had he been disturbed in his offending. David Fuller was either confident that he was not going to be disturbed when sexually abusing the deceased in the mortuaries or did not care if he was. From observation of the noise generated, the extent to which the deceased were moved and the state of

¹² Response from N131, APT, worked in mortuaries at the Trust since 2012.

undress of David Fuller himself, the Chair concluded that it is hard to credit that such activity could occur unnoticed while staff were present elsewhere in the mortuary and does not consider it likely that staff could have been in the mortuary at these times.

The Inquiry did find three instances where David Fuller's offending coincided with the APTs releasing the deceased to funeral directors. Records show that in each case a single APT was conducting the release. We heard that, until recently, it was common for two APTs to be involved in this task. It is possible that the two APTs on duty on those occasions could have been occupied releasing the deceased. However, we are unable to corroborate this. In any case, the Inquiry's Independent Advisers are of the view that this task would not occupy the APTs for very long, and, given the proximity of the receiving and releasing area of the mortuary to the post-mortem room, unusual noises coming from the post-mortem room could not have gone unnoticed.

In two further instances of in-hours offending, mortuary records show that the deceased were released to funeral directors after David Fuller had offended in the mortuary on those days. This indicates that mortuary staff had not left early for the day, but we do not know where they were at the time of the offences.

The Inquiry was told by some staff that the mortuary is sound-proof. One told us, *"if I'm working in one room, you can't necessarily hear normal working noises in another"*.¹³ Another told the Inquiry that *"the department is very sound-tight"*.¹⁴ Dr Dominic Chambers, who has worked as a pathologist at the Trust since 2010, and has been the Designated Individual (DI)¹⁵ since 2014, said that *"you can't hear anything from the rest of the Department [mortuary]"* when in the viewing and office areas (see Figure 1).¹⁶ We also heard that the APTs sometimes play a radio: *"You know we tend to have the radio on in the office so we wouldn't necessarily hear if he's being quiet that fridges are opening and closing and things in the post-mortem room."*¹⁷

However, this contrasts with evidence the Inquiry heard from a hospital porter who told us about an instance when they heard unexpected noises in the post-mortem room,¹⁸ and by David Fuller himself, who told us that during one instance of offending he heard porters entering the mortuary. These instances are covered in more detail later in this chapter.

In addition, by the nature of their work, APTs routinely access all areas of a mortuary unexpectedly throughout the working day – for example, to undertake cleaning, re-stock equipment and consumables, access the linen store, or take items to or remove items from the post-mortem room. David Fuller could not have known that he would not be disturbed if mortuary staff were present but elsewhere in the mortuary.

13 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

14 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

15 The individual designated on the Human Tissue Authority licence as the person under whose supervision the licensed activity is authorised to be carried out.

16 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

17 Witness transcript of N140, APT, worked in mortuaries at the Trust since 2017, based at Maidstone Hospital.

18 Witness transcript of N322, porter since 2006.

At interview, the three APTs told the Inquiry that they did not personally supervise contractors and maintenance staff when undertaking tasks in the post-mortem room of the mortuary, as they did not have time to do so.

This opinion that the mortuary staff were too busy to supervise contractors and maintenance staff was shared by Mr Peter Deal,¹⁹ who was the Mortuary Manager between 2016 and 2021, and by Dr Chambers, who stated: “[T]here aren’t enough of you to just have someone standing there constantly making sure that that’s what they’re doing. You have to trust, you have to trust people, don’t you?”²⁰

The Human Tissue Authority (HTA) regulates mortuaries in England that undertake post-mortem examinations, store bodies and samples for scheduled purposes under the Human Tissue Act 2004, and remove samples from the deceased for these purposes. The role of the HTA is examined in more detail in Chapter 6. The HTA standards were revised in April 2017, including one relating to security that states: “Security arrangements should ensure oversight of visitors and contractors who have a legitimate right of access.”²¹ However, this amendment post-dates the majority of occasions when David Fuller offended during mortuary working hours.

That the APTs permitted David Fuller to undertake maintenance in the post-mortem room, unsupervised, while the deceased were laid out there, is covered in more detail in Chapter 3.

Earlier in this chapter, we explained that David Fuller told the Inquiry that he offended against deceased people left out overnight in the post-mortem room at Kent and Sussex Hospital and Tunbridge Wells Hospital. The Inquiry identified that three of the 12 instances of offending that occurred during mortuary working hours were committed against deceased people the day prior to their PME. The Inquiry has therefore considered the possibility that David Fuller committed offences on deceased people left out in the post-mortem room during mortuary working hours while he undertook maintenance work in the post-mortem room unsupervised.

The three instances of offending during mortuary working hours that occurred the day before the deceased had a PME happened in December 2015, January 2016 and September 2016. It is important to note that the Inquiry has not been able to confirm that, at the Tunbridge Wells Hospital mortuary, deceased people were left out in the post-mortem room in the years prior to 2018. However, the evidence of poor working practices in the mortuary over many years, which is explored in Chapters 3 and 4, together with the following evidence concerning capacity in the mortuary, suggests that the practice of leaving deceased people out overnight before a PME was likely to have been established well before 2018.

The Inquiry was told by Mr Kenneth Crossley, the Lead APT, and N131, an APT, that deceased people began to be left out in the post-mortem room overnight in 2018,

19 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

20 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

21 HTA, Post-mortem Examination Code of Practice and Standards, April 2017.

that this became “*semi-routine*” practice and that the purpose was for ease, to assist the PME (see Chapter 3).²²

However, Mr Crossley and N131 also told the Inquiry that the rationale for leaving deceased people out overnight to aid the PME the following day came from the fact that it had been agreed as a contingency measure:

“So, my experience is, when we got our HTA licence, [in 2014] obviously, we were looking after people that had passed away in the community as well, and, at that point, every winter, we would struggle for capacity. And, as a trainee, I was on-call as well and I used to get quite anxious on a Friday afternoon when there wasn’t any spaces. So, I would go to our manager, ask, ‘What are we going to do if we reach capacity?’ And to our DI, and they could never really give assistance or advice. And the only advice that they would give is that we could use the post-mortem room as additional capacity in those pressured periods. So, off the back of that ...”²³

“There was a contingency arrangement agreed by management and our DI that that post-mortem room area could be used as an overflow space. Because of that, we would consider it safe for us to put patients in, if they were having a post-mortem the following day.”²⁴

The mortuary at Tunbridge Wells Hospital gained its HTA licence to provide post-mortem services in 2014. The evidence of N131 indicates that, soon after, the mortuary began to struggle for capacity due to the increase in activity brought about by receiving bodies of the deceased whose deaths were under investigation by the coroner (community deaths).

Mr Deal told the Inquiry that mortuary capacity was an issue, particularly in the winter periods:

“[W]hen I came in in 2016, we were using temporary storage units every winter at Tunbridge ... we had to double up in 2017. We had no choice. We ran out of space ... And that was a real ... it was a massive burden. Every ... that winter was absolutely terrible and afterwards, I said, ‘No, this can never happen again. We need more space.’ So, the doubling up was ... I was aware from Dom. He said, ‘We’ve got to do it,’ and I went, ‘Only if we have to do it.’ And that was put to Theresa, my line manager, the cell path service manager. It was a fait accompli; we had no other choice ... it didn’t sit well with me, which is why I put in the business case for the expansion.”²⁵

The evidence of Mr George Taylor, Mortuary Manager between 2011 and 2016, supports this. He told the Inquiry that the deceased were ‘doubled up’ in fridges due to capacity issues during his period of tenure, saying: “*Yes, it did happen. Yeah...*”²⁶ Mr Jim Withell, Cellular Pathology Service Manager from 2006 to 2017, informed the Inquiry

22 Witness transcripts of Mr Kenneth Crossley and N131.

23 N131, APT, worked in mortuaries at the Trust since 2012.

24 Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

25 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

26 Mr George Taylor, biomedical scientist, Mortuary Manager, 2011–2016.

that this practice only happened as a last resort to prevent decomposition and that he was not involved in decisions related to this practice.²⁷

The doubling up of deceased people in refrigerated units is the placing of two deceased people on one tray in the refrigerated space. It is not considered suitable practice by the HTA and disregards the dignity of the deceased.

Issues around mortuary capacity, which were noted by the HTA during its 2018 inspection, the management response and, in particular, the delay in implementing measures to address those issues are covered in more detail in Chapters 4 and 6.

It is clear from the evidence of Mr Taylor, Mr Deal, Mr Crossley and N131 that there were ongoing capacity pressures in the mortuary, particularly during the winter period, exacerbated by the start of PME services at Tunbridge Wells Hospital in 2014. It is also clear that this meant undesirable contingency measures, not consistent with safeguarding the dignity and safety of the deceased, were taken, specifically the doubling up of the deceased.

At interview, Mr Deal and Dr Chambers denied being aware that the deceased were being left out overnight, but this is contradicted by the evidence of the APTs, who claim it was sanctioned by them as a contingency measure. Regardless of how it came about, it is clear from the evidence of the APTs that the deceased were left out in the post-mortem room in the period prior to 2018, and possibly as early as 2014.

- While it is not possible for the Inquiry to conclude that this was the case, it is a matter of great concern that the practice of leaving the deceased out in the post-mortem room might have provided greater opportunities for David Fuller to offend on more than the three instances to which he has admitted, and that this could have made it easier for David Fuller to offend on three of the 12 instances of in-hours offending.
- The Inquiry has not been able to determine with a high degree of certainty how David Fuller was able to commit his crimes during mortuary working hours. While we have considered various possibilities as to how David Fuller was able to do so, none of them is plausible from the evidence we reviewed. It remains hard to believe not only that he took the risk of offending during normal mortuary working hours but that this was unnoticed by the mortuary staff who, we are told, were actually present in the department. Despite the potential explanations provided by the mortuary staff, the Inquiry does not consider it likely that staff could have been in the mortuary at these times.

27 Response of Mr Jim Withell, Cellular Pathology Service Manager, 2006–2017.

- From the evidence we have heard, it appears that David Fuller was able to commit in-hours offences because he was allowed by staff to go unaccompanied into the post-mortem room ostensibly to undertake maintenance, confident that he would not be disturbed. The Inquiry heard evidence (see Chapter 3) that David Fuller would undertake tasks in the post-mortem room while the deceased were laid out. Mortuary staff demonstrated a lack of curiosity about what he was doing there and accepted at face value what he told them. Staffing shortages in the mortuary may have compounded this, as may inadequate management of the mortuary and the management response to mortuary capacity issues – these are considered further in Chapter 4. The alternative explanations are that staff were not present in the mortuary when they should have been or that they were aware of, but chose to ignore, David Fuller’s offending. Kent Police have found no evidence that the latter was the case, concluding that David Fuller acted alone at all times.²⁸

2.3 Nature of the offending

David Fuller sustained an injury to his back in 2004. David Fuller told us that, initially after the accident, *“I could only just about walk, let alone lift anything or move anything. I was really incapacitated to the point of not being able to function.”* We asked David Fuller how he was able to offend given his ongoing health problems, which he told us meant that he had restricted movement and chronic pain:

“With a multitude of painkillers ... with morphine and tramadol and paracetamol, codeine, a mix of ... whole combination of way more than I should take. But that’s in order for me to even get to work, let alone walk around and do things. And on top of that, I had on 7 hours a day, 8 hours a day a TENS unit for pain relief attached to my back ... for the sciatica, down through my left leg. And on top of that, I had a back strengthening support, wore that all day long as well to get my back in a position where it didn’t actually then start to ...”

David Fuller told us that he used the hydraulic trolleys to move the deceased from the fridges. When challenged about the apparent discrepancy between David Fuller’s health problems and his ability to manoeuvre the deceased around the post-mortem room, David Fuller told us that his ability over the years to cope with chronic pain improved:

“So, although, yes, you still have to be able to physically be capable of offending, I’m not denying that, but the progression from not being able to cope with pain, to cope with pain was a gradual process over those years.”

We asked David Fuller how he selected his victims in the mortuary. At first, he told us that he was not making any pre-emptive decisions about who to select. On further questioning, David Fuller told us that he would check the mortuary logbook, used by

28 Confirmation to the Inquiry, Kent Police, 11 July 2023.

porters to record the details of the deceased they had transported to the mortuary, to identify if they were high risk:

"So, whether they had serious infections and COVID, etc., all those different things, but it wouldn't say what the problem was, it would be high risk. And so those, on a selection basis, this sounds just absolutely terrible, on a selection basis, they would naturally not be offended against."

David Fuller went on to tell us that he would also look at the mortuary logbook after he had offended, to assist him in the cataloguing of his crimes: *"And that came into that equation, into that process that I needed to document it correctly."*

We were told by David Fuller that mortuary staff knew he was looking at the logbook and that they believed the purpose of this was to assist him to produce graphs showing the temperature of the fridges:

"I'd mentioned it [looking at the log-book] to Ken and the girls in there when I produced the graphs, the technical graphs that showed spikes of unnecessarily high temperatures when the doors had been left open too long."

Q: *So, the mortuary staff knew that you were [looking at the log-book]?*

A: *Yeah. I mean it was open there for you to read. It's not something that was hidden away, you had to get out and then, because it was there for the porters to write in for when they brought down the deceased and put their information on."*

One of the APTs told the Inquiry that they did not know that David Fuller was looking at the mortuary logbook, as they thought the mortuary logbook was locked away in the office. They commented that there was an admissions logbook that the porters used, which was stored in the fridge room.²⁹ However, even if David Fuller had incorrectly named the admissions logbook the mortuary logbook, the Inquiry considers that this was still not a credible reason for needing to view a logbook that contained confidential information and is therefore an example of mortuary staff demonstrating poor practice and a lack of curiosity.

Nine porters interviewed by the Inquiry confirmed that the logbook was accessible in the mortuary for them to record when they had brought the deceased to the mortuary.³⁰

When asked what measures David Fuller had taken to guard against him being discovered, he responded that he had been able to lock himself in the post-mortem room of the mortuary at the Kent and Sussex Hospital in such a way that the door could not have been unlocked from the outside. He told us that, from 2011, he similarly locked himself in the post-mortem room in the mortuary of the new Tunbridge Wells Hospital. David Fuller went on to say that he knew there were only two keys to this room: one that was in the possession of mortuary staff and was kept in the mortuary office, and one that was kept in a key safe in the Interserve office. He could be confident that, outside mortuary working hours, if he had the Interserve key to the post-mortem room, it was unlikely that anyone would enter. The fridges containing the deceased are double-ended and accessible from both the post-mortem room and the

²⁹ Response of N131, APT, worked in mortuaries at the Trust since 2012.

³⁰ Witness transcripts of N142, N272, N318, N320, N322, N324, N339, N341 and N343.

receiving room and are often left unlocked. Porters could therefore place the deceased in the fridges without needing to go into the post-mortem room. Security in the mortuary is considered in Chapter 5.

The Inquiry was told by an Interserve manager on an occasion sometime between 2014 and 2016 but possibly earlier, at Tunbridge Wells Hospital, when they had sought to join David Fuller in the post-mortem room after being told by the helpdesk that he was there responding to a fault with the pneumatic tube system. When trying to open the door, the manager found it was locked:

"[T]he door was locked, and I was like, 'Dave, where are you?', you know, 'hello?' and there was no one in there, and it's all quiet. And then I was like 'well the door's locked so he can't be in there, so I came back out ... and the memory's a bit hazy, but I was like, 'are you sure Dave's in there?' and 'yeah, he's definitely in there because he's gone to go and do the ticket', you know, because there was a job docking for it. And I was like, 'oh', and I couldn't honestly tell you if I remember then looking for the key and the key being missing or not, but I do know that I went back in there, and I'm ... I think I even knocked on the door, and David opened the door. And I'm like, 'what the hell? Why have you got the door locked?' and he's like, 'oh you know what it's like, you get a bit spooky in there; it gets a bit' – and I didn't think anything of it, and it'll pain me for the rest of my life probably, but I didn't think anything of it untoward ... [A]s soon as he said that, I'd seen the ladders were up, and my focus then went on to that for his safety ... I kind of had to reprimand him because I was really furious because he wasn't allowed to use ladders ... And these ladders were quite tall ones. You had to get right up into the ceiling."³¹

The Interserve manager told us that, although they could not be clear on the time the episode occurred, they believed it was later in the afternoon or early evening, as their working hours at the time were 8am to 4.40pm or 5pm. They believed the episode took place after the mortuary staff had left for the day.

It is not possible to know what David Fuller was doing inside the post-mortem room on this occasion. However, the episode illustrates how David Fuller could lock himself in the post-mortem room, preventing entry by anyone else, and on being challenged could give a seemingly plausible explanation for his behaviour. The lack of curiosity among David Fuller's Interserve colleagues is explored in more detail in Chapter 3.

The layout of the mortuary meant that there was a strong possibility that anyone entering the post-mortem viewing gallery, a raised gallery from which others – for example, the police or coroner's staff – could observe PMEs, could have seen David Fuller offending. When asked about this, David Fuller told us that, outside mortuary working hours, the only person likely to need access would be an Interserve electrician to maintain or repair the lift in there. He told us of one occasion when he was disturbed in his offending by a fellow Interserve engineer who was walking along the corridor that ran along the wall outside the mortuary:

31 Witness transcript of N567, worked in maintenance at Kent and Sussex Hospital then Tunbridge Wells Hospital, 1999–2016, Interserve manager, 2014–2016.

"The only person that would come to the viewing gallery would have been either myself or another engineer doing his check on the lift.

...

And that's why I said to you yesterday about [X] had come along, he was either going to be doing that check or whatever for it, we never discussed it afterwards, is that I was, I was here [in the post-mortem room] I heard him saying, come along and say, 'David, are you in here?'. I had gone round this way [out of the mortuary and into the corridor] to meet him in this direction, and so he never saw what ...

Q: *But that was always a risk that somebody could have come in?*

A: *Yes, but that, in order to get from there to there to there would be noise levels that you would hear. It's not something that you would not hear because this is an open viewing gallery."*

David Fuller told us that he would take care to leave the mortuary and the bodies of the deceased as he found them:

"Because of minimal, minimal interaction with all the stuff that's in there. So, everything would be put back as it would have been before I entered. You know, that in terms of anything, apologies for digressing, but anything that I've ever done in my life, I put everything, if I take something apart, I put it back together as it was or the better. So, that wouldn't have made any difference to this offending, I would have still put everything back as it was before."

During their viewing of a sample of the offending material in order to assess whether there were missed opportunities to detect David Fuller's offending, the Independent Advisers to the Inquiry noted the considerable lengths to which David Fuller went to re-dress and re-position the deceased, and his extreme meticulousness in re-positioning items that had been placed with the deceased in exactly the same position that they were prior to his offending. The Independent Advisers noted that it would therefore have been extremely unlikely that any disturbance to the body of the deceased would have been noticed and led to suspicion of the offending.

David Fuller did, however, tell us that on a few occasions he was not as meticulous:

"I think probably I didn't on a few occasions where my memory is ... the rush to put everything back is not necessarily something that you can organise and plan. It's a case of what did it look like beforehand and try and put it back as it was, whether that was accurate enough for anyone to notice. No one ever said, so I can't really ..."

When asked, the three APTs told us that they had not noticed anything unusual about the state of the post-mortem room or the mortuary that might have resulted from inappropriate activity occurring while they were off-duty. We heard that, as it was not uncommon for porters, or maintenance staff such as David Fuller, to access the receiving area of the mortuary out of hours, anything that might be out of place would be attributed to this without suspicion. While portering staff did not have access to the post-mortem room at any time, maintenance staff could access the post-mortem room out of hours using the Interserve key.

Ms Sharon Edwards, a Lead APT who worked in the mortuary at the Kent and Sussex Hospital between 2000 and 2011, also told the Inquiry that she had not noticed anything unusual that might have happened overnight. When asked if there was ever an occasion where she thought somebody had been in the mortuary, Ms Edwards replied: *"I never had any of those thoughts or feelings around somebody's been in here that shouldn't."*³²

Despite David Fuller's explanation of the measures that he took to avoid detection, the Inquiry is struck by the risks he took in committing his crimes. There are staff at the Trust who require access to the mortuary at any time of day and night: porters have 24-hour access to enable them to bring the deceased to the mortuary. While they may not have been able to access the post-mortem room where David Fuller committed his offences, they might have heard him or suspected that someone was in there at an unexpected time of the night. David Fuller had no way of knowing or predicting when this might be the case.

The Inquiry interviewed 15 porters or portering supervisors at the Trust, three of whom had worked at the hospital since the 1980s.³³ The porters we spoke to were selected as those who most often worked night shifts and so were most likely to be taking the deceased to the mortuary at times when David Fuller was offending. Only one recalled seeing David Fuller in the mortuary: *"[H]e was someone who worked there during the day you know, he's the supervisor you know."*³⁴

David Fuller told the Inquiry that he had heard porters entering the mortuary to deliver the deceased, while he was in the adjacent post-mortem room offending:

"And I've heard them coming in and out.

Q: *While you were offending?*

A: *Yes. Yes.*

Q: *And what did you do when you heard that?*

A: *Stopped and put everything back to normal and exited after they'd left."*

One porter recalled hearing a noise in the mortuary sometime around 2019 to 2020:

"[T]here was this one time that I was with a colleague who no longer works with us now. We was doing one and it was round about 6 o'clock in the evening and we took a body down from the ward, down into the mortuary and we heard a massive bang. And me and him looked at each other and instantly like, 'oh my God what was that? What was that?'. I can't honestly say it was him but we notice that the light was on. So in the mortuary, you've got one side which is the way you come in to pop bodies – the deceased in and there is like a doorway in between the fridges which is got a little rectangular window in – and the light was on in there, which happened every now and again, we've seen the light on there. Perhaps the morticians tend to turn it off but that one occasion it must have been about two years – two, three years ago

32 Witness transcript of Ms Sharon Edwards, Lead APT, worked in Kent and Sussex Hospital mortuary, 2000–2011.

33 Witness transcripts of porters and portering supervisors N272, N273, N315, N316, N317, N318, N320, N322, N324, N327, N334, N339, N341, N343 and N371.

34 Witness transcript of N320, porter since 2006.

– and we heard a massive bang and we was really, obviously spooked out. And he said to me like, 'Do you think...?' and I was like, '... to be honest with you, I don't really want to think about it', you know."³⁵

There is no way of knowing if David Fuller was responsible for the noise this porter heard. The porter did not investigate further and did not raise what he had heard with anyone. Had he done so, and had it been acted on, it could have provided an opportunity to investigate what had happened on this occasion.

When asked if he had any concerns about being disturbed while he offended, David Fuller replied:

"I think in the back of my mind I was thinking maybe what happens if I get disturbed? Because at the end the bubble will burst at that point and then everything will come out and the whole, your whole relationships all the people that you've ever known to the point of obviously and, you know, in 2020 is when that happened. And, you know, the world crashes down."

David Fuller told us that he acted alone, and there was no collusion. In relation to the mortuary staff, David Fuller said: "[T]hey trusted me, and I broke their trust."

Reliance on trust alone was not sufficient to safeguard the dignity of the deceased and prevent David Fuller from committing his appalling crimes.

What we have found

- David Fuller was able to sexually abuse the bodies of women and girls in the mortuary, undetected, for 15 years. He was extremely brazen in his offending and appeared confident that he was not going to be disturbed.
- David Fuller was most likely to offend between 6pm and 8pm, and second most likely to offend between 4pm and 6pm. His offending increased in 2018 and 2019, with 40 per cent of his known offences happening in these two years alone.
- David Fuller used the mortuary admissions logbook when selecting his victims and to assist him in the cataloguing of his crimes. Mortuary staff knew that David Fuller looked at the admissions logbook, accepting that this was for the purpose of monitoring the fridge temperatures. This was not a credible reason and demonstrates a lack of curiosity and poor practice by the anatomical pathology technologists (APTs).

35 Witness transcript of N322, porter since 2006.

- He offended in the mortuary at Tunbridge Wells Hospital during working hours, when other staff should have been on duty, on 12 occasions between June 2015 and June 2017. The Inquiry has not been able to determine how David Fuller was able to commit his crimes during mortuary working hours. From the evidence we have heard, it appears that David Fuller was able to do so because he was allowed by staff to go unaccompanied into the post-mortem room, ostensibly to undertake maintenance. The Inquiry considers it extremely unlikely that David Fuller would have taken the risk of offending when APT staff were present elsewhere in the mortuary.
- The deceased were left out of the mortuary fridges overnight at Kent and Sussex Hospital. This practice appears to have occurred at Tunbridge Wells Hospital initially as a contingency measure, from at least 2014, and later, in 2018, becoming a regular practice to ease the post-mortem examination process. This was not in line with Human Tissue Authority requirements and did not safeguard the security and dignity of the deceased.
- David Fuller committed offences on deceased people who had been left out of the mortuary fridges overnight on two occasions at Kent and Sussex Hospital and on one occasion at Tunbridge Wells Hospital. It is of great concern to the Inquiry that the practice of leaving the deceased out overnight could have provided greater opportunities for David Fuller to offend on other occasions.

Chapter 3:

David Fuller's employment and working practices

Please note that this chapter contains details of the preparation of the deceased prior to post-mortem examinations taking place. Only relevant and necessary information is included, but, nonetheless, the material may be distressing to read.

In this chapter, we consider David Fuller's employment at Maidstone and Tunbridge Wells NHS Trust (the Trust). We look at how he came to be employed there, both as an employee of the Trust and later as an employee of Interserve (Facilities Management) Ltd (Interserve). The chapter examines David Fuller's working practices regarding the maintenance tasks he undertook in the mortuary and how these may have enabled him to offend.

We also look at what others knew about David Fuller at the Trust and their perceptions of him.

Finally, we examine whether David Fuller behaved inappropriately in other areas of the Trust and whether any complaints or concerns were raised about him.

3.1 David Fuller's employment

David Fuller began an apprenticeship as an electrician in 1971. He worked as an electrician for various employers before beginning his first NHS role as an electrical maintenance craftsman in 1989 at the old Kent and Sussex Hospital. This was initially on a temporary basis which then became permanent. His early NHS employer was Tunbridge Wells Health Authority; his employment moved to Kent and Sussex Weald NHS Trust in 1994. This Trust merged with Mid Kent Healthcare NHS Trust in 2000 to become Maidstone and Tunbridge Wells NHS Trust.

In 2002, David Fuller successfully applied for promotion to the role of electrical maintenance supervisor at the Trust and continued to be based at Kent and Sussex Hospital.

When Kent and Sussex Hospital was decommissioned in 2011, David Fuller moved to the new Private Finance Initiative (PFI) Tunbridge Wells Hospital at Pembury. Under the PFI arrangements, Interserve provided facilities management services to the Trust and David Fuller's employment was transferred to that company.

In December 2020, the month of David Fuller's arrest, his employment transferred to Mitie Group PLC (Mitie) following its acquisition of Interserve.¹

3.1.1 David Fuller's previous convictions

In this section, we consider David Fuller's history of criminal convictions and the checking of these by both the NHS and his subsequent employers.

David Fuller had a history of criminal convictions in the 1960s and 1970s. In March 1967, when he was 12, David Fuller was convicted of a non-violent, non-sexual offence resulting in a community order. In August 1969, when he was 14, David Fuller was convicted of a non-violent, non-sexual offence resulting in a community order, probation and compensation. In April 1973, when David Fuller was 18, he was convicted of three counts of burglary and theft dwelling and asked for 23 other offences to be taken into account. In July 1977, when he was 22, David Fuller was convicted of burglary and theft dwelling and asked for three other offences to be taken into account.

David Fuller did not receive custodial sentences for any of these convictions. None of the offences counted as automatic barring offences, which are the most serious ones resulting in someone being automatically barred from working in regulated activity with children and/or vulnerable adults.

The process of 'taking into account' is an administrative procedure, subject to sentencing guidelines, and has no statutory foundation. It provides individuals who are arrested with an opportunity to admit to any further, similar offences that they have committed. These further offences must not be more serious than the one for which the individual was arrested. The arresting police force will then decide whether to charge those offences separately, in addition to the arresting offence, or whether to have the additional offences taken into consideration at sentencing. This decision will depend on the circumstances of the case but may include factors such as the severity of the offence and whether a separate trial is in the public interest. Offences that are taken into account are not convictions and are seen as a way for the offender to 'wipe the slate clean' and to ensure that they will not be charged separately for the additional offences in the future. Offences taken into account would not be included on a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) certificate.

3.1.2 Criminal record checks

Criminal record checking is the process of employers assuring themselves that an employee does not have a criminal record that would make them unsuitable for their role.

There was some form of criminal record check in place for the duration of David Fuller's employment as both an employee of the NHS and in his subsequent employment by Interserve and Mitie.

1 Given that David Fuller's employment was with Interserve (save for two days at the end of his contract), the Inquiry refers to Interserve rather than Mitie in this Report. However, as Interserve's facilities management business was acquired by Mitie, the Inquiry engaged with Mitie where necessary in relation to its work on this Report.

Between 1987 and 1997, the Department for Education held a list called 'List 99', a confidential register of adults who had been barred or suspended from working with children or who needed to have conditions applied to them when working with children. Employers could apply to their local police force for a check against List 99 to ascertain an individual's suitability for specific work. List 99 was later known as the Independent Safeguarding Authority Children's Barred List.

The Police Act 1997 introduced a process of application to the police for a criminal record certificate or enhanced criminal record certificate.

In March 2002, the CRB was introduced in order to replace the process of police vetting. On 1 December 2012, the CRB merged with the Independent Safeguarding Authority to form the DBS. Initially, DBS certificates were issued to both the individual and their employer. This was revised in 2013 and from then on certificates were only issued to the individual.

The Rehabilitation of Offenders Act 1974 (the Act) allows most convictions (except those where the sentence is over 48 months) and all cautions, reprimands and final warnings to be considered 'spent' after a certain period.

Some roles are exempt from the Act. In these cases, the employer is entitled to request details of spent and unspent convictions and cautions that are not protected and to take this information into account when determining someone's suitability for the role.

In 2013, the rules around exempt roles changed. From 29 May 2013 onwards, non-specified cautions and convictions (mainly offences which are non-violent and not related to safeguarding) would be automatically 'filtered' from standard and enhanced DBS certificates, once a certain amount of time had passed since the sentence. All convictions resulting in a custodial sentence, whether or not suspended, would always be disclosed. Non-specified adult convictions are filtered after 11 years and non-specified youth convictions after 5.5 years. Job applicants are legally entitled to withhold filtered cautions and convictions from employers. When these rules were first introduced in 2013, if an applicant had more than one caution, reprimand, warning or conviction of any kind, then all would be disclosed, and none would be filtered. However, this rule was removed in 2020.

If a conviction, caution, reprimand or final warning becomes spent, it does not need to be disclosed unless the employer has deemed the role to be exempt from the Act.

3.1.3 Criminal record checks while David Fuller was employed by the NHS, 1989 to 2010

Kent Police have advised the Inquiry that it has not been possible to ascertain who recruited David Fuller into his initial temporary role and subsequent substantive role at Kent and Sussex Hospital. The Inquiry has seen evidence held by Kent Police that David Fuller was required to sign the following declaration on his application form for the substantive role:

"Because of the nature of the work for [which] you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 by

*virtue of the Rehabilitation of Offenders Act (Exemptions) Order 1975. Applicants are, therefore, not entitled to withhold information about convictions which for other purposes are 'spent' under the provisions of the Act and, in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action by the Authority. Any information given will be completely confidential and will be considered only in relation to an application for positions to which the Order applies."*²

David Fuller falsely indicated that there was no information to declare. The Inquiry has seen evidence from Kent Police that his convictions would not have qualified him to be on List 99 at the time. David Fuller provided an account to the Inquiry about his failure to disclose previous convictions on his first application form in November 1988. He informed the Inquiry that he did discuss his spent convictions but as he did not receive a custodial sentence it was agreed that it was not necessary to disclose them on his application form. He did not state with whom he discussed the spent convictions nor with whom it was agreed that disclosure was not necessary. The Inquiry considers that David Fuller should have disclosed his previous convictions on his application form. Although these convictions were spent convictions from the perspective of the judicial system, as a hospital electrician employed by the NHS, he was not exempt from the requirement to disclose them.

When David Fuller applied for promotion to the role of supervisor in 2002, he again falsely claimed on his application form that he had no convictions to declare. David Fuller informed the Inquiry that his convictions were not discussed in detail and he assumed the same process applied that he had been through when first applying for the role in 1988. The Inquiry has seen evidence from Kent Police that the job description for this role did not stipulate that a CRB check was required.

We reviewed the Maidstone and Tunbridge Wells NHS Trust's Disclosure Policy that we believe was in force at the time of David Fuller's promotion to supervisor. This policy is undated but has a review date of 2006. The policy states that, should an existing member of staff apply and be successful in obtaining another position within the Trust, a new disclosure form would not be applied for unless the change in post involved lone working with vulnerable adults or children.

The Inquiry reviewed the Trust's 'Confirmation of Appointment' form that was completed for David Fuller in April 2002. It contains a section for 'disclosure' requiring 'yes' or 'no' to be circled and a section for 'level of disclosure' requiring 'enhanced' or 'standard' to be circled. None of the answers was circled.

In April 2002, the Trust wrote to David Fuller offering him the supervisor role. The letter states that his appointment was dependent on him having "*a satisfactory disclosure report from the Criminal Records Bureau*".³ However, there is no evidence that a CRB check was carried out. The Trust told the Inquiry that the appointment letter was incorrect and should not have included any reference to a CRB check, as one was not required in line with Trust policy at the time.⁴

2 Evidence shared by Kent Police.

3 MTW NHS Trust, letter to David Fuller, 2 April 2002.

4 Response received during the Inquiry's Fairness Process from MTW NHS Trust.

- By 1988, David Fuller's most recent spent conviction was over ten years old. Two of the prior convictions occurred when he was under 18, all convictions were non-custodial and the offences were not violent or sexual. On their own, these offences may not have been detrimental to his employment.
- Nevertheless, from the evidence reviewed, it is clear that David Fuller misled his NHS employer about his convictions when he first applied for a job in 1988 and again when he applied for promotion in 2002. From the evidence, it is the Inquiry's view that David Fuller's initial and subsequent NHS roles were exempt from the Act. He therefore had a legal obligation to disclose his prior convictions when applying for these roles, but he did not do so.
- Although the nature of the offences might not have been detrimental to his employment, his prospective employer might have questioned his suitability for employment given the number of offences. If concealment of his previous convictions was later identified and found to be deliberate, this could have been treated by his employer as a serious misconduct matter.
- The Inquiry found no evidence that David Fuller's NHS employer knew that he had not been truthful in his applications.

3.1.4 Criminal record checks while David Fuller was employed by Interserve from 2011

In 2011, David Fuller's employment transferred to Interserve when he moved to the new Tunbridge Wells Hospital, a PFI hospital. The PFI arrangements are explained in the Background chapter of this Report.

There was a subcontract between the Special Purpose Vehicle (SPV) company, which owns Tunbridge Wells Hospital and manages the complex PFI arrangements, and Interserve, which provided facilities management services at the hospital. This subcontract states that only staff who were transferring to the new hospital and becoming Interserve employees who may have access to children and/or access to people receiving clinical services were required to complete a CRB check. A list of roles to whom this applies is not included in the subcontract.

The Inquiry has seen evidence from Kent Police that Interserve made an application for an enhanced CRB check on David Fuller in April 2011. The evidence shows that David Fuller ticked 'no' in the section on the CRB application form for applicants to declare whether they had any convictions, cautions, reprimands or warnings. David Fuller accepted that he did not disclose his convictions in 2011. Despite this, an enhanced CRB certificate would have been produced, shared with his employer, and would have contained information on David Fuller's previous convictions.

At this time, it would have been normal practice for the employer to receive a copy of the CRB certificate as well as the individual. The Inquiry has seen Interserve records which show that a 'pass' was recorded against David Fuller's criminal record check in

2011.⁵ However, we have not been able to identify how, on what basis and by whom the decision to approve the 2011 certificate was made.

- Consideration of the offences outlined on the CRB certificate in 2011 could have provided an opportunity for Interserve to question why they were not known about previously. We have seen no evidence to suggest that this happened. Interserve not questioning why there was a discrepancy between what David Fuller declared and the information on his certificate was a missed opportunity to consider his honesty.

The PFI contract between the SPV and the Trust, and the subcontract between the SPV and Interserve as the facilities management provider, state that the Trust should be notified of any person employed or engaged in the provision of any of the contracted services who has new convictions or whose previously unknown convictions become known. N4, the PFI Contract Manager employed by the SPV, told the Inquiry that they were unaware that David Fuller had previous convictions until he was arrested, and the news broke.⁶

- The Inquiry has found no evidence that the Trust had been notified of David Fuller's convictions after he applied for a CRB check in 2011. This was a failure by Interserve to notify the Trust of David Fuller's convictions and was in breach of the PFI contract and subcontract.

The Inquiry has seen evidence held by Kent Police that, in 2015, Interserve instigated a DBS check of all its employees working at Tunbridge Wells Hospital. This was in response to *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile*, the 2015 report by Kate Lampard and Ed Marsden.

On this occasion, David Fuller ticked 'yes' in the section of the DBS application form for applicants to declare convictions, cautions, reprimands or warnings. David Fuller informed the Inquiry that he did declare these convictions to his employer and that he had at least three meetings with managers and Human Resources (HR) to discuss them. At this time, the DBS certificate would only have been sent to the individual and not to their employer, who would only have been notified that the certificate had been issued.

David Fuller's line manager at the time was Mr Trevor Crittenden. He told the Inquiry that David Fuller had brought the DBS certificate, containing details of his convictions, in to show him. He said that David Fuller had told him that the burglary offences were because "he was going through a divorce at the time and he'd, he actually broke back into his old house to get some of his clothes back". Mr Crittenden told the Inquiry that, once he was aware of the convictions, he adhered to the process set out in the HR policy governing this issue.⁷ Mr Crittenden explained that he completed a form detailing the convictions and emailed this to HR at Interserve.⁸ Mr Crittenden informed the Inquiry that he was not trained to make any decisions regarding DBS checks and

5 Extract of Interserve Human Resources compliance tracker, Mitie.

6 Witness transcript of N4, Contract Manager, Kent and East Sussex Weald Hospital Ltd.

7 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

8 Ibid.

that he did not make any judgements from the information David Fuller provided to him. He said that the policy required HR to notify him of any actions required following HR's assessment.⁹ Mr Crittenden told the Inquiry that he had no response from HR on the matter, apart from an acknowledgement email.¹⁰

The Inquiry received a copy of this form, known as the 'Employee DBS certificate form', from Kent Police. It states:

"This form must be completed and submitted to HR Operations and should only be completed in the following circumstances:

- *The employee has presented their full and original DBS certificate to you – photocopies are not to be accepted under any circumstances.*
- *The employee has refused to allow you, the line manager/supervisor/HR Champion, to take a copy of their DBS disclosure certificate."*

The Inquiry interviewed N555, the Interserve HR Business Partner who was in post when David Fuller applied for a DBS check in 2015. N555 was unaware of David Fuller's convictions and was surprised that David Fuller's line manager had not brought this matter to their attention directly. N555 told the Inquiry that, in the event of disclosure of convictions, a risk assessment would be made, focusing on the sentence awarded and in the context of the person's role. When asked if it would have been usual practice in 2015 to have checked to see if convictions had been previously disclosed, they said that it would have been presumed that the convictions had been evaluated by the recruiters at the point of recruitment.¹¹

The Inquiry has seen evidence held by Kent Police that shows that the 2011 and 2015 enhanced CRB and DBS checks were logged in the Interserve HR records as approved, and that there were no risk assessments attached. Mitie told the Inquiry that it had found a note confirming that a risk assessment was undertaken by Interserve for the 2015 DBS check.

The Inquiry reviewed Interserve's 2017 'Manager's Guide to the Recruitment of Ex-Offenders and Criminal Record Checks'. The guide did not require a DBS check to be renewed unless a change in role resulted in an individual working directly with children and/or vulnerable adults. The PFI contract and subcontract did not stipulate a requirement for a criminal record check to be carried out on Interserve employees on a periodic basis. The subcontract did stipulate that Interserve should follow the Trust's policies but was not explicit about its DBS policies.

3.1.5 Criminal record checks while David Fuller was employed by Mitie, December 2020

Mitie's Chief of Staff and General Counsel, now Chief Legal Officer, Mr Peter Dickinson, told the Inquiry that Mitie began negotiations to acquire Interserve in April 2020,

⁹ Response received during the Inquiry's Fairness Process from Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

¹⁰ Ibid.

¹¹ Witness transcript of N555, Interserve HR Business Partner, 2007–2017.

signed a conditional deal in June 2020 and then completed the acquisition on 1 December 2020.¹² David Fuller was arrested on 3 December 2020.

Mitie told the Inquiry that nothing was disclosed by Interserve to Mitie that suggested anything untoward regarding inappropriate criminal behaviour. The company said that DBS checks were not validated as part of Mitie acquiring Interserve. This was within the context of the company carrying out limited due diligence on the 27,000 employees who were transferring from Interserve to Mitie:

“We can carry out limited due diligence, recognising that the information that can be provided to us by a seller is restricted under the terms of data protection act etc, and ordinarily when one is buying a company, there is a limited amount of information which is provided and that’s provided normally on an anonymised basis. And that’s the age of the employee, their pay rates, their written terms of employment, whether or not they are in unionised employment and is there a collective agreement which in some way governs their terms and conditions.”¹³

- In conclusion, it is clear to the Inquiry that David Fuller did not disclose his criminal convictions when appointed to his NHS roles in 1989 and 2002.
- In 2011, David Fuller falsely declared that he had no previous convictions. The convictions would have been apparent on the copy of the 2011 CRB certificate received by Interserve, but there is no evidence that any action was taken in relation to the information.
- Interserve failed to notify the Trust of David Fuller’s previous convictions, which came to light in 2011 and 2015. This may be because Interserve was under the impression that the Trust would already have been aware of the convictions given the dates on which the offences had occurred. However, this was in breach of the contract between Interserve and the SPV, and in breach of the PFI agreement between the SPV and the Trust.

3.2 David Fuller’s working practices

In this section, we explore David Fuller’s working practices and their relationship with his offending, how frequently he visited the mortuary, the work tasks he undertook there, and the extent to which they gave him the cover and opportunity to commit crimes.

In conducting its work the Inquiry interviewed employees and ex-employees of Interserve, and in this chapter we include what they told us about David Fuller’s performance, practices, ill health and behaviour. Mitie, which acquired Interserve in December 2020, conducted its own internal investigation into how David Fuller was able to offend. Mitie told the Inquiry that its findings in relation to what David Fuller’s colleagues and ex-colleagues knew about him differed from those of the Inquiry.

12 Witness transcript of Mr Peter Dickinson, Chief of Staff and General Counsel, now Chief Legal Officer, Mitie Group PLC.

13 Ibid.

When interviewing David Fuller's colleagues, Mitie did not hear of any concerns about his performance or behaviour. It appears that individuals, as could perhaps be expected, were more forthcoming with providing information to the Inquiry than they were to Mitie.

3.2.1 Working hours

When David Fuller's employment transferred from Maidstone and Tunbridge Wells NHS Trust to Interserve in 2011, his usual working hours were recorded as 8am until 4.30pm Monday to Friday, with an average of two hours per week overtime. In February 2016, Interserve authorised a change in his contracted working hours during school term time to 9am to 5pm.¹⁴

David Fuller's working hours changed again in July 2016, to 11am until 7pm. The Inquiry was told that this was an informal arrangement between Interserve supervisors to ensure that there was a supervisor available between 7am and 7pm to oversee engineers' shift handovers.¹⁵

According to one of his fellow supervisors, N551, David Fuller welcomed this change: *"[I]n hindsight now, he sort of bit my hand off with that offer."*¹⁶

However, N153, who worked at Kent and Sussex Hospital, then was an Interserve employee from 2011, observed that, in practice, David Fuller very rarely oversaw the shift handover at 7pm, and he continued to stay later at work: *"7:30 suddenly became 9 o'clock, 10 o'clock, and we used to say, haven't you got a home to go to? And he ... would make some excuse."*¹⁷

- David Fuller was most likely to offend in the mortuary between 6pm and 8pm and second most likely to offend between 4pm and 6pm. His change in working hours to 11am until 7pm in 2016 does not appear to have affected the pattern of his offending, although instances of him offending increased substantially in 2018 and 2019 (see Chapter 2). This change in working hours did, however, give David Fuller a legitimate reason to be at work during the periods he offended most.

3.2.2 Overtime and long working hours

David Fuller had a reputation among his Interserve colleagues for working long hours and some thought he often claimed overtime for these additional hours. Of the 30 Interserve employees and ex-employees the Inquiry took evidence from,¹⁸ 47 per cent spoke of David Fuller working late.^{19,20} We heard that colleagues thought David Fuller

14 David Fuller's Interserve employee file.

15 Witness transcripts of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020; and N551, Interserve supervisor, 2014–2017.

16 Witness transcript of N551, Interserve supervisor, 2014–2017.

17 Witness transcript of N153, worked at Kent and Sussex Hospital, Interserve employee from 2011.

18 The Inquiry took evidence from 30 Interserve employees, of whom one provided a written statement and 29 were interviewed.

19 Witness transcripts of N126, N127, N128, N133, N147, N153, N155, N157, N164, N169, N407, N409, N410 and N505.

20 Where quantitative evidence is used, percentages are rounded to the nearest whole number.

worked long hours because either it had been agreed by his manager, or he needed the extra money from overtime because of financial difficulties, or because he had no life outside work and nothing to go home for.

The Inquiry heard from some Interserve employees, including N162 and N410, that nobody questioned why David Fuller worked long hours, despite it being a subject of office banter:

*"[H]e was always staying later than seven o'clock. He'd always run over ... I don't think anyone really did question it. I think, you know, he was just working late. That was just what David did."*²¹

"[E]verybody talked about it to be honest with you. We all used to say, 'why does he stay until that time'?"

Q: *So it was discussed in the office, was it?*

A: *Yeah, 'I wish he'd go home' [laughs] ... it'll be time to come back if you don't go home soon."*²²

N153 told us that they did not raise concerns about David Fuller's long hours because they saw it as a matter for David Fuller's line manager:

*"I used to say to him, haven't you got a home to go to Dave? He didn't really answer ... he would say 'oh I have got all this work to do', and I am thinking if you can't do your work in your hours then there is a problem, but you know that is not for me to interfere, that should be his manager should be asking those questions."*²³

However, we heard from N410, who worked at Kent and Sussex Hospital switchboard from 2008 to 2010, and was an Interserve helpdesk employee from 2010 to 2019, that they did raise concerns with an Interserve manager, but their concerns were dismissed:

*"He very seldom left that hospital before midnight ... and he used to say he had so much to do. But why did he have so much to do, when the other supervisors didn't? ... So I often queried that."*²⁴

N158, Account Manager for Interserve and then Mitie, from 2020, spoke about David Fuller's additional hours worked as not being unusual:

*"We did a sample check as part of the internal Mitie investigation [into how David Fuller had offended] of the records within the system, the time on site and all the time on the tasks and this that and the other. It was generally pretty much aligned. They were all ... yes so there's two electrical supervisors and we did a comparison against those and they were pretty much in balance."*²⁵

21 Witness transcript of N162, Interserve helpdesk employee, 2020–2022.

22 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

23 Witness transcript of N153, worked at Kent and Sussex Hospital, Interserve employee from 2011.

24 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

25 Witness transcript of N158, Account Manager, Interserve then Mitie, from 2020.

The Inquiry has looked at the only available overtime records for David Fuller. They show that he claimed for overtime on 26 occasions between 10 December 2019 and 9 October 2020, but only one of these had prior approval. In this period, there are only two instances when David Fuller's overtime claims coincide with dates he is known to have offended – one in December 2019 and one in March 2020.

The Inquiry has seen an email dated 19 August 2015 from David Fuller to his line manager at the time, saying that he was only claiming for half of the overtime hours he had worked.²⁶

- From the evidence available to the Inquiry, it appears that, while David Fuller was regularly working more than his contracted hours, the additional hours were not always claimed as overtime. While we cannot speculate about David Fuller's motivation for not doing so, it may have contributed to him not being noticed as an outlier among his colleagues.

The management response to David Fuller working long hours, regardless of whether these were claimed as overtime or not, is discussed later in this chapter.

3.2.3 Maintenance tasks

The maintenance team at the former Kent and Sussex Hospital were directly employed by Maidstone and Tunbridge Wells NHS Trust and were part of the Estates department. The Inquiry was told by N571, who worked at Kent and Sussex Hospital on the helpdesk from 2006 and then as an Interserve manager from 2011 to 2017, that maintenance tasks would be called through to the coordinator in the Estates department, who would then pass them on to the maintenance supervisors, including David Fuller, to allocate to engineers.²⁷

The move to the new PFI hospital at Tunbridge Wells in 2011 brought additional formality and process to how maintenance tasks were allocated. This was governed by a subcontract between the SPV and Interserve, which includes measures for how well Interserve delivered the facilities management service. There were financial penalties in place if Interserve did not meet the required standard in the timeframes specified in the contract. Following the move to the new PFI hospital, the maintenance team were directly employed by Interserve.

The Inquiry heard that there were two types of maintenance task: planned routine maintenance that was scheduled in advance; and reactive maintenance tasks, when something had broken or was faulty and needed repairing. We were told by Interserve employees and ex-employees that reactive maintenance tasks, including those in the mortuary, should have been notified to the Interserve helpdesk and then allocated to a relevant engineer.²⁸ The Inquiry has also seen this process set out in the Interserve helpdesk procedure document, dated 2017.²⁹

26 Email, David Fuller to N550 (Interserve manager, 2015–2018), 19 August 2015.

27 Witness transcript of N571, Kent and Sussex Hospital helpdesk employee from 2006, Interserve manager, 2011–2017.

28 Witness transcripts of N127, N128, N129, N153, N155, N156, N157, N160, N164, N169, N171, N172, N392, N407, N408, N409, N410, N505, N542 and N551.

29 Interserve, Tunbridge Wells Hospital Helpdesk Manual, September 2017.

Each reactive maintenance task was assigned a category and a timeframe within which it should be resolved. Routine tasks had to be attended to by an engineer within one hour and resolved within 48 hours. Urgent tasks had to be attended to by an engineer within 30 minutes and resolved within eight hours. Tasks classified as an emergency had to be attended to by an engineer within 30 minutes and resolved within four hours. Failure to attend to and resolve tasks within these timeframes would attract a financial penalty for Interserve of between £7.08 for a routine task and £42.47 for an emergency task, at 2017 rates. Interserve was also obliged to ensure that its staff received training and supervision to make certain the contract was properly complied with.

3.2.4 David Fuller undertaking maintenance tasks in the mortuary

David Fuller is logged on Interserve's maintenance system as undertaking 35 reactive maintenance jobs in the mortuary between 24 July 2012 and 9 October 2018.³⁰ This is the largest number of any engineer, the next nearest being 28 jobs undertaken.

There is only one instance of the date of a task allocated on the maintenance system to David Fuller coinciding with a date he was known to have offended, in September 2014. It is clear from the fact that he is known to have offended on 67 occasions in the same six-year period, and that only one of these coincides with him being allocated a reactive maintenance task, that David Fuller was in the mortuary more often than was recorded and that he was not relying on logged jobs as an opportunity to offend.

The Inquiry has seen a record of the number of times David Fuller's swipe card was used to access the mortuary between 16 December 2019 and his arrest on 3 December 2020. Earlier records are not available as the Trust's access system automatically deletes this data after a year. David Fuller entered the mortuary 444 times during this one-year period. There are no reactive maintenance jobs allocated to David Fuller on the system after 9 October 2018,³¹ which is surprising given the number of times he accessed the mortuary between December 2019 and December 2020. Access to the mortuary is considered further in Chapter 5.

David Fuller undertaking maintenance tasks in the mortuary was well known among his colleagues. We spoke to 29 employees or ex-employees of Interserve. Of these, 17, or 59 per cent, knew that he went into the mortuary to attend to the refrigerated units ('fridges') containing the bodies of the deceased.³² Six of these were in a managerial role, three were supervisors and two worked on the helpdesk; the remaining six were engineers. In addition, 66 per cent of David Fuller's colleagues (19 people) knew that he went into the mortuary to attend to the pod system (the system for delivering samples around the hospital; maintenance access to this was above the post-mortem room ceiling).³³

30 Extract from Interserve maintenance system shared with Inquiry by Mitie, October 2022.

31 Confirmed in email from Mitie, February 2023.

32 Witness transcripts of N127, N128, N129, N147, N155, N156, N157, N158, N164, N169, N392, N407, N408, N409, N410, N505 and N551.

33 Witness transcripts of N126, N127, N128, N147, N153, N155, N156, N157, N158, N160, N164, N169, N172, N392, N407, N409, N505, N551 and N567.

- Given the level of awareness among David Fuller's Interserve colleagues that he attended to maintenance tasks in the mortuary, it is concerning that no connection was made to the low number of reactive jobs that were logged to him on Interserve's maintenance system, and that any connection was not raised formally or queried by David Fuller's Interserve colleagues.
- Under the terms of the PFI subcontract between the SPV and Interserve, Interserve was not paid for the number of reactive maintenance jobs it completed. However, there were financial penalties in place if Interserve did not resolve tasks within set time periods (see above). It was therefore important, within this contractual arrangement, for Interserve to have accurate reporting of the maintenance tasks its employees were undertaking. This appears not to have been the case for the maintenance tasks that David Fuller undertook.

N158, Account Manager at Interserve then Mitie, from 2020, told the Inquiry: *"I try and drum into my team that every single job has to be logged, it has to be logged live. Just to ensure that we've got that tracking history of all ... of anything that goes on."*³⁴ When asked if there could be a financial loss to not logging a job, they said: *"No, how the contract's set up we're paid a fixed price."*³⁵

Mr Dale Vaughan, General Manager at Interserve between 2010 and 2015, told us: *"If he'd [David Fuller] done the work, it should have gone through the ... system"* but went on to say that it was an assumption that this was the case.³⁶

The management response to David Fuller undertaking maintenance tasks in the mortuary that were not logged on the Interserve system is considered later in this chapter. David Fuller informed the Inquiry that the maintenance jobs he undertook in the mortuary were necessary.

3.2.5 David Fuller's relationship with mortuary staff

The Inquiry heard from David Fuller's colleagues at Interserve that he was the 'go-to' person for tasks in the mortuary and that he had a good relationship with mortuary staff, who would often ask for him by name.

N156, who was an Interserve helpdesk employee from 2015, and a manager from 2020, told us that mortuary staff would call and ask specifically for David Fuller:

"They trusted David and I suppose if you do something for so long you have more of an expertise in that area, so he just seemed more familiar with that area."

Q: *Okay, and did anybody ever query why they always used to ask for David?*

A: *Absolutely not, no. No."*³⁷

34 Witness transcript of N158, Account Manager, Interserve then Mitie, from 2020.

35 Ibid.

36 Witness transcript of Mr Dale Vaughan, General Manager, Interserve, 2010–2015.

37 Witness transcript of N156, Interserve helpdesk employee from 2015, manager from 2020.

N158 said that David Fuller had *“a great relationship with the mortuary staff ... because he was in there every day, he was their point of contact. They trusted him.”*³⁸ They went on to say that mortuary staff would refer to David Fuller as *“Uncle Dave”*.³⁹

This nickname for David Fuller was also referred to by three other Interserve employees⁴⁰ and one of the mortuary staff based at Maidstone Hospital, N140, who has worked in mortuaries at the Trust since 2017.⁴¹ In addition, the Inquiry has seen an email from N131, an anatomical pathology technologist (APT), who has worked in mortuaries at the Trust since 2012, to David Fuller, where they addressed him as *“Uncle David”*.⁴²

Drawing on their professional experience, the Inquiry’s Independent Advisers informed us that David Fuller being present in the mortuary so frequently – *“every day”* – is extremely unusual and does not represent the normal practice and behaviour that they have observed in other hospital mortuary settings.

N410, who worked at Kent and Sussex Hospital switchboard from 2008 until 2010, and then worked for Interserve on the helpdesk until 2019, told us:

*“We queried, once or twice, why David was going into the mortuary without a paper trail, and he told us he was doing them a favour. If we ever queried anything with the then manager or the office, we were just told to shut up, basically.”*⁴³

N410 told us that David Fuller’s explanation for there being no paper trail for the jobs was because *“[h]e always used to say ... the mortuary staff, like Ken [Mr Kenneth Crossley, Lead APT], that worked in the mortuary, asked him to do it during the day, when he was there.”*⁴⁴ N410 said that David Fuller spent a lot of time in the mortuary – *“An awful lot of time ... he always had a job to do”* – and that the mortuary staff asked him to undertake tasks.⁴⁵ N410 said that David Fuller told them that the hoist in the mortuary was often breaking and needed fixing or that the lighting required attention.⁴⁶

Staff working in the mortuary at Tunbridge Wells Hospital confirmed that they had a good working relationship with David Fuller and that they would ask him to do maintenance jobs because he was helpful.

The Lead APT, Mr Kenneth Crossley, who has been employed by the Trust and its predecessors since 1986 and has worked in mortuaries at the Trust since 1994, spoke of approaching Interserve staff informally to see if anyone was available to undertake a job, such as a simple repair on a hoist. He explained that this might not have been within the remit of Interserve but avoided taking a hoist out of service while a formal repair request was made. Mr Crossley, when asked if David Fuller was ever asked to

38 Witness transcript of N158, Account Manager, Interserve then Mitie, from 2020.

39 Ibid.

40 Witness transcripts of N164, N407 and N505.

41 Witness transcript of N140, APT, worked in mortuaries at the Trust since 2017, based at Maidstone Hospital.

42 Email, N131 (APT, worked in mortuaries at the Trust since 2012) to David Fuller, 3 December 2020.

43 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

44 Ibid.

45 Ibid.

46 Ibid.

mend anything when in and around the mortuary, said: “[I]f he was there because he was very obliging. He was very erm, helpful and very amenable. Erm, so the rapport was that he would be the go-to if, if er, there was an issue.”⁴⁷

N131 confirmed that David Fuller would be asked to undertake a job on an informal basis, such as applying WD-40. Such jobs would not be logged retrospectively onto the Interserve maintenance system.⁴⁸

Ms Sharon Edwards, Lead APT, who worked at Kent and Sussex Hospital mortuary between 2000 and 2011, recalled that the working relationship with David Fuller pre-dated him working for Interserve:

“I vaguely remember him [David Fuller] being in the mortuary at my request. If I needed – and I can be very clear about this because whenever the maintenance guys, and I can’t remember any of their faces. I just remember that they were all great. I got on very well with them all. And even this horrible monster, I ... I had no red flags with him at all.”⁴⁹

David Fuller spoke to the Inquiry about his good relationship with staff in the mortuary and how they would ask him to do jobs. He attributed this to some extent to the longevity of his working relationship with Mr Crossley: “Ken and I went back a long, long way to then, back to 1989.”

David Fuller told us that him being seen as the go-to person for the mortuary originated from when he was working at the old Kent and Sussex Hospital, prior to moving to the new PFI hospital at Tunbridge Wells in 2011. He described how, in his opinion, it was easier to get jobs done quickly when the maintenance team were employed by the NHS:

“Yes, we had worked together for a long time. And once I became supervisor, then I was in, basically in charge of all the repairs and all the maintenance schedules anyway. So, if Ken needed something doing he would just let us know we’d just go down and repair things ... It was a lot easier to do when you were employed by the NHS directly because you know, at the end of the day, if [they] needed something do[ne] in a hurry they just picked up the phone and we rushed down and particularly me would rush down and see what the problem was and then arrange for the repairs to be happening.”

Mr Crossley told the Inquiry that he did not remember David Fuller from Kent and Sussex Hospital:

“Erm, I knew, I know he worked at the Kent and Sussex, but I never met him at the Kent and Sussex. Erm, and I must have seen him in the early days of the Pembury, Tunbridge Wells Hospital. I don’t remember him from the early days. It was more latterly, probably the last four, five, five, six years or something like that, you know.”⁵⁰

47 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

48 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

49 Witness transcript of Ms Sharon Edwards, Lead APT, worked in Kent and Sussex Hospital mortuary, 2000–2011.

50 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

Mr Crossley was based at the mortuary at Maidstone Hospital until around 2010 but worked on rotation at the Kent and Sussex Hospital mortuary prior to moving there permanently in 2010. Reference is also made to Mr Crossley working in the mortuary at Kent and Sussex Hospital in 2009 in an external report on the mortuary.⁵¹

David Fuller spoke about his close working relationship with mortuary staff on transfer to the new PFI hospital at Tunbridge Wells:

“Q: Would Mr Crossley, for instance, or his colleagues have the same sort of relationship with other members of the maintenance staff to pick up the phone and say, ‘can you come and help us with X’?”

A: Not very often. I would say at the new hospital, they relied on me to actually prepare the work and get a relevant person to go and do the job if it was out of my scope. Or was something I couldn’t manage. So, you know, whether that was because he knew that I would get the job done, because there were delays in various other tasks which came under planned maintenance which affected the way they work, which if we didn’t carry out the planned maintenance and there was a problem, then you’ve got sort of a double edged sword. You either, you know, you’re at fault whether you did it, you know you did or you didn’t do it.”

- David Fuller developed a trusted working relationship with mortuary staff who asked for him by name to attend to maintenance tasks in the mortuary. This close working relationship was known among his Interserve colleagues. The Inquiry considers that the frequency of David Fuller’s visits to the mortuary and the closeness of his relationship with mortuary staff was unusual.

3.2.6 The mortuary maintenance tasks associated with David Fuller

The Inquiry heard that there were two tasks in the mortuary at the new PFI hospital at Tunbridge Wells that people most closely associated with David Fuller: maintenance of the mortuary fridges and repair of the pod system. The pod system transfers samples around the hospital, with a maintenance access point being located in the ceiling of the post-mortem room.

David Fuller carrying out tasks in the mortuary was well known among his colleagues. Of the 29 employees or ex-employees of Interserve the Inquiry spoke to, 59 per cent knew that David Fuller went into the mortuary to attend to the fridges and 66 per cent knew that he went into the mortuary to attend to the pod system.

Mortuary fridges

David Fuller told the Inquiry that, at the old Kent and Sussex Hospital, he got into a practice of checking mortuary fridges as shown to him by his supervisor:

51 Mr James Lowell and Mr Terry Johnson, Independent Review of Mortuary Services, MTW NHS Trust, September 2009.

"He passed on all the information he could to me of all our checks that we had to do ... that's when he showed me the systems that were connected to the mortuary ... physical checks to make sure that the equipment was working that's in the fridges and so on. They would overheat in the summer, and they would pack up overnight and the systems in there weren't readily alarmed in a central location, so you had to check it every night, every night before you go home ... So, that would be my end of shift would be to actually go round and check things."

At the new PFI hospital in Tunbridge Wells, an external company monitored and serviced the mortuary fridges.⁵² This included calibration of temperature readings and alarm functionality tests.

In addition, the Inquiry heard that the mortuary fridges at Tunbridge Wells Hospital were remotely monitored by Interserve via the building management system (BMS). If a mortuary fridge went outside set parameters, an alarm would trigger on the BMS and this would be investigated by Interserve. Fourteen employees or ex-employees of Interserve told us that David Fuller sat by the BMS system and/or that he monitored it.⁵³

Despite this system for remotely monitoring the temperature of the mortuary fridges, and the regular servicing and maintenance by the external company, we were told that David Fuller would regularly go into the mortuary and open the fridge doors to place a temperature probe inside. It appears that this practice was not questioned, and some of his Interserve colleagues put forward explanations as to why it happened.

Mr Crittenden, David Fuller's line manager in the periods 2012 to 2015 and 2016 to 2020, gave an explanation as to why, although the fridge temperatures were monitored remotely by the BMS system, it was helpful to have local readings/data from probes that could be placed in the fridges:

"We had a few issues with the body fridges ... the compressor units were housed out a room outside, which was far too small, not designed correctly as far as we were concerned. So, the compressors couldn't dissipate the heat, were overheating, we were having issues with failures of compressors etc, but he was investigating that [with] a tiny tag temperature sensor which could be put into the fridges to monitor the temperature flows etc. The temperature probes that we had, the tiny tags were actually data loggers as well, so you could actually minute-by-minute, then follow the temperatures as to how they responding etc, so you can produce graphs, produce data ... Remote monitoring could be done, could be viewed but it was easier just to pop a tag into the specific area you wanted to measure and then you could just take that out and download all the information you wanted, rather than trying to keep an eye on everything."⁵⁴

52 UKAS assessment report, 2019.

53 Witness transcripts of N128, N129, N133, N147, N155, N157, N160, N164, N392, N407, N408, N505, N506 and N551.

54 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

N408, an Interserve manager at the hospital between 2018 and 2020, explained:

"[David Fuller] told me he'd had to go into the mortuary because the fridges were playing up ... his thing was, which we all knew because of the way that the design was, the condensers ... weren't in the open ... [and they] ... would at ... times overheat because they weren't getting enough air through them. So, if we had a really hot summer, we were trying to pump air into the area, to try and get cold air across to the coils to make them work. So, then that would ... upset all the, what I would call the body fridges. So, then you knew you were going to get a couple of calls on them ... And it would normally be David that monitored them. Because he was there of an evening ... During the day, up to sort of five o'clock, you had all the morticians and everybody there. From five o'clock onwards, you didn't have anybody ... So, you know, he openly admitted he had been in there to check the fridges ... Cos all the fridges were alarmed to the BMS. So, we would get a signal on the BMS to say, 'the fridge is going out of parameter' ... And then someone has to react and ... we had to get them back into parameters within four hours. You didn't wait around. You just had to get on and get it done."⁵⁵

N408 also gave an account of a conversation they had with David Fuller about door sensors on the fridges in the mortuary, where they appear to have challenged David Fuller on the need to monitor the fridges:

"[O]n one occasion we did go into what I would call the 'collection side'. The morticians weren't there. It was out-of-hours. And he showed me a door sensor to the first fridge, because it was playing up. And my thing to him is, 'why haven't we just changed it? Why you keep coming in monitoring it? Just get it changed.' ... And he was like, 'but, what about the cost?'. I went, 'I don't care.' I said, 'send it to me, I'll sign it off' ... If it costs me £200, it's going to save me more in your time than it is to, you know, just change the [connector]."⁵⁶

The Interserve General Manager at Tunbridge Wells Hospital between 2015 and 2017, Mr Andy Curley, told the Inquiry that the Trust raised the issues with the mortuary fridges alarming with Interserve, and Interserve in turn raised them with an independent fridge manufacturer. It appears from this exchange that there was no ongoing requirement to monitor the fridges because they were working:

"Well, the thing is about the refrigeration going out. I had a meeting with the head of the Trust,⁵⁷ and she said that Interserve would be in serious trouble if we couldn't resolve the issues with the refrigeration with the alarms going off. So I spoke to the mortician. He said that he hadn't got a problem and so I called in an independent refrigeration company who said it was all working perfectly. They gave me a quote, made me move the outdoor condensers, they're the white boxes with the fans on, from under where the ambulances go, to the outside wall which is a lot of money I

55 Witness transcript of N408, Interserve manager, 2018–2020.

56 Ibid.

57 Ms Jeanette Batten (formerly Rooke), employed with Trust predecessor organisations since 1988, Associate Director of Estates and Facilities Management, 2011–2013, Director of Estates and Facilities Management, 2013–2019.

assume. It improved a little but, but you know, can't see anything wrong [with] that refrigeration system.”⁵⁸

Drawing on their professional experience, the Inquiry's Independent Advisers informed us that David Fuller's very frequent presence in the mortuary to monitor the fridge temperatures was unnecessary, extremely unusual and does not represent the normal practice and behaviour that they have observed in other hospital mortuary settings.

David Fuller's monitoring of fridge temperatures in the mortuary was not part of the planned maintenance schedule with the Trust.⁵⁹ Nor has it been continued by other engineers since his departure. N158, Account Manager for Interserve then Mitie from October 2020, told the Inquiry that there was no requirement for David Fuller to proactively check the temperature of the fridges:

“[H]e basically manufactured this check which then was seen as best practice if you like, for him to make sure that those body stores were working properly ... there's no requirement to do that. It's all automated and those fridges would go into alarm if there was an issue.”⁶⁰

N158 reflected that, since David Fuller's arrest, “we never had any issues or any alarms and we still haven't today with those body stores.”⁶¹

- From the evidence available, it is clear to the Inquiry that, while David Fuller entering the mortuary to regularly check the temperature of fridges was well known by his Interserve colleagues, there was a lack of curiosity about why he needed to do so. David Fuller's monitoring of the fridge temperatures was unnecessary and extremely unusual given the comprehensive remote monitoring arrangements in place. However, it became accepted practice.

David Fuller opening fridges in the mortuary was also accepted by mortuary staff, despite it being at odds with their Standard Operating Procedures (SOPs).

The Trust's four SOPs for mortuary housekeeping tasks that were in place between November 2011 and October 2022 set out the process for mortuary staff to check and record fridge temperatures on a daily basis, together with instructions to escalate faults to Estates at Maidstone Hospital or Interserve at Tunbridge Wells Hospital.⁶² It is clear in the SOPs that this daily checking and recording of fridge temperatures is the responsibility of mortuary staff rather than Interserve. The four SOPs were approved by the Pathology Clinical Director/Mortuary Manager in 2011, the Mortuary Manager in 2014, and the Lead APT in 2015 and 2018.

58 Witness transcript of Mr Andy Curley, Interserve General Manager, 2015–2017.

59 Mitie investigation, May 2022, p.16.

60 Witness transcript of N158, Account Manager, Interserve then Mitie, from 2020.

61 Ibid.

62 The Method for Mortuary Housekeeping Tasks V1.1; V1.2; V1.3; The Cellular Pathology Mortuary SOP Mortuary Housekeeping Tasks.

The three APTs based at Tunbridge Wells Hospital were aware that David Fuller was regularly checking the temperature of the fridges in the mortuary.⁶³

When asked why David Fuller needed to check the fridge temperatures when it was the responsibility of the mortuary staff to do so, Mr Crossley, the Lead APT, said:

*"I know that sometimes he did come in and say that he'd picked up – he didn't use the word anomaly – but he picked up an anomaly on the graph. He was privy to the electronic side of monitoring, you know. We just saw a visible display, and he'd bring in a graph and say something's jumped. Did you release? Was the fridge door open for a period of time during that thing, because he picked up some issue if you like or a blip, and he'd come in to see if everything was alright."*⁶⁴

When questioned again on where the requirement for David Fuller to undertake fridge temperature checks came, Mr Crossley said:

*"I think the way he put it was that it was the display may not be a true account of the inside temperature of the fridges ... there could be a temperature differential of several degrees through the [bank of fridges] ... he did these 24-hour checks or whatever it was to, to get a true understanding of the internal temperature of the fridges."*⁶⁵

Mr Crossley explained that the temperature check would involve David Fuller placing a probe into the fridge.

When asked why David Fuller would undertake fridge temperature checks when the SOPs set out that this was the responsibility of mortuary staff, N131, an APT who has worked in mortuaries at the Trust since 2012, said that they thought this was because of the need to take the reading from a physical monitor in the fridge, to check that the reading was correct. N131 said that David Fuller would do this "a couple of times a month" and that this would require him to open the fridge. As the deceased people in the fridge would be covered, N131 told us they considered that this was an acceptable task for an electrician to undertake.⁶⁶ N131 said that they believed there to be a requirement for David Fuller to manually check the fridges and that he had been trained by the manufacturers to deal with the fridges at a local level.

At a level of seniority above the APTs, Mortuary Managers at the Trust were unaware that David Fuller was opening fridges in the mortuary to check temperatures.

Mr Thomas Farrell, the Mortuary Manager between 2010 and 2012, told the Inquiry that it was easier for mortuary staff to check the fridge temperatures at Tunbridge Wells Hospital than it had been at the old Kent and Sussex Hospital, and that staff checked them on a regular basis. When asked why David Fuller would be checking the fridge temperatures, Mr Farrell said: "I would say maybe that's part of his role. But again,

63 Witness transcripts of N130, APT, worked in mortuaries at the Trust, 2014 to 2023; N131, APT, worked in mortuaries at the Trust since 2012; and Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

64 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

65 Ibid.

66 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

*I would say that's unusual purely for the fact that the mortuary staff check it.*⁶⁷ Mr Farrell confirmed that he was not aware that maintenance staff were checking the fridge temperatures in the mortuary when he worked there.⁶⁸

Mr George Taylor, the Mortuary Manager between 2011 and 2016, did not know that David Fuller was checking the temperature of the mortuary fridges and told the Inquiry that he could not “see any reason” why this should be the case as they were monitored remotely.⁶⁹

Mr Peter Deal, Mortuary Manager between 2016 and 2021, told the Inquiry that there was automated fridge monitoring in place at the mortuary at Tunbridge Wells Hospital. However, when asked why, if this was the case, David Fuller also needed to check fridge temperature readings, Mr Deal said that he did not know: “I have no explanation for why he would be involved.”⁷⁰ When asked if he would have authorised David Fuller accessing the fridges to monitor the temperatures, Mr Deal said: “Good god, no, there was no need.”⁷¹ Mr Deal was, however, aware that David Fuller was involved in the maintenance of the fridges. He told the Inquiry about an encounter with David Fuller during a Human Tissue Authority (HTA) inspection in 2018:

“I believe ... that I met him once at the HTA inspection in 2018 when he brought down temperature monitoring logs for the fridges at the request of [the HTA] during the inspection and literally, this gentleman walked in with a folder, gave it to Dom [Dr Dominic Chambers, the Designated Individual] and walked out.”⁷²

- It appears from the evidence we have heard that the Mortuary Managers between 2010 and 2021 were not aware that the SOPs regarding monitoring fridge temperatures were not being adhered to. Nor were they aware that David Fuller was opening fridges where the deceased were placed in order to check temperatures. The lack of internal controls and effective management of the mortuary is considered in Chapter 4.

Mortuaries that are licensed by the HTA are required to have a Designated Individual (DI) in place. DIs are legally responsible for making sure that the mortuary is run in line with HTA requirements in order to remain licensed. The role of the DI is considered further in Chapter 4.

The DI at the Trust from 2014, Dr Chambers, told the Inquiry that he too had encountered David Fuller at the HTA inspection of the mortuary in 2018:

“I said I don't, I don't know about the fridge temperatures, that's not my area of speciality, or my area of expertise ... I said Ken [Mr Crossley, Lead APT], do you know about the fridge temperatures ... the specifics of fridge temperature management, and he said to me 'no', he said 'but I'll go next door and see if Dave's available, because he looks after the fridges'. And he went next door and he got Dave and he brought

67 Witness transcript of Mr Thomas Farrell, Mortuary Manager, 2010–2012.

68 Ibid.

69 Witness transcript of Mr George Taylor, biomedical scientist, Mortuary Manager, 2011–2016.

70 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

71 Ibid.

72 Ibid.

*Dave into the fridge room and Dave came walking into the fridge room er, with a clipboard and possibly a little rucksack, I don't know. And he stood in front of the two regulators and talked to them about fridge temperatures and fridge management for about, probably about 10, 15 minutes, maybe. And then he went away."*⁷³

This episode suggests that the DI at the Trust, despite his legal accountability for the running of the mortuary, was not aware of its SOPs and did not question the role of an Interserve supervisor in managing the fridges in the mortuary.

- From the evidence reviewed, SOPs regarding the monitoring of the temperature of the mortuary fridges were not adhered to by mortuary staff. There was a lack of curiosity on the part of the Mortuary Manager and the DI about why David Fuller was physically monitoring the temperature of the mortuary fridges when this was done remotely and should in any case have been the responsibility of mortuary staff. In carrying out these regular checks, David Fuller normalised his presence in the mortuary, so that seeing him in there was not regarded as being out of the ordinary.

The pod system

The other maintenance task in the mortuary closely associated with David Fuller was repairing the pod system.

The pod system is not equipment specific to the mortuary. It is a computer-controlled pneumatic tube system that transports things – for example, specimens and results – around the hospital at Tunbridge Wells.

Of the 29 employees or ex-employees of Interserve that the Inquiry interviewed, 19, or 66 per cent, knew that David Fuller went into the mortuary to attend to the pod system. Of these, six were in a managerial role, four were supervisors and three worked on the helpdesk; the remaining six were engineers.⁷⁴

At Tunbridge Wells Hospital, the Pathology department, where specimens are sent, is located above the mortuary. We heard that blockages would frequently occur at the entry/exit point to this department. To unblock these, an Interserve engineer would need to climb a ladder to access the maintenance hatch in the void of the ceiling in the post-mortem room and physically unblock the pod system. We heard that this would present problems as the hatch could not be accessed while the post-mortem room was being used for post-mortem examinations (PMEs).⁷⁵

Ongoing problems with the pod system in this location were well known among Interserve staff.⁷⁶ This part of the pod system was moved from the ceiling void into the Pathology department itself in late 2020.

73 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

74 Witness transcripts of N126, N127, N128, N147, N153, N155, N156, N157, N158, N160, N164, N169, N172, N392, N407, N409, N505, N551 and N567.

75 Witness transcripts of N124 and N505.

76 Witness transcripts of N126, N127, N128, N147, N153, N155, N156, N157, N158, N160, N164, N169, N172, N392, N407, N409, N505 and N551.

- The Inquiry considers that the location of the access point, in the post-mortem room itself, was clearly unsuitable and provided an inappropriate requirement for maintenance staff to access the post-mortem room.

The Inquiry was told by N128, an Interserve manager from 2019, that David Fuller would carry out repairs in the mortuary outside working hours, as this was when the mortuary staff would have finished their jobs:

*"[I]f he was going into the mortuary to do work and if he knew that he was doing it and he'd already spoken to them, he wouldn't have gone in there till after four o'clock because we wait until they finish doing their jobs. And the mortuary staff all are gone at four o'clock. So, if he was having to go in and see a void or going somewhere, he would have had to have waited till four o'clock."*⁷⁷

David Fuller claimed that the pod system was most likely to break down between 4pm and 6pm:

"[T]he peak times for breakdowns for that [pod] system was between 4 and 6 p.m., so 4 p.m. to 6 p.m. Multiple use from pathology above and the pharmacy. So, the breakdown would be in that particular time, nearly every day, nearly every day ... I would liaise with him [Mr Crossley, Lead APT] of when we could actually go and fix certain things that needed doing."

David Fuller was known to have a bad back and associated health issues. This limited his ability to undertake physical tasks such as climbing ladders and lifting. Seventy-two per cent of Interserve employees or ex-employees who spoke to the Inquiry talked about David Fuller having a bad back or some other long-term health issue, and of him being desk-bound.⁷⁸ David Fuller's ill health is explored in more detail later in this chapter.

- Despite David Fuller's colleagues being aware of his bad back, we found little evidence that they questioned whether he should have been climbing ladders in the post-mortem room to repair the pod system.

N127, who worked at Interserve from 2016, told us that David Fuller was reluctant to do physical jobs generally, but would do them in the mortuary:

*"We've got quite strict SLAs [service-level agreements] and at the time we were severely understaffed, and we needed sometimes just someone to walk up there have a look, make it safe or you know pass the information what needs doing. And he wouldn't do that because of his bad back let alone use step ladders or something like that. And then he'd have his own step ladders in the mortuary doing working on a unit quite often."*⁷⁹

⁷⁷ Witness transcript of N128, Interserve manager from 2019.

⁷⁸ Witness transcripts of N126, N127, N128, N133, N147, N153, N156, N158, N160, N164, N169, N171, N407, N408, N409, N505, N542, N551, N566, N567 and N571.

⁷⁹ Witness transcript of N127, Interserve employee from 2016.

This view was shared by N409, an Interserve employee from 2014:

“He was desk-bound. But then he frequented the mortuary as well. Especially out of – in the evenings when all the management had gone home ... I remember ferrying the tallest ladder we have from one end of the hospital to the mortuary. And yes, he would take the ladder and then go in there.”⁸⁰

One of David Fuller’s colleagues helped him in this task. N147, who has worked in maintenance at hospitals within the Trust and its predecessor organisations since 1988, and as part of Interserve from 2011, told the Inquiry that they recalled assisting David Fuller to repair the pod system due to his ill health:

“I’ve been in there before with him. Because obviously he’s got his dodgy feet and stuff and obviously his back and that and he might say ‘oh can you give us a hand footing the ladder’ and stuff. Sometimes it is a 2-man job because you have to get quite high up, above the ceiling and that. Yes, no, it is, it definitely is a 2-man job, I wouldn’t really recommend one person doing it.”⁸¹

N157, an Interserve employee from 2010, and a supervisor from 2015, told the Inquiry that they were surprised that David Fuller undertook this task because *“[i]t’s a solid ceiling and we had a hatch and it’s a squeeze ... you have to get inside of the ceiling to work on that unit. It’s not so easy [a] job to do it.”⁸²*

- From the evidence we heard, it appears that David Fuller climbing ladders in the post-mortem room to repair the pod system was accepted, despite his colleagues being aware that he had a bad back. This reinforces our conclusion that there was a lack of curiosity about David Fuller doing physical tasks despite his ill health.

The three APTs who worked in the mortuary at Tunbridge Wells Hospital knew that David Fuller was repairing the pod system and allowed him to access the post-mortem room, unsupervised, to do so. All three provided statements to the Inquiry. All three made similar statements: *“[I]t was not unusual for DF to ask to be let into [the post-mortem] room to ‘unblock’ the pod system”, and “There was no requirement to supervise him hence he was left to complete the work he had advised he had arrived to carry out.”⁸³* They also said that *“[t]here was no cause for mortuary staff to check in”* on David Fuller when he was undertaking work in the post-mortem room.⁸⁴

At interview, the three APTs were asked about their understanding of the HTA standard 2017 relating to security, which states: *“Security arrangements should ensure oversight of visitors and contractors who have a legitimate right of access”*, and, specifically, the term

80 Witness transcript of N409, Interserve employee from 2014.

81 Witness transcript of N147, worked at hospitals within the Trust since 1988 and Interserve from 2011.

82 Witness transcript of N157, Interserve employee from 2010, supervisor from 2015.

83 Written transcripts of N130, APT, worked in mortuaries at the Trust, 2014–2023; N131, APT, worked in mortuaries at the Trust since 2012; and Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011, January 2023.

84 Ibid.

*"ensure oversight".*⁸⁵ All three told the Inquiry that they did not personally supervise contractors and maintenance staff when undertaking tasks in the mortuary as they did not have the time to do this.⁸⁶

One APT, N131, told the Inquiry that they did not believe there to be a requirement to supervise David Fuller when he was in the post-mortem room to undertake maintenance tasks, as they were under the impression that it was part of his role. They confirmed that he arrived with a tool bag and clipboard and there appeared to be a legitimate reason for him accessing the post-mortem room during working hours. They also commented that he would usually contact the department beforehand to say what jobs he needed to do and how long he would need to carry them out. They told the Inquiry that they did not regard him as a visitor but rather as an authorised member of Interserve staff, who used his access card to gain entry. This appeared to them to be in accordance with the local security arrangements.⁸⁷

Mr Deal, Mortuary Manager between 2016 and 2021, told the Inquiry that this level of supervision was infeasible given the number of staff in the mortuary. Dr Chambers, the current DI, also told the Inquiry: *"[T]here aren't enough of you to just have someone standing there constantly making sure that that's what they're doing. You have to trust, you have to trust people, don't you?"*⁸⁸

David Fuller told the Inquiry that he carried out maintenance work when the deceased were laid out in the post-mortem room at Tunbridge Wells Hospital and that Mr Crossley, the Lead APT, knew about this: *"And quite often Ken would say, 'would you mind being able to look at this? Would you mind doing that when there are bodies out?'"*

The Inquiry asked Mr Crossley if he had allowed David Fuller to undertake maintenance tasks in the post-mortem room when the deceased were laid out there. He responded:

*"If it was maintenance and we had patients out in the post-mortem room, they would've been covered up. It must've been something to do with the pod system, that was, by its very design, located above the post-mortem room ceiling, and that's where the access point was for this pod system that does samples and that up to the labs. Not from the mortuary, but other areas of the hospital. I can't recall any other requests that we would've asked him if we knowingly had patients out in the post-mortem room. I'm not saying I didn't, but I can't recall that being."*⁸⁹

Leaving the deceased out overnight in the post-mortem room was explained by Mr Crossley as being both for contingency purposes, if there was limited fridge room, and to aid the post-mortem process:

85 Witness transcripts of N130, APT, worked in mortuaries at the Trust, 2014 to 2023; N131, APT, worked in mortuaries at the Trust since 2012; and Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

86 Ibid.

87 Response received during the Inquiry's Fairness Process from N131, APT, worked in mortuaries at the Trust since 2012.

88 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

89 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

“You must appreciate that the fridges would take the deceased down to about three degrees. That makes them difficult to work with when they’re having a post-mortem. It’s more dangerous for the APTs and it’s not conducive to an efficient and smoother running post-mortem examination, because of that. ‘Cause the body is ... has gone harder, the organs are more rigid, the fat tissues are more solid, and it is a more difficult process to do. Putting them in overnight, it was still a cool room, it’s not like a warm room like this room, but it just elevated the temperature just that couple of degrees and made the process better for all concerned.”⁹⁰

When asked if this had become routine practice, Mr Crossley responded: “A semi-routine practice”, and, when pressed, told us that it had occurred “frequently”.⁹¹ Mr Crossley said that leaving the deceased out overnight to aid the post-mortem examination “was piggybacked off the assumption that it was an okay place to put patients overnight, because it was deemed as okay for contingency purposes”.⁹² Mr Crossley could not recall when the practice had started. See Chapter 2.

The other APTs at Tunbridge Wells Hospital confirmed that the deceased were left out in the post-mortem room overnight.⁹³

This practice was still taking place after David Fuller’s arrest, when in January 2021 it came to the attention of Mr Miles Scott, Trust Chief Executive since 2018, and was reported to the HTA. Mr Scott told us that it “clearly was some very old-fashioned practice that had continued” and that it was done “at the behest of certain pathologists. So that the bodies were easier to work on”.⁹⁴

“They were A: ready very first thing in the morning. And B: easier to work on. And that’s why they did that ... I’m not an APT but I understand that that was relatively common practice, quite a number of years ago. But would not be considered to be good practice now. Quite rightly ... not because it’s kind of practically unsafe or something, but because it’s not a dignified ... it’s not appropriate. And it’s done for the – it’s a practice that’s about the convenience of the pathologists and the convenience of the team ... and they’ve just got the balance wrong ... even if you shroud the body, you’ve got the balance wrong between the convenience of the staff [and] the dignity of the body.”⁹⁵

Dr Chambers, the DI at the Trust from 2014, who conducts PMEs at Tunbridge Wells Hospital, and Mr Deal, the Mortuary Manager between 2016 and 2021, both told the Inquiry that they were not aware that the deceased were being left unrefrigerated overnight prior to PMEs.

The Independent Advisers to the Inquiry noted, based on their experience, that this practice of leaving the deceased overnight in the post-mortem room is not in line with normal mortuary practice. They also noted that if fridges were properly maintained at the

90 Ibid.

91 Ibid.

92 Ibid.

93 Witness transcripts of N130, APT, worked in mortuaries at the Trust, 2014 to 2023; and N131, APT, worked in mortuaries at the Trust since 2012.

94 Witness transcript of Mr Miles Scott, Trust Chief Executive since 2018.

95 Ibid.

correct temperature, the idea that this practice would in some way mean the bodies of the deceased were *"easier to work on"* is unfounded in relation to routine practice.

- Leaving the deceased out of fridges overnight in the post-mortem room is not in line with HTA requirements and does not safeguard the dignity and safety of the deceased.
- From the evidence reviewed by the Inquiry, it is clear that staff in the mortuary at Tunbridge Wells Hospital did not question how appropriate it was to allow David Fuller unsupervised access to the post-mortem room. By leaving the deceased out overnight in the post-mortem room, the mortuary staff did not safeguard the dignity and safety of the deceased, especially when they were aware that maintenance staff, including David Fuller, may have entered the room to carry out repairs.

This practice compromised the safety of the deceased, leaving David Fuller able to sexually offend against the deceased left out in this way on one occasion at Tunbridge Wells Hospital, and potentially more in both the hospitals where he worked, as discussed in Chapter 2.

We were struck that the reported discussion between David Fuller and Mr Crossley, the Lead APT, about this practice appears to have focused on consideration of David Fuller's wellbeing, rather than any consideration of the dignity and safety of the deceased.

That this practice was still taking place following David Fuller's arrest is concerning and illustrative of the lack of internal controls and management in the mortuary, as set out in Chapter 4.

3.2.7 Mortuary toilet

In addition to entering the mortuary to carry out maintenance tasks, we heard that David Fuller would go in to use the toilet there. David Fuller told us that he used the mortuary disabled toilet as a consequence of his health problems.

That David Fuller used the mortuary toilet was known by his Interserve colleagues. Five employees or ex-employees of Interserve told the Inquiry that David Fuller would go into the mortuary to use the toilet.⁹⁶ Of those, two commented that they or others did not feel comfortable in the mortuary.

N155, an Interserve employee from 2018, said that other Interserve staff did not use the mortuary toilets as: *"No-one likes going in there."*⁹⁷

N409, who worked for Interserve from 2014, said that others in the Interserve team also knew that David Fuller used the mortuary toilet as he would talk about it in the office. N409 went on to say that they did not like to use the Interserve toilet either so would use other toilets at the hospital. However, N409 would not have considered using the mortuary toilet as: *"I've never felt comfortable in the mortuary. But yes. I didn't question*

⁹⁶ Witness transcripts of N153, N155, N164, N409 and N410.

⁹⁷ Witness transcript of N155, Interserve employee from 2018.

that. I thought maybe he was a bit lazy to go upstairs, so he'd just go next door. That's what I thought at the time."⁹⁸

- This is an example of the lack of curiosity shown by David Fuller's Interserve colleagues regarding his behaviour at work. Using the mortuary toilet gave David Fuller another seemingly legitimate reason to visit the mortuary and contributed to the normalisation of his presence there.
- It is not clear to the Inquiry whether mortuary staff knew how frequently David Fuller used the toilet in the mortuary. However, as the fact that he did was well known to his Interserve colleagues, the Inquiry is of the view that the mortuary staff should have known about the practice and should have questioned it.

3.2.8 Others feeling uncomfortable in the mortuary

Of the 29 employees or ex-employees of Interserve the Inquiry interviewed, 41 per cent spoke about how they or their colleagues did not like going into the mortuary.⁹⁹ Of those 12, four commented in some way that they were therefore happy for David Fuller to do the jobs that warranted entering the mortuary.

*"If you don't have to go in [the mortuary], you don't want to go in because, alright it's a hospital, but it's not nice, if you know what I mean?"*¹⁰⁰

*"To be honest, I don't like going in there anyway, do you know what I mean?"*¹⁰¹

*"He was the sort of 'go to' man for the mortuary I mean ... most of us others it is not the most pleasant place to work in and I have personally you know I work in there but I don't find it pleasant so if he was prepared to go in there so be it, let him go in and do it you know erm."*¹⁰²

*"And I made sure I went [to the mortuary] with a colleague of mine. Because I'd never felt comfortable working in there. Especially on out of hours."*¹⁰³

*"It [the mortuary] just wasn't a place ... they [engineers] used to be absolutely petrified going in there to be honest with you ... But David would always say, 'well I'll do it, then'. [N410, when asked if anyone found this curious, replied:] No. Not really, they were just glad that he did it, really."*¹⁰⁴

98 Witness transcript of N409, Interserve employee from 2014.

99 Witness transcripts of N127, N129, N147, N155, N156, N160, N169, N408, N409, N410, N551 and N566.

100 Witness transcript of N129, Interserve employee from 2020.

101 Witness transcript of N147, worked at hospitals within the Trust since 1988 and Interserve from 2011.

102 Witness transcript of N169, Interserve employee from 2015.

103 Witness transcript of N409, Interserve employee from 2014.

104 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

- While a significant proportion, 41 per cent, of David Fuller's colleagues interviewed by the Inquiry felt uncomfortable going into the mortuary, they did not appear to have been curious about why he was so willing to do so. They did not make connections between their own feelings of discomfort with the mortuary and David Fuller's apparent ease working in that environment.

3.3 Management and supervision of David Fuller

David Fuller began his employment in the NHS when he joined Kent and Sussex Hospital in 1989 as an electrical maintenance craftsman. He became an electrical maintenance supervisor on promotion in 2002. His employment transferred to Interserve in 2011.

3.3.1 Disciplinary matters

The Inquiry is aware of one disciplinary issue involving David Fuller.

A meeting was held in May 1998 where David Fuller was told to remove non-Trust computing and printer equipment and to immediately cease non-Trust-related work on site, either within or outside working hours. The note on David Fuller's personnel file says that this was not a formal disciplinary matter. However, it does say that performance monitoring of David Fuller was to take place. There are no further documents relating to this matter in the personnel files.

3.3.2 Appraisal

The Inquiry has evidence of only one appraisal undertaken for David Fuller throughout his 31-year employment with the NHS and then Interserve.

The appraisal was conducted in November 2010 by his NHS line manager at that time and is very positive. This appraisal states: "*[N]o previous appraisal has been carried out.*"¹⁰⁵ The form also states: "*David would be very happy to be Tupid [transferred] over to the PFI 19th May 2011.*"¹⁰⁶

The 2020 Interserve Colleague Handbook and the 2017 Employee Handbook state: "*[A] performance and development review process (PADP) meeting will take place with your line manager at the end of your probation and usually annually thereafter for appraisal purposes.*" An undated Induction Policy from Interserve also refers to an annual performance appraisal review. The Interserve Record Retention Policy states that appraisals should be kept for "*6 years after employment ceases*". However, Mitie, which took over Interserve in 2020, confirmed that no records of further appraisals for David Fuller can be found.¹⁰⁷ From the evidence available to the Inquiry, it would appear that Interserve was not complying with its own guidance.

¹⁰⁵ Information from Kent Police.

¹⁰⁶ Ibid.

¹⁰⁷ Email response of N13, 25 October 2022.

3.3.3 Sickness absence

David Fuller sustained an injury to his back at work in 2004. The Inquiry has seen evidence that there were ongoing issues with back pain which were the cause of several periods of sickness absence during David Fuller's employment, substantially so between 2007 and 2008, and in 2010, involving several weeks of absence from work and occupational health referral and advice.

The Inquiry reviewed evidence that David Fuller was absent from work with back problems between April and October 2010.¹⁰⁸ There was a break in offending between March and November that year which might be explained by this period of sickness. David Fuller's personnel file shows that, between October and December 2010, there was a planned, phased return to work, with a gradual increase in the number of hours worked and duties undertaken. The Inquiry found that, in November and December 2010, David Fuller offended on five occasions during this phased return to work.¹⁰⁹ There is no evidence that David Fuller offended during periods of sickness.

By December 2010, it appears from David Fuller's personnel file that he was working his full contracted hours and undertaking a mix of sedentary and active duties. Occupational health advice anticipated a tentative increase in the physical duties David Fuller could undertake but noted some caution about prolonged activity.

David Fuller told us that he experienced continuing difficulties with his health as a consequence of his back injury, and that on the transfer of his employment to Interserve in May 2011, he was taken on as a desk-bound supervisor. The Inquiry was told that this was the case by Mr Crittenden, David Fuller's line manager in the periods 2012 to 2015 and 2016 to 2020. Although not his line manager at the time, Mr Crittenden told the Inquiry that he was aware that, on transferring to Interserve in 2011, David Fuller had a health and safety risk assessment and was advised to be predominantly desk-bound:

"[H]e was supposed to be limited to not climbing on ladders, not lifting heavy weights etc, so he was, although he wasn't completely desk bound, he was predominantly desk bound, but he could get up and move about and go out and work on some of the systems."¹¹⁰

This contrasts with evidence the Inquiry heard of David Fuller undertaking physical work – for example, climbing ladders in the mortuary (from N409):

"He was desk-bound. But then he frequented the mortuary as well. Especially out of – in the evenings when all the management had gone home ... I remember ferrying the tallest ladder we have from one end of the hospital to the mortuary. And yes, he would take the ladder and then go in there to, you know [repair the pod system] ... And he would say he could carry on from here. All he needed [was] to ferry it from where it was stored to the mortuary for him to do his job."¹¹¹

108 David Fuller personnel file.

109 Offending data from Kent Police.

110 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

111 Witness transcript of N409, Interserve employee from 2014.

Mr Crittenden said that 90 per cent of the time, David Fuller was working within the health and safety risk assessment. David Fuller told us that at Interserve:

"My working day was constantly office bound shall we say, because within the new hospital everything was computerised and system analysing and alarm systems, all just surrounding me. So, if I didn't want to, I just could sit there all day and just watch the alarm systems ... And my job was to monitor everything like that and give out the information to the engineers to go off and do something about it."

However, David Fuller also told us: *"[I]t was never the intention to be fully office bound"*:

"Well, unfortunately you never have enough staff ... so I've always had to go round and do minor tasks and assessments of jobs to see how bad, because although a computer tells you that something's wrong, it's only an alarm to say something's wrong, then you physically have to go and inspect it to then give that information to the engineers for them to go off and do it, or I would fix it myself."

David Fuller's personnel file shows that there were further episodes of sickness and, in March 2017, an occupational health referral listed among the reasons 'historic back problems' and 'leg circulation issues'. Mr Crittenden estimated on the referral that 15 per cent of David Fuller's daily activities required physical agility and strength.

- The evidence in relation to David Fuller's sickness absence from work and related occupational health assessments reinforces to the Inquiry that there was a lack of questioning in relation to the tasks that David Fuller was known to be undertaking in the mortuary, despite his ill health. That David Fuller had a bad back or some other long-term health issue was well known among his Interserve colleagues. Sixty-nine per cent of Interserve employees and ex-employees who spoke to the Inquiry talked about David Fuller being desk-bound.¹¹²

3.3.4 Performance and working hours

The Inquiry heard that David Fuller had an established practice of working long hours, often into the evening and later. This is described earlier in this chapter; here, we consider the management response.

We heard from one Interserve supervisor and two Interserve managers that there was concern about David Fuller's slow work pace, which meant that he frequently worked late into the evening.¹¹³

N392, an Interserve manager from 2010 to 2016, told us that, although they were not David Fuller's line manager, they had *"stand up rows"* with him about unfinished work and that *"on a regular basis the frustration in relation to David's performance would be raised"*.¹¹⁴

112 Witness transcripts of N126, N127, N128, N133, N147, N153, N156, N158, N160, N164, N169, N171, N407, N408, N409, N505, N542, N551, N566 and N571.

113 Witness transcripts of N392, Interserve manager, 2010–2016; N551, Interserve supervisor, 2014–2017; and Mr Andy Curley, Interserve General Manager, 2015–2017.

114 Witness transcript of N392, Interserve manager, 2010–2016.

N392 told us: “[O]n a regular basis, he was either poorly or he’d sort of promised something and he’d be working until 10 o’clock to get something done” but that “all you saw was this great skillset that you couldn’t afford to lose from the team because technically he was great.”¹¹⁵

N392 told us that they regularly – “every team meeting”¹¹⁶ – raised concerns about David Fuller but that they were told to back down:

“I’d be like ‘David, give it to the boys! Get it done tonight! Why are we picking up penalties because you’re fanning around!’. He used to drive me crazy. But everyone would say to me, ‘You’ve got to stop breathing down his neck. He’s NHS, he’s old school, calm down.’”¹¹⁷

When N392 was asked if they had ever raised a concern formally, they told us:

“Not formal, no ... that was my first experience of working with anyone that works in the public sector. I’ve always worked in the private sector. And I was suddenly going to – I’m not being rude in any way, shape, or form but I’d go over to Maidstone hospital, and I’d see exactly the same thing happening with their Estates team. Very slow, at their own pace, they’ve got jobs open for like two years. It wasn’t unusual. There’s a bucket underneath the ceiling tiles and it’s been there for six years, and Maggie’s complained but nobody cares. ‘There’s not enough money, there’s not enough time.’ So, because I’ve been exposed to other characters of this nature, because he would get there, because he did get the work done eventually, because he stayed so late to get it done, I just thought he was doing his due diligence. And it would infuriate me because I would be like ‘Well why’s he – come on! Like no.’ And we’d hand out as much work as we could, but you were dealing with someone who was part of the family. It was just David’s way.”¹¹⁸

N551, an Interserve supervisor from 2014 to 2017, told the Inquiry that David Fuller was slow at preparing the planned maintenance schedules for the engineers, which would be incomplete at month-end.¹¹⁹ However, instead of addressing David Fuller’s performance, managers gave the task to someone else:

“So, he kind of dithered over it a lot ... numerous excuses of him having to work late because he was struggling getting the PPMs [planned preventative maintenance] done or there was a problem, so he would quite often stay late ... he took too long to do them and pretty much the following month when they were issued out, I was having to go through them and sort a lot of problems out and mistakes out. So, it come to the point where the estate officers went enough is enough. Can you do it? So that’s kind of how that come about. He would still work long hours, because he would find a reason to stay late, you know ... There would always be something that he would need to deal with that would kind of mean he’d be there late.”¹²⁰

115 Ibid.

116 Ibid.

117 Ibid.

118 Ibid.

119 Witness transcript of N551, Interserve supervisor, 2014–2017.

120 Ibid.

In 2016, concerns continued to be raised. The Inquiry has seen evidence that one Interserve manager, N550, and a supervisor, N551, raised concerns with David Fuller about the hours he was working:

*"Dave as for the length of time you are on site, I would like you to stick to the times that day time supervisors have always done, as from 1st March 2016 please can you keep your working times to 08:00am - 16:00pm. I appreciate this is a big change for you, hence over a month's notice."*¹²¹

*"I am really concerned about the times you are working to though. I do not want you working so late unless it is absolutely imperative or an emergency, if you have issues getting your workload done then we need to look at this and how we can deal with it. I would like to sit down with you next week so we can discuss and sort."*¹²²

In contrast, Mr Crittenden, David Fuller's line manager, told the Inquiry that David Fuller's working hours were not a concern:

*"No. No, honestly ... the impression I got was that he was always productive ... As a rule, we tended to make it almost like a flexible hours ... I didn't have any concerns or issues about what he was doing."*¹²³

Mr Crittenden had known David Fuller since the late 1980s and worked with him from 2011, becoming David Fuller's line manager in 2012. Mr Crittenden told the Inquiry that David Fuller was *"almost autonomous in the way that he was working"*, and that this was largely expected as a supervisor.¹²⁴ Mr Crittenden felt that David Fuller was *"very efficient"; "thorough, somebody who would like to delve into something and take it apart and get it fixed"*.¹²⁵

N147, who had worked with David Fuller at hospitals within the Trust since the late 1980s, told us that David Fuller and Mr Crittenden were *"good friends and I think Trevor just used to let him get on with it, do you know what I mean. Dave was sort of like his own entity, Trevor just used to let Dave get on with whatever he was doing."*¹²⁶

That Mr Crittenden did not address David Fuller's slow work pace was a matter of frustration for Mr Curley, the Interserve General Manager, who worked at Tunbridge Wells Hospital between 2015 and 2017. Mr Curley told us that David Fuller was:

*"Very unproductive and always had an excuse about an illness ... or family issue and he didn't want to go home ... he decided when I said I would stop his pay [overtime] ... he said he would work late at night free because he didn't have a good home life ... I said that's up to you, work the hours for nothing. As long as I see some productivity out of it."*¹²⁷

121 Email, N550 (Interserve manager, 2015–2018) to David Fuller, January 2016.

122 Email, N551 (Interserve supervisor, 2014–2017) to David Fuller, November 2016.

123 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

124 Ibid.

125 Ibid.

126 Witness transcript of N147, worked at hospitals within the Trust since 1988 and Interserve from 2011.

127 Witness transcript of Mr Andy Curley, Interserve General Manager, 2015–2017.

Mr Curley felt that Mr Crittenden made allowances for David Fuller: *“I tried to get him not to work them hours with him but it just carried on.”*¹²⁸ Mr Curley described David Fuller as *“unmanageable”*:¹²⁹

*“He was one of these type of people, been there so long you couldn’t manage him properly because he’d been like that for a long time according to his work colleagues.”*¹³⁰

Mr Curley told the Inquiry that, although he tried to address David Fuller’s practice of working long hours, other priorities meant that he could not see this through. Mr Curley also told us that he encountered cultural resistance which he put down to the resentment of staff who had transferred from the NHS to Interserve: *“And I was trying to break a culture and it wasn’t just Mr Fuller, with the rest. They wouldn’t tell me anything.”*¹³¹

In contrast, Mr Crittenden, David Fuller’s line manager, told the Inquiry: *“I was actually defending David almost on a daily basis to this onslaught from [Mr Curley], so it wasn’t a nice situation to be in.”*¹³² Mr Crittenden told us that he raised a concern with Interserve HR department, following an episode between Mr Curley and David Fuller that particularly upset David Fuller.¹³³ Mr Crittenden informed the Inquiry that others had raised no concerns with him about David Fuller’s working hours, only his level of productivity.¹³⁴ The Inquiry considers that, although concerns may not have been raised directly with Mr Crittenden, he did know that it was David Fuller’s practice to work well beyond his contracted hours.

- In conclusion, the Inquiry notes that there is some disagreement regarding the exact nature of the concerns raised with Mr Crittenden, David Fuller’s line manager, about David Fuller’s working practices, whether they related to his long working hours or only about his levels of productivity. It is clear to the Inquiry, however, that whatever concerns were raised they were not fully addressed. There was a failure to address the established practice of David Fuller regularly working late into the evening, and this was permitted to continue for many years. It appears that aspects of David Fuller’s performance at work were overlooked because of long-standing relationships between him and managers and the value they placed on his perceived technical expertise.
- A significant proportion of David Fuller’s offences – 62 of the 140 offences – were committed between the hours of 6pm and 8pm, with 19 offences occurring between 8pm and midnight. Had the performance issues been addressed more vigorously, stopping David Fuller regularly working late into the evening, it may have limited his opportunity to offend in the mortuary.

128 Ibid.

129 Ibid.

130 Ibid.

131 Ibid.

132 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller’s line manager, 2012–2015 and 2016–2020.

133 Ibid.

134 Ibid.

- Concerns about David Fuller's slow work pace and consequent impact on his working hours were the subject of discussion among Interserve managers in 2013 but were not resolved. The practice persisted, not unnoticed by Interserve managers. An informal arrangement in 2016 to improve shift handover permitted David Fuller to work late starts and finishes, but still he continued to work beyond his shift. Interserve's General Manager, Mr Curley, told the Inquiry that, during the period 2015 to 2017, he was pressing Mr Crittenden, David Fuller's line manager, to address these performance issues, but David Fuller's work hours remained unchecked. However, Mr Crittenden contends that he was not informed about concerns about David Fuller's working practices, only about his productivity.¹³⁵
- The change to David Fuller's shift pattern in 2016 gave him a legitimate reason to be at work during the timeframe in which he most frequently offended and during which he knew he was unlikely to be disturbed. The failure to manage David Fuller's working hours was a missed opportunity which could have prevented him from committing offences in the mortuary.

3.3.5 Work undertaken in the mortuary

Earlier in this chapter, we explored the maintenance tasks that David Fuller undertook in the mortuary. Here we consider the managerial response to the tasks David Fuller undertook there and the amount of time he spent there.

David Fuller entered the mortuary 444 times between December 2019 and December 2020 and offended on 20 occasions during that time.¹³⁶ Yet there is no record of David Fuller undertaking reactive maintenance work in the mortuary after 9 October 2018. It is therefore clear to the Inquiry that David Fuller was in the mortuary more often than was recorded.

It was well known among David Fuller's Interserve colleagues that he visited the mortuary frequently to respond to faults with the pod system and to attend to the fridges.¹³⁷ Of the 22 Interserve employees who spoke of David Fuller attending to the fridges and/or pod system in the mortuary, seven were in a managerial role and four were in a supervisory role.

N408, an Interserve manager from 2018 to 2020, told the Inquiry that David Fuller would often tell them that he had attended to maintenance tasks in the mortuary, such as the fridges over-heating in the summer months, but that they did not check that these tasks had been logged on the Interserve system: *"I honestly never checked, is the honest answer. I took his word for, 'cos I had no reason not to."*¹³⁸

135 Response received during the Inquiry's Fairness Process from Mr Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

136 David Fuller's swipe card, 16 December 2019 to 3 December 2020.

137 Fifty-nine per cent of the 29 Interserve employees we spoke to knew that David Fuller went into the mortuary to attend to the fridges. Sixty-six per cent of the 29 Interserve employees we spoke to knew that David Fuller went into the mortuary to attend to the pod system.

138 Witness transcript of N408, Interserve manager, 2018–2020.

However, N128, an Interserve manager from 2019, told the Inquiry of an instance when David Fuller removed door guards from the external doors to the mortuary, without going through the usual process:

"[N]ormally that would have gone through as a small works variation because we're removing an asset, if that makes sense ... it has to be a variation to add an asset, likewise if you're taking one away. So that was my, that was my thing that he took this off, but he hadn't gone through the proper process to actually remove it. It was more a favour rather than an actual job.

Q: *Do you know if anybody questioned him about carrying out that job?*

A: *No ... it was like I say he was, he was, he was ranked as a manager, so, if David felt it was, it was something that needed to be done and he'd been asked to do it [by the mortuary staff] and he done it, no one would have questioned it."*¹³⁹

Yet the Inquiry was told by N410, who worked at Kent and Sussex Hospital switchboard from 2008 to 2010, and then for Interserve helpdesk between 2010 and 2019, that they did raise concerns with managers:

*"We queried, once or twice, why David was going into the mortuary without a paper trail, and he told us he was doing them a favour. If we ever queried anything with the then manager or the office, we were just told to shut up, basically."*¹⁴⁰

However, four of the managers we spoke to could not recall concerns being raised about David Fuller's work in the mortuary.¹⁴¹ Mr Vaughan, General Manager at Interserve from 2010 to 2015, told us:

*"As far as I am aware, none of his line managers [brought] that to me saying 'We've got a problem here. David's doing work and it's not being recorded.'"*¹⁴²

N392, an Interserve manager from 2010 to 2016, told us: *"I don't ever remember anyone saying to me 'David's doing too many jobs in the mortuary.' That conversation definitely never happened."*¹⁴³

- Interserve was contracted to resolve tasks within set time periods, and it was therefore important to have accurate reporting of the maintenance tasks its employees were undertaking. This does not appear to have been the case with the maintenance tasks that David Fuller was undertaking in the mortuary.

139 Witness transcript of N128, Interserve manager from 2019.

140 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

141 Witness transcripts of N392, Interserve manager, 2010–2015; N408, Interserve manager, 2018–2020; Mr Dale Vaughan, General Manager, Interserve, 2010–2015; and Mr Andy Curley, Interserve General Manager, 2015–2017.

142 Witness transcript of Mr Dale Vaughan, General Manager, Interserve, 2010–2015.

143 Witness transcript of N392, Interserve manager, 2010–2016.

- As explored earlier in this chapter, David Fuller developed a practice of regular monitoring of the fridge temperatures in the mortuary. There was no requirement for these checks to be carried out given the remote monitoring in place, but this practice went unchallenged by Interserve managers. The evidence we have heard indicates a failing of successive Interserve managers to question and challenge the work that David Fuller was undertaking in the mortuary.

3.4 Perceptions of David Fuller

In this section, we consider perceptions of David Fuller prior to his arrest by those who worked with him. We examine whether there is consistency in those perceptions, and if there is evidence of contrasting perceptions. We then consider to what extent those perceptions contributed to David Fuller being able to offend, unnoticed, for so long.

Sixty witnesses shared their perceptions of David Fuller with the Inquiry, providing insight into his behaviour at work.

3.4.1 Interserve employees

The Inquiry spoke with 29 Interserve employees and ex-employees who worked with David Fuller. A small number had worked with him since the 1980s.

The predominant view we heard of David Fuller was that he was a polite, kind, well-mannered, gentle, placid and intelligent man. The majority of David Fuller's Interserve colleagues, 69 per cent, described him in positive terms:

*"Polite, courteous, kind ... Totally a lovely bloke ... family man ... very professional."*¹⁴⁴

*"I just seen him as a really sweet old man ... he was always, always really nice to everyone."*¹⁴⁵

We heard that David Fuller was helpful, easy to chat to, had shared interests with some colleagues, and that he was at times an advocate for staff, raising concerns with managers on behalf of others.¹⁴⁶

Seven of David Fuller's colleagues described him as a father figure or mentor and we heard accounts of deeper, familial-type relationships:¹⁴⁷

*"He was everybody's you know great uncle sort of character."*¹⁴⁸

144 Witness transcript of N164, Interserve employee from 2017.

145 Witness transcript of N506, Interserve helpdesk employee from 2016.

146 Witness transcripts of N126, N133, N155, N157, N169, N392, N409, N410 and N506.

147 Witness transcripts of N128, N392, N407, N409, N505, N506 and N571.

148 Witness transcript of N128, Interserve manager from 2019.

Two female colleagues, who had known David Fuller for a number of years, told us that they trusted him, that he was a confidant and that they did not feel unsafe in his presence:

*"He was classed as my work husband because we got on so well. But he knew a lot about me, we talked about each other's lives you know, in my eyes he was my work dad ... I wouldn't have said any of his behaviour towards me was unusual. He was there if I needed him, we'd go up and have breakfast in the canteen or lunch sometimes, you know, I never worried about being on my own with him ... No issues, did not feel unsafe being in his presence at all."*¹⁴⁹

*"[H]e was a confidant for years ... he would walk me back to my car ... And if anyone was gonna walk me back to my car it would be David because I, he, it was David like he was the most trustworthy."*¹⁵⁰

*"[H]e was Mr reliable if you had a problem."*¹⁵¹

Three Interserve managers, N408, N128 and N156, told us that David Fuller was respected and held in high regard, with N408 saying that *"all the other managers spoke very highly of him"*.¹⁵²

Forty-five per cent of Interserve staff¹⁵³ spoke of David Fuller's technical expertise, including two Interserve managers who told us that David Fuller was technically brilliant in his role, with knowledge of hospital systems that staff relied on:

*"[T]echnically David was the best when it came to the systems in the hospital ... he would bring whatever it was ... and he'd take it apart at his desk and we'd be like 'have you called the contract' 'no, no, no we can do this ourselves' and he'd fix things."*¹⁵⁴

*"We had a bank of BMS, pneumatic tube controllers, nurse call systems, that type of stuff. And David was a whizz on it. David knew absolutely everything you could do with them systems. Any issue we had with them, David would solve it, not a problem."*¹⁵⁵

This view was shared by Mr Crittenden, David Fuller's line manager in the periods 2012 to 2015 and 2016 to 2020, who described him as having *"a wealth of experience"*, being *"diligent"* and *"somebody who was seemingly proactive in resolving issues and sorting issues and identifying issues before they got to the stage of oh God, it's fallen over"*.¹⁵⁶

149 Witness transcript of N571, Kent and Sussex Hospital helpdesk employee from 2006, Interserve manager, 2011–2017.

150 Witness transcript of N392, Interserve manager, 2010–2016.

151 Ibid.

152 Witness transcript of N408, Interserve manager, 2018–2020.

153 Witness transcripts of N129, N147, N153, N155, N156, N162, N164, N169, N392, N408, N506, N551 and N567.

154 Witness transcript of N392, Interserve manager, 2010–2016.

155 Witness transcript of N408, Interserve manager, 2018–2020.

156 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

In contrast, three members of Interserve staff doubted David Fuller's technical expertise.¹⁵⁷ N126, an Interserve employee from 2019, told us that they "*didn't count on him*" because "*any bigger problem we had, when I asked him, he wasn't right*".¹⁵⁸ Mr Curley, the Interserve General Manager at Tunbridge Wells Hospital from 2015 to 2017, told us that he preferred the work of another electrical engineer.¹⁵⁹

These observations were in the minority. However, they demonstrate that there were senior staff within the Interserve team at Tunbridge Wells Hospital that doubted David Fuller's technical capabilities. If taken further, these views could have challenged the perception among Interserve staff that David Fuller was the 'go-to' man for specific hospital systems that gave him seemingly legitimate reasons to frequent the mortuary and therefore a cover for his crimes.

Another prominent perception expressed by David Fuller's Interserve colleagues was that he was a reserved and quiet man at work,¹⁶⁰ who "*kept himself to himself*";¹⁶¹ did not like change¹⁶² and sat in a corner of the office surrounded by paper and the BMS computer system.¹⁶³

*"He hated change, absolutely detested change ... He was stuck in a far side of the office where no-one could oversee what he was doing. It was literally his little area ... David was what I'd call old school. So, it was all paper."*¹⁶⁴

*"There was a lot of stuff we wanted to change to bring him more ... in a modern way, he was quite stuck into his ways. He was very stuck in his ways."*¹⁶⁵

*"Dave Fuller is an old guy who has got a bad back, you know, and lives over there in the corner playing with his computer."*¹⁶⁶

The Inquiry heard that David Fuller had a tendency to keep things to himself: "*David tended to keep everything locked away ... everything was constantly locked away*",¹⁶⁷ and, although the Inquiry heard that David Fuller was helpful, a mentor to younger staff and a source of advice to others,¹⁶⁸ N551, an Interserve supervisor between 2014 and 2017, told the Inquiry that it was difficult at times to get technical knowledge out of David Fuller:

*"[I]t was very much if you asked David how can we fix this – 'Oh no, leave it to me, I'll sort it out' kind of thing."*¹⁶⁹

157 Witness transcripts of N126, N127 and N566.

158 Witness transcript of N126, Interserve employee from 2019.

159 Witness transcript of Mr Andy Curley, Interserve General Manager, 2015–2017.

160 Witness transcripts of N129, N153, N158, N164, N409, N410, N566 and N567.

161 Witness transcripts of N156, N542, N551 and N567.

162 Witness transcripts of N156 and N408.

163 Witness transcripts of N147, N155, N408 and N505.

164 Witness transcript of N408, Interserve manager, 2018–2020.

165 Witness transcript of N156, Interserve helpdesk employee from 2015, manager from 2020.

166 Witness transcript of N155, Interserve employee from 2018.

167 Witness transcript of N551, Interserve supervisor, 2014–2017.

168 Witness transcripts of N126, N155, N157, N169, N392, N409 and N505.

169 Witness transcript of N551, Interserve supervisor, 2014–2017.

The Inquiry heard that David Fuller's sickness absence was the subject of office banter, that he was in financial difficulty,¹⁷⁰ that he seemed to colleagues to have no life outside work;¹⁷¹ and some told us that they felt sorry for him:¹⁷²

*"[W]e thought he had money issues and he had domestic issues at home. That's the picture he painted to some of us, you know, so. And he was always at work ... sometimes he would stay on until midnight. And yes, sometimes we pitied him that way. We thought he had no life outside of work. That's the way I saw him. And some other guys did too."*¹⁷³

The Inquiry also heard accounts of negative types of behaviour displayed by David Fuller in the workplace. Eleven Interserve colleagues spoke of David Fuller in this way, with descriptions ranging from being "moody", "challenging" or "strong-willed", to him displaying anger, having a temper and not being a person to cross.¹⁷⁴ Two of these Interserve employees held supervisory or managerial positions and spoke in most depth about David Fuller showing bad temper or anger in the workplace:

*"Strong-willed, I think is the best way to put it. He was very strong-willed ... You know, there was a couple of times ... David had come across as though you wouldn't [want to] cross him ... you could just tell you had pushed a button, and you needed to leave him well alone ... He was never physical, he was never abusive to me, at all ... It was just, you could just tell, he had got to [the end of] his line, and just, yeah, that's it, done."*¹⁷⁵

*"There was a couple of instances where we had cross words because I didn't agree with some of the stuff that was going on, as in respect of how he was building the work for the engineers with his PPMs and that ... we did have a bit of a row once as well and again it was over PPMs because they've taken off of him because he took so long to do them and it was given to me and he didn't like it and he sort of come in giving it a bit large and I sort of, you know, I stood my ground with him and wouldn't put up with his nonsense ... because I'd spoken to one of the electricians, he didn't like it."*¹⁷⁶

Another Interserve manager, N156, spoke of David Fuller not being willing to admit fault:

*"[David Fuller] never liked to admit if he'd done something wrong which I found quite frustrating ... he didn't take ownership was one of his traits."*¹⁷⁷

The Inquiry also heard an allegation that David Fuller lied about a colleague's work. This is covered in more detail later in this chapter.

170 Witness transcripts of N126, N127, N153, N169, N409 and N506.

171 Witness transcripts of N147, N153, N156 and N169.

172 Witness transcripts of N156, N164 and N409.

173 Witness transcript of N409, Interserve employee from 2014.

174 Witness transcripts of N126, N133, N156, N158, N169, N171, N392, N407, N408, N410 and N551.

175 Witness transcript of N408, Interserve manager, 2018–2020.

176 Witness transcript of N551, Interserve supervisor, 2014–2017.

177 Witness transcript of N156, Interserve helpdesk employee from 2015, manager from 2020.

The Inquiry has seen no evidence that these aspects of David Fuller's behaviour at work were addressed in any way.

- It appears to the Inquiry that there was an acceptance among the Interserve staff that David Fuller was a colleague who did not fully engage with them, who was set in his ways and who, as we have heard earlier in this chapter, built his role around the tasks he wanted to undertake, which gave him seemingly legitimate reasons to be in the mortuary. There was a tolerance of the negative aspects of David Fuller's behaviour, perhaps because of the perception that he was an ageing man, in poor health, who some pitied, but who was relied upon for his technical knowledge and experience.

3.4.2 Mortuary staff

The three APTs who worked in the mortuary at Tunbridge Wells Hospital at the time of David Fuller's arrest, described him with notable uniformity, using the same language ("meek and mild", "helpful", "obliging"), and similar terms such as "friendly" and "nice". Mr Crossley, the Lead APT, gave this description:

"He's very calm. Very erm, if he came into the department and we was even, just in the office doing paperwork, [sound of tapping] there's a little tap on the door and he'd come in, 'Am I disturbing? I need to ...', and he'd ask before he could go through to another department or something like that. Very polite, very amenable to one erm, of the girls had something that she had delivered for her boyfriend. He repaired it for her, you know? He was always willing to help yeah, and that's why he did become a go-to within the Interserve. Erm, if there was a nut needing tightening or the hoist was playing up in some way and it was a 2 minute fix, it's David there. And he was very obliging."¹⁷⁸

Earlier in this chapter, we heard that David Fuller would visit the mortuary frequently and that he became the main contact for mortuary staff on maintenance issues, and a trusted person who they left to get on with maintenance.

An example of this is an episode recounted by N131, an APT who had stayed late at work to do paperwork when David Fuller entered the mortuary out of hours. David Fuller explained that he was responding to an alarm from one of the fridges. However, N131 had not heard an alarm:

"I said, 'what you doing here?' and he said that he needed to – the alarm had gone off and I said there isn't – because there's – you can hear an alarm as well. He said 'I just want to just check the ...' – 'I went, yes, fine! Like how long you are going to be and then that was it."¹⁷⁹

178 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

179 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

N131 told the Inquiry that they did not feel the need to report the discrepancy of not hearing the alarm, nor did they indicate that they were disquieted by David Fuller's presence out of hours and in circumstances when they were alone.

David Fuller's line manager, Mr Crittenden, told the Inquiry that his perception of David Fuller's relationship with mortuary staff was that it "*grew organically*" from the interaction they had at the former Kent and Sussex Hospital, continuing at the new Tunbridge Wells Hospital: "*I think it just grew organically. Because of the way that he was, he had already been, interacted with the Trust previously in the other mortuary and come here, it was almost organic growth onto that.*"¹⁸⁰

David Fuller was not known to former Mortuary Managers who were based at Maidstone Hospital.

3.4.3 Perceptions of others

The Inquiry spoke to 25 portering and domestic staff who worked at Maidstone and Tunbridge Wells NHS Trust. Thirteen, or 52 per cent, knew David Fuller or had seen him around Tunbridge Wells Hospital.¹⁸¹ Of these, six members of staff described David Fuller in positive terms, such as "*nice*", "*polite*" and "*charming*".¹⁸² Four described him as "*very quiet*", "*never really making eye contact*" or "*withdrawn*".¹⁸³

The Inquiry spoke to 16 people working in security and estates at the Trust. Five of these knew David Fuller and were able to comment on their perception of him.¹⁸⁴ Their perception was of a "*helpful*", "*pleasant*" man who was "*quiet*", "*kept himself to himself*" and was "*meek and mild*". To some, he "*wouldn't engage*" and was "*difficult to interact with*".

A small number of people had perceptions of David Fuller that stand out from this predominant view.

N431, a senior nurse who worked at hospitals at the Trust and its predecessor organisations on and off from 1997, told the Inquiry that their first impressions of David Fuller were that "*he made my skin crawl ... not that he did anything ... But he's a bit strange.*"¹⁸⁵ This witness told us that their colleagues had described him as "*definitely a strange guy ... Hairs on the back of your neck.*"¹⁸⁶ They did not elaborate on the reason for such strong observations.

Two witnesses who had chance encounters with David Fuller gave their impressions of him, and these are covered in more detail in the following section of this chapter.

180 Witness transcript of Mr Trevor Crittenden, Interserve supervisor then manager, David Fuller's line manager, 2012–2015 and 2016–2020.

181 Witness transcripts of N142, N240, N315, N316, N317, N318, N320, N322, N327, N339, N341, N532 and N534.

182 Witness transcripts of N318, N320, N322, N327, N339 and N532.

183 Witness transcripts of N142, N315, N318 and N320.

184 Witness transcripts of N4, N396, N543, N546 and N561.

185 Witness transcript of N431, a senior nurse who worked at hospitals at the Trust and its predecessor organisations on and off from 1997.

186 Ibid.

3.5 Evidence of other inappropriate or unlawful activities by David Fuller in other areas of the Trust

The Inquiry heard four accounts of David Fuller engaging in inappropriate activity.

3.5.1 David Fuller taking an unsolicited photograph

As part of its investigation, Kent Police found evidence that David Fuller had taken an unsolicited photograph up the skirt of a female member of Interserve staff sometime prior to 2014. N392, an Interserve manager from 2010 to 2016, spoke to the Inquiry of her shock that David Fuller had done this:

"I didn't even, didn't even know he could use technology in that way like he was never a phone person, he was never a ... you know you'd be like 'Dave for goodness sake take your phone with you I've been trying to phone you' and he'd be like 'oh I'm ever so sorry.'"¹⁸⁷

The incident demonstrates that David Fuller was using technology furtively to take unsolicited, highly intrusive photos. It is also illustrative of how misplaced the feelings of trust were, held by female Interserve staff towards David Fuller, with whom they felt safe to walk to their cars at night.

The Inquiry is not aware of any evidence of other similar activity by David Fuller.

3.5.2 David Fuller appearing at the bedside of a deceased patient

The Inquiry heard an account by N393, an agency nurse who worked at Kent and Sussex Hospital, when, sometime between 2004 and 2006, they came across David Fuller while performing last offices on a patient who had died. Last offices are the preparation of the body of the deceased. N393 was undertaking the last offices alone as they could not find anyone to assist. It was about 6am.

N393 left the patient's cubicle for a short a period of time and, when they returned, was shocked to find David Fuller in the cubicle:

"So, I come back, I open the curtain up and I saw David Fuller bending over the lady's face, but it was very, very close and it just, I didn't see him touching himself, I didn't see anything sexual, it just looked wrong. But it was more also his reaction, it was not 'omg, you've made me jump', it wasn't that look, it was excuse my language 'shit, I've been caught'. Everything about the way that he looked at me was, was he'd been caught doing something wrong. I immediately challenged him, and I said to him 'who are you?' and he said 'oh, oh, I know her, I know her, I'm just saying my goodbyes to her', and I said 'well you need to leave, you need to leave'. So, anyway he come from out the curtain, I didn't see him disappear, but he obviously did leave."¹⁸⁸

¹⁸⁷ Written transcript of N392, Interserve manager, 2010–2016.

¹⁸⁸ Witness transcript of N393, agency nurse, worked at Maidstone and Tunbridge Wells Trust.

N393 told us that, immediately after the incident, they went over to the nurse's station to report what had happened. N393 told us that the two members of staff at the nurse's station did not appear concerned and that they felt dismissed by them. N393 told us that one of them said: "[O]h, that's just David."¹⁸⁹ David Fuller has denied that the person N393 saw with the deceased patient was him.

Given the passage of time, N393 cannot remember the ward number or the names of the two members of staff who were at the nurse's station.

N393 told us that they were so concerned about the incident that they contacted the nursing agency and filled out an incident report. The nursing agency in question has been taken over by several companies in the intervening years, and the Inquiry has been unable to trace either the report or any evidence that it was sent to or received by Maidstone and Tunbridge Wells NHS Trust. When questioned about the incident by the Inquiry, David Fuller denied that it had happened.

N393 said that when they saw media footage of David Fuller following his arrest, they recognised him straight away as the man they had seen on the ward and they reported the incident to Kent Police.

We have no way of corroborating this allegation. However, it raised a serious matter. Had the complaint been received by the Trust, it could have provided an opportunity to question if David Fuller's behaviour was acceptable in a hospital setting.

3.5.3 David Fuller propositioning a female nurse

The Inquiry heard an account from a former nurse of an encounter with David Fuller in the 1990s at the former Kent and Sussex Hospital where he sexually propositioned her. She did not take the incident any further at the time. The former nurse contacted Kent Police when David Fuller's offending became publicly known and spoke to the Inquiry about the incident. David Fuller has denied that he propositioned this nurse.

3.5.4 Incident in the car park

Mr Sean Briggs, the Trust's Chief Operating Officer since 2018, told the Inquiry about an incident with David Fuller in the Tunbridge Wells Hospital car park around May 2020. David Fuller became overly concerned about a parking manoeuvre that did not directly involve him.

Mr Briggs described David Fuller as being "*very rude ... he just wouldn't leave and ... he just seemed very cross and perturbed by the situation*".¹⁹⁰ Despite asking David Fuller to return to his day job, the situation escalated:

¹⁸⁹ Ibid.

¹⁹⁰ Witness transcript of Mr Sean Briggs, Chief Operating Officer since 2018.

"And anyway, he did eventually leave and kind of, he brought like a posse of six or seven people back with him ... Seven people sort of coming towards us, sort of led by David Fuller saying this gentleman's very inappropriate and he's parked here, and luckily the Facilities Manager came at the same time and sort of they found the car."¹⁹¹

We understand from Mr Briggs that David Fuller wrote to Mr Kevin Rowan, the Trust Secretary, saying that he was upset by the event and that it had affected his health. Mr Briggs told us that he invited David Fuller to meet and discuss the event with him. However, David Fuller did not take him up on his offer. David Fuller informed the Inquiry that these details are factually incorrect.

No formal action was taken in response to the incident in the car park, and it was accepted that David Fuller's behaviour had been out of character.

It is doubtful that this incident, and the incident involving the propositioning of a nurse, on their own would have resulted in action being taken. However, they could have provided opportunities to consider David Fuller's behaviour at work.

3.6 Complaints and concerns about David Fuller

In this section, we consider whether any complaints were made about David Fuller, and whether those who worked most closely with him were aware of how to raise a concern.

Earlier in this chapter, we heard evidence of one disciplinary matter relating to David Fuller, in 1998 about the use of personal computing equipment on Trust premises. In addition, the Inquiry heard that there was ongoing concern about David Fuller's performance at work, and that he undertook tasks in the mortuary without the appropriate paperwork. Neither of these resulted in a formal complaint or concern being raised.

The Inquiry heard about two other matters where there were concerns about David Fuller's conduct at work.

The first was an account by N126, an Interserve employee from 2019, who told the Inquiry that their manager had suggested that they report David Fuller for lying about their work sometime between 2019 and 2020. They decided not to do so:

"And then he [manager] said, yeah I heard that Fuller said you refused a job. I say 'yeah, really?' I say 'what job?' I say 'I never refuse a job.' And he said that he literally had to take some device put in my hands to go and do the job. I said 'no that's a lie.' And that was the first lie, then there was a second, and he asked me 'do you wanna report that?' I said 'he's old and grumpy, I don't.'"¹⁹²

Had this been reported, it could have provided an opportunity to consider David Fuller's behaviour.

¹⁹¹ Ibid.

¹⁹² Witness transcript of N126, Interserve employee from 2019.

The second account, by N162, an Interserve helpdesk employee from 2020 to 2022, was of David Fuller disappearing for a period of time at work during the evening when he was uncontactable by the Interserve helpdesk:

“Yes. So, there was one evening that I did a late shift – and this was during COVID – and the NHS used to provide us with a jacket potato for dinner, and they would serve that in the education and training kitchen between four and six. And I was doing a late shift, so I was doing 11am till 7pm, and I needed to go ... I wanted to go up and get, like, a jacket potato, but, obviously, I didn’t wanna leave the phones unmanned. So, I was waiting for David to come back down. And he was gone for ... he was just gone for hours, wasn’t picking up his mobile, his radio wasn’t in range ... David literally did not appear for, like ... it must’ve been about two hours. He just disappeared completely. [On return] He was like, ‘Oh, no. My phone’s on my desk.’”¹⁹³

A formal concern was not raised. N162 told us that they thought at the time that David Fuller was simply trying to avoid being given a job.

- With the exception of the disciplinary matter in 1998, the Inquiry found no evidence that any formal concerns or complaints about David Fuller were made during the course of his employment in the NHS and at Interserve. However, it is evident from these accounts that there were occasions when David Fuller’s colleagues had concerns about his behaviour at work. Had these concerns been reported, they could have provided opportunities to question and consider his behaviour at work.

3.6.1 Raising concerns in general

Interserve

Ninety-six per cent of the 30 employees or ex-employees of Interserve we took evidence from said that they understood how to raise concerns. Of those in a supervisory or managerial role, seven had experience of doing so.¹⁹⁴ Two of these had identified concerns about David Fuller’s performance but did not raise these formally.¹⁹⁵

Of those not in a supervisory or managerial role, four had experience of raising concerns at work.¹⁹⁶ One had raised concerns about David Fuller undertaking work in the mortuary without the correct paperwork and working long hours.¹⁹⁷ This individual did not feel that their concerns were taken seriously by their manager and we did not find any evidence that they were taken further.

It appears that, while Interserve staff knew how to raise concerns, for some reason they did not do so when they observed or identified the concerns about David Fuller’s behaviour explored elsewhere in this chapter.

193 Witness transcript of N162, Interserve helpdesk employee, 2020–2022.

194 Witness transcripts of N127, N392, N407, N408, N542, N551 and N566.

195 Witness transcripts of N392 and N566.

196 Witness transcripts of N155, N162, N410 and N506.

197 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

Mortuary staff

None of the six former and current APTs at the Trust whom the Inquiry spoke to had raised a concern about David Fuller.

All six said that they knew how to raise a concern. However, those who had done so had not always had good experiences. Two APTs currently working at the Trust told us that their confidence in raising concerns and them being treated seriously had increased since the introduction of new management arrangements for the mortuary.¹⁹⁸

N131, an APT at the Trust since 2012, told the Inquiry that their confidence in raising concerns had increased in the last year, with the introduction of a new full-time Mortuary Manager, who had experience of being an APT:

“Q: So, you say now you’re happy to report concerns?”

A: Yes.

Q: So previously was that not the case?”

A: Just with the management structure it wasn’t present. It was there on paper, but I just didn’t feel – I feel like my experience – I feel like I’ve missed out because now we’ve got [the new Mortuary Manager] I can see what I’ve missed out ... if that make sense. I always thought perhaps a mortuary is just one of those departments that people don’t really want to get involved with and I was really wrong because we’ve got someone now that is all for it and all for us and promoting patient care and putting us – you know, raising us up into the rest of the trust rather than being, you know, down, you know, forgotten about – so, yes, I just feel more confident because I’ve got a working relationship with the mortuary manager that does take what you say seriously and understands what you’re saying as well so.”¹⁹⁹

N140, an APT at the Trust since 2017, based at Maidstone Hospital, also spoke about increased confidence in raising concerns since the new mortuary management arrangements have been in place:

“Oh, I’m happy [laughs]. I make sure my voice is heard.

Q: Okay do you think others in the team feel the same way about reporting incidents?”

A: Now I think yes, before I don’t, when it was Peter Deal as manager I don’t think they were as vocal about things because Peter was very much a brush it under the table if it’s not a real issue. I would say now with [the new Mortuary Manager] in position I think because [they’re] much more open and we can see a lot more changes are coming, and they are good changes so I would imagine now other people would take the opportunity to speak up.”²⁰⁰

198 Witness transcripts of N131, APT, worked in mortuaries at the Trust since 2012; and N140, APT, worked in mortuaries at the Trust since 2017, based at Maidstone Hospital.

199 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

200 Witness transcript of N140, APT, worked in mortuaries at the Trust since 2017, based at Maidstone Hospital.

- Those who worked closely with David Fuller and therefore had most opportunity to observe his behaviour – Interserve employees, and mortuary staff – all told the Inquiry that they knew how to raise a concern.
- It appears that confidence among mortuary staff that concerns will be treated seriously has increased since the introduction of new management arrangements in 2022.

What we have found

Criminal record checks on David Fuller

- David Fuller had four criminal convictions in the period from March 1967 to July 1977. He did not disclose these to his NHS employer when he applied for a job in 1988 nor when he applied for promotion in 2002. David Fuller did not disclose these to Interserve prior to these convictions coming to light on a Criminal Records Bureau certificate in 2011. Opportunities to consider David Fuller's honesty and continued employment in light of his failure to disclose his convictions were missed.
- The Trust was not notified of David Fuller's previous convictions in 2011 or 2015. This was in breach of the Private Finance Initiative subcontract between Interserve and the Special Purpose Vehicle and in breach of the Private Finance Initiative agreement between the Special Purpose Vehicle and the Trust.

David Fuller's working practices

- David Fuller had a reputation among his Interserve colleagues for working long hours, often staying much later than he was contracted to. They believed the reasons for this were because it had been agreed by his manager; he needed the extra money from overtime because of financial difficulties; or because he had no life outside work and nothing to go home for.
- David Fuller was most likely to offend in the mortuary between 6pm and 8pm and second most likely to offend between 4pm and 6pm. His change in working hours to 11am until 7pm in 2016 does not appear to have affected the pattern of his offending, although instances of him offending increased substantially in 2018 and 2019 (see Chapter 2). This change in working hours did, however, give David Fuller a legitimate reason to be at work during the periods he offended most.
- The additional hours he worked were not always claimed as overtime.

Maintenance tasks

- David Fuller entered the mortuary 444 times during a one-year period between December 2019 and December 2020. There were no reactive maintenance jobs allocated to David Fuller during this time. Despite it being important within the contractual agreement between Interserve and the Special Purpose Vehicle to have accurate reporting of maintenance tasks undertaken, this appears not to have been the case for the maintenance tasks that David Fuller undertook. It is concerning that no connection was made regarding the low number of reactive jobs logged to David Fuller and the work he was undertaking there. This does not appear to have been questioned.
- It was well known by David Fuller's Interserve colleagues that he went into the mortuary at Tunbridge Wells Hospital to attend to the fridges and repair the pod system. While a significant proportion of David Fuller's colleagues told the Inquiry that they felt uncomfortable going into the mortuary, they do not appear to have been curious about why he was so willing to do so. They did not make connections between their own feelings of discomfort with the mortuary and David Fuller's apparent ease working in this environment.
- David Fuller had health issues due to an accident which had left him with a bad back. This was well known by his Interserve colleagues. They displayed a lack of curiosity about why he was willing and able to undertake physical jobs in the mortuary when his bad back prevented him from doing so elsewhere in the hospital.
- David Fuller was seen as the 'go-to' person to do jobs in the mortuary at Tunbridge Wells Hospital. The Inquiry heard that he had a good working relationship with mortuary staff who would on occasion ask for him by name to do jobs for them.
- David Fuller's very frequent presence in the mortuary to monitor the fridge temperatures was unnecessary and extremely unusual given the remote monitoring arrangements in place, but it became accepted practice.
- David Fuller would regularly open fridge doors in the mortuary at Tunbridge Wells Hospital to check the temperature of the fridges. This was not questioned by mortuary staff who accepted that this was part of David Fuller's role. The Mortuary Manager and the Designated Individual did not question the appropriateness of an electrical maintenance supervisor opening fridges where the deceased were placed, despite this being out of line with mortuary policy.
- Mortuary staff allowed David Fuller to undertake maintenance tasks, unsupervised, in the post-mortem room at Tunbridge Wells Hospital while the deceased were laid out in the room. This was a failure to safeguard the dignity and safety of the deceased.
- David Fuller normalised his presence in the mortuary, therefore seeing him in there was not regarded as out of the ordinary.

Management and supervision of David Fuller

- The Inquiry saw evidence of only one appraisal undertaken for David Fuller throughout his employment with the NHS and then Interserve. This was in 2010 when he was employed by the Trust.
- Interserve managers knew that David Fuller regularly worked long hours, late into the evening, and that this became an established practice. This was not sufficiently questioned or challenged and was permitted to continue for many years.
- Concerns about David Fuller's slow work pace and consequent impact on his working hours was the subject of discussion among Interserve managers in 2013 but were not resolved. The practice persisted, not unnoticed by Interserve managers.
- The tasks David Fuller undertook in the mortuary were not accurately recorded on the Interserve system. Successive Interserve managers failed to question and challenge the tasks David Fuller was undertaking in the mortuary, in particular the monitoring of fridge temperatures. There was no requirement for these checks to be carried out, but they became established practice. David Fuller was permitted to work in a manner that suited him.
- The change to David Fuller's shift pattern in 2016 gave him a legitimate reason to be at work during the timeframe in which he most frequently offended and during which he knew he was unlikely to be disturbed. The failure to manage David Fuller's working hours was a missed opportunity which could have prevented him from committing offences in the mortuary.

Perceptions of David Fuller

- David Fuller developed a trusted relationship with mortuary staff which enabled him to normalise his presence in the mortuary. The absence of leadership in the mortuary (explored in Chapter 4) meant that this went unnoticed.
- David Fuller formed close relationships with some Interserve colleagues and had the confidence of his line manager. He was well regarded for his technical knowledge by most, but a minority questioned how reliable his knowledge was.
- The Inquiry heard several examples from Interserve managers of David Fuller displaying negative forms of behaviour at work, including confrontations with colleagues. We heard that David Fuller did not like to be challenged or admit fault. There was a tolerance of the negative aspects of his behaviour, and such behaviour was allowed to pass unquestioned.

Inappropriate behaviour

- The Inquiry heard four accounts of David Fuller engaging in inappropriate activity. In three of these incidents, if further investigation had taken place, it might have provided an opportunity to question if David Fuller's behaviour was acceptable.

Complaints and concerns

- In addition to the disciplinary matter in 1998 relating to the use of personal computer equipment at work, the Inquiry heard evidence of four areas of concern raised about David Fuller at work: ongoing concerns about his performance; undertaking tasks in the mortuary without the appropriate paperwork; lying about a colleague's work; and disappearing while on duty. None of these resulted in a formal complaint or concern being raised.
- Almost all those asked by the Inquiry said that they knew how to raise a concern. For some reason, Interserve staff did not do so when they observed or identified concerns about David Fuller's behaviour at work. Had these concerns been reported, they could have provided opportunities to question and consider his behaviour at work.
- Mortuary staff knew how to raise a concern or complaint, but they told the Inquiry that they had more faith that there would be resulting action since the leadership in the mortuary had changed in the period after David Fuller's arrest.

Chapter 4:

Mortuary management and oversight

This chapter outlines the management arrangements for the mortuary service at Maidstone and Tunbridge Wells NHS Trust (the Trust) between 2005 and 2020, and, in particular, the supervision, oversight and assurance of the mortuary service. David Fuller offended on 140 occasions between 2005 and 2020, with the date of one of those occasions remaining unknown. The management of the mortuary and the associated governance arrangements are considered in order to ascertain whether the service was well managed and delivered services in line with the standards and requirements applicable at the time. This is clearly a critical issue, given that David Fuller was able to commit sexual offences against the deceased in these mortuaries during these years.

4.1 The management arrangements for Maidstone and Tunbridge Wells NHS Trust mortuaries, 2005 to 2020

The Inquiry heard evidence about the mortuary service, from 2005 up to David Fuller's arrest in December 2020, which presented a consistent picture of a service that was struggling. We heard that it was an isolated service, with limited on-site management support, and the managers who were in place did not have relevant professional experience to provide support to and oversight of mortuary staff. The Inquiry found that, while there was a change in premises and some of the personnel changed over the years, perennial problems persisted. These problems included mortuary staff not adhering to Standard Operating Procedures (SOPs), a cultural resistance to change, and managers who had little or no mortuary experience providing limited managerial oversight of the mortuary service. We also note that there was confusion regarding who was responsible for the mortuary service at an executive level between 2010 and 2020.¹ This confusion resulted in general management having limited oversight of the mortuary, which is discussed in more detail below.

The Inquiry reviewed internal and external reports about the mortuary as well as documentation; we also analysed interviews from current and former staff. We first examined arrangements from 2005 to 2011 in Kent and Sussex Hospital, and then from when the mortuary service moved to the new Tunbridge Wells Hospital site, in

¹ Witness transcript of Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

September 2011, until December 2020. Next in this chapter, we look at the overall management structure from 2005 to 2020.

4.1.1 Accountability structure for the mortuary

The Inquiry considered how a succession of executive directors, with responsibility for the oversight of the mortuary in their portfolio, were held accountable to the Trust Board for their management responsibilities. The Inquiry heard that the role of Chief Operating Officer was a key role in terms of executive accountability for the mortuary. However, there was a difference in how the Chief Operating Officers perceived their responsibilities for the mortuary, which the Inquiry considers accurately reflects confusion at an executive level about accountability for the mortuary.

The Inquiry notes that there was no consensus between the individuals who held the post of Chief Operating Officer regarding management responsibilities for the mortuary service. Ms Nikki Luffingham, Chief Operating Officer from 2008 to 2011, told the Inquiry that her responsibilities regarding the mortuary were blurred:

*"[U]nder specialist services, pathology would have been under my jurisdiction and then obviously all of the HTA [Human Tissue Authority] stuff and the body parts, Alder Hey it had all happened all around the same time. So whether or not it was officially in my portfolio, I became involved in the managers and obviously the path ... Chief Pathologist was the designated individual and all those things. So it all started to come my way. And that team who were reporting the actions, because there was an HTA visit, and a big action plan needed. That obviously went to path board, to me in the Ops boards and then up to Trust board. So, it became mine in a bit of default. So whilst I might not have been managing the contract with Kent County Council and the mortuary stuff, obviously the team all came to me. Blurred edges."*²

When the Inquiry provided Ms Luffingham with a copy of the transcript of her interview, she clarified her comments regarding blurred lines:

*"Specialist Services were certainly in my portfolio which included pathology. The blurred edges were around the county mortuary contract and the feeling from staff they were managed by the council. This was one of the reason management of the dept was challenging for the ADO [Associate Director of Operations] and Clinical Director."*³

Ms Luffingham further commented during her interview:

*"I think there were blurred edges and so therefore that is why it needed to come in somewhere safely, with the general managers, with the associate director of operations, it needed to be put in to one place so that we could keep much closer eye on things."*⁴

The Inquiry asked Ms Luffingham if this change had occurred as a result of a perceived gap in mortuary management and oversight, which had come to light as a result of

2 Witness transcript of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011.

3 Ms Nikki Luffingham's comment on her transcript received on 25 June 2023.

4 Witness transcript of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011.

activities undertaken by the Human Tissue Authority (HTA). Ms Luffingham agreed with this statement.⁵ Ms Luffingham also told the Inquiry that, in recognition of the fact that mortuary management arrangements needed to be strengthened, an Associate Director of Operations was introduced into the management structure and this brought an increased focus on governance arrangements. This Associate Director of Operations between 2008 and 2010 was Ms Colette Thompson (formerly Donnelly).⁶ Ms Thompson was clear in her evidence to the Inquiry when asked about her role:

*"[T]he responsibility day to day was for the operational running of the division and that included guiding strategic direction and operational leadership to delivery [sic] high quality services."*⁷

After Ms Luffingham left in 2011, Ms Angela Gallagher was appointed to the position of Chief Operating Officer.⁸ In contrast to Ms Luffingham, Ms Gallagher did not perceive herself to be the accountable officer for the mortuary service to the Trust Board, although she did understand herself to have a role to play in communicating any issues raised with regard to the mortuary:

*"Well I was the Accountable Executive for the operations part of the organisation. But I don't believe I considered myself the Accountable Officer for the mortuary. Per se. I would have seen that as the ... as the Clinical Lead and the Management. But, you know, through me, as the sort of like the Board Executive, then if there were any issues of the mortuary, I would expect to be the first person that would ... that would be contacted be [sic] – either by the Clinical Director or by the General Manager. If anything was, you know, if anything was remiss or there was anything that needed reporting. But as the Accountable Officer, no, I don't think I saw myself as ... as that person."*⁹

The Inquiry considers that Ms Gallagher gave confusing evidence about her responsibilities for the mortuary service. She did not see herself as accountable for the mortuary but seemed to say that, as an executive director, she expected to be contacted about any issues arising in the mortuary. This appears to have reduced her role of Accountable Executive for the mortuary to that of a conduit for information-sharing. However, we have reviewed the Trust Board papers for the period of Ms Gallagher's tenure as Chief Operating Officer and can find no instances when she reported to the Trust Board regarding matters relating to the mortuary service. There was only one instance between 2011 and 2018 when the mortuary was discussed by the Trust Board, and this was initiated by Dr Sara Mumford.¹⁰ This instance could support Ms Gallagher's perception that the mortuary was not included in her portfolio. The Inquiry considers that Ms Gallagher's evidence indicates a wider confusion about the management of the mortuary within the Trust.

5 Ibid.

6 Witness transcript of Ms Colette Thompson (formerly Donnelly), Associate Director of Operations, 2008–2010.

7 Ibid.

8 MTW NHS Trust, Executive appointments 2005–2020.

9 Witness transcript of Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

10 MTW NHS Trust, Board minutes, Part 1, 28 January 2015.

Ms Gallagher retired in 2018 and Mr Sean Briggs replaced her as Chief Operating Officer in December 2018.^{11,12} The Trust had undertaken a structural review of all its services in 2018, merging clinical leadership and general management. Following this review, they appointed a Chief of Service for each service area. Mr Briggs told the Inquiry that the Chief of Service for Pathology reported into him and that he considered himself the accountable officer for the mortuary:

*"[A]s Chief Operating Officer I'm absolutely responsible for the running of that service and things like our HTA various reviews, they'd be things that I'd work with the Chief of Service Ritchie Chalmers and her divisional team to work with the Pathology Directorate to try and again support them and help them."*¹³

Mr Briggs also told the Inquiry that, prior to the current arrangements being implemented in late 2018 and early 2019, there had been a triumvirate structure of general management, medical management and nursing management operating at a directorate level. He told the Inquiry that, in his view, this structure had created a looser reporting structure, while the current structure had clear lines of accountability.¹⁴

The Inquiry reviewed the role of Chief Operating Officer in order to understand the accountability structure for the mortuary service. The Inquiry accepts the evidence of Ms Luffingham, who told us that the role of Chief Operating Officer was one of significant magnitude with competing priorities.¹⁵ However, even accepting the wide scope of the role, the Inquiry considers that there was confusion regarding accountability for the mortuary service between 2011 and 2018 in terms of the Chief Operating Officer's role.

We then reviewed the Trust reporting and governance structures through which the mortuary reported to the Trust Board.

The mortuary service has always come within the remit of the pathology service and, over the years, the pathology service has been subject to a number of reorganisations (see Figure 5). In 2012, it became part of a wider directorate called Pathology, Radiology, Pharmacies and Therapies.¹⁶ In 2016/2017, it came within the Diagnostic and Clinical Support Services Division; following a Trust restructure of governance structures, it was reorganised again in 2018, when it came within the Core Clinical Support Services Division.^{17, 18}

11 Witness transcript of Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

12 MTW NHS Trust, Executive appointments 2005–2020.

13 Witness transcript of Mr Sean Briggs, Chief Operating Officer since 2018.

14 Ibid.

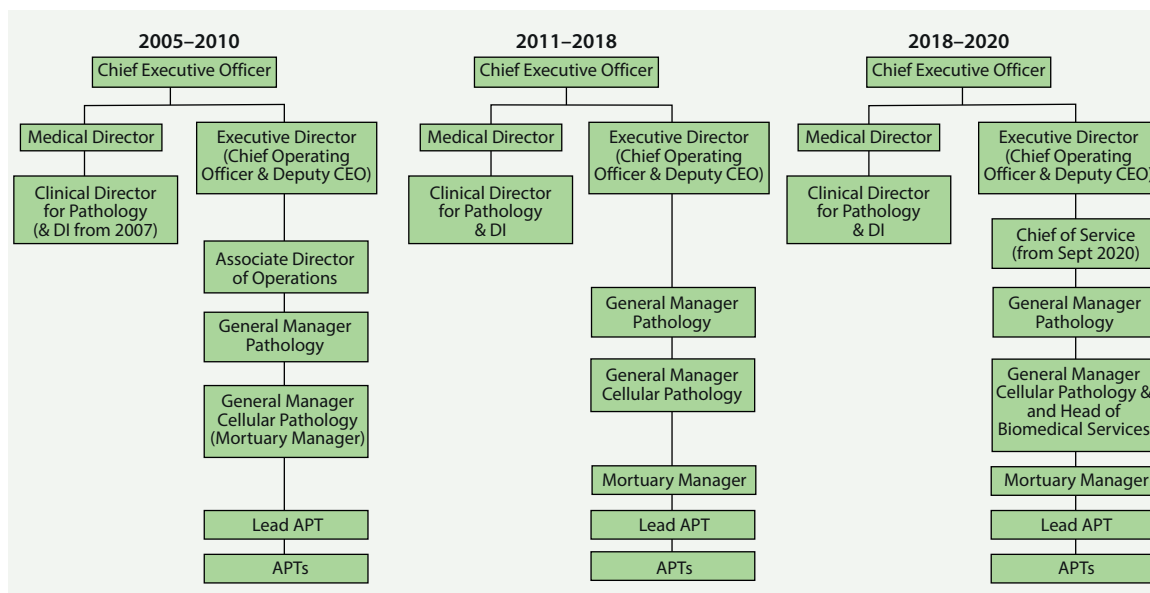
15 Response received from Ms Nikki Luffingham, Chief Operating Officer, during the Inquiry's Fairness Process.

16 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

17 Ibid.

18 Witness transcript of Mr Kevin Rowan, Trust Secretary since 2013.

Figure 5: Lines of accountability from mortuary staff to Chief Executive, 2005 to 2020



Source: Inquiry.

4.2 Management of the mortuary at Kent and Sussex Hospital, 2005 to 2011

David Fuller committed sexual offences against his deceased victims on 22 occasions between 2005 and 2011 in the Kent and Sussex Hospital mortuary. One of his offences took place between 2005 and 2009. However, most of his offences at Kent and Sussex Hospital took place in 2010 and 2011. In 2010, David Fuller offended in the Kent and Sussex Hospital mortuary on eight occasions and in 2011 he offended in the same mortuary on 13 occasions.

From 2005 to 2007, the Trust’s mortuary services were provided across two sites: the old Kent and Sussex Hospital and Maidstone Hospital. The General Manager for the mortuary at this time was Mr Jim Withell,¹⁹ the Cellular Pathology Service Manager, who was managed by Mr Nigel Leftley,²⁰ the General Manager for Pathology until December 2010. Mr Mark Holland²¹ took over from Mr Leftley in December 2010 and remained in position as the General Manager for Pathology until March 2022. The lead anatomical pathology technologist (Lead APT) was Ms Sharon Edwards.²² Mr Kenneth Crossley²³ took over from Ms Edwards as Lead APT in 2011.

There were two other leadership positions of importance for the mortuary service: the Clinical Director for Pathology, whose role was to provide clinical leadership for the

19 Witness transcript of Mr Jim Withell, Cellular Pathology Service Manager, 2006–2017.

20 Witness transcript of Mr Nigel Leftley, General Manager for Pathology, early 2000s–2011, Designated Individual, May–December 2010.

21 Witness transcript of Mr Mark Holland, General Manager for Pathology, 2010–2022, then Head of Service for Pathology.

22 Witness transcript of Ms Sharon Edwards, Lead APT, worked in Kent and Sussex Hospital mortuary, 2000–2011.

23 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

pathology service, and, from 2006, the role of Designated Individual (DI). The position of DI is a statutory post, introduced by the Human Tissue Act 2004, which places a responsibility on the holder to ensure that the HTA licence conditions are met.²⁴ This role, which is additional to the appointee's main position, is discussed in detail in Chapter 6. The positions of Clinical Director for Pathology, from 2005, and DI, from 2006, were held by Dr Graham Russell until 2010.²⁵ Dr Mumford took over the position of Clinical Director for Pathology in 2010.²⁶ The position of DI became a difficult position to fill, the reasons for which will be discussed in more detail below.

The Human Tissue Act 2004 introduced legislation regulating mortuary services in 2006. The Trust made an application for its HTA licence in 2006. The Inquiry was informed that, at this time, organisations that submitted an application were deemed to have the application granted.²⁷ The HTA undertook an inspection to support this process in 2007.²⁸ The detail of the application process is discussed in Chapter 6. The licence was granted allowing post-mortem services to take place on the Kent and Sussex Hospital site only, and the Maidstone mortuary became a body store, as its premises were not deemed fit for the purpose of undertaking post-mortem examinations (PMEs).

The Inquiry heard that there were significant problems within the mortuary service during the period 2005 to 2011, prior to the move to the new Tunbridge Wells Hospital. Staff gave evidence to the Inquiry that the mortuary service at the Trust was isolated, and that staff felt ignored by Trust management and did not receive training opportunities:²⁹ *"Not very supported, no. I got to be honest. We were left to get on with it down there, I have to say."*³⁰

We also heard that senior management did not address concerns about the condition of the mortuary raised by staff:

*"We might report something that that needed repair and then you'll never hear from them again. Just thinking back now, the floor was in a state of complete disrepair in the – in the post-mortem room and we wrote and wrote – even then – they were just ignored."*³¹

*"[B]ecause I think the premises was quite old and dilapidating perhaps not fit for service it just struggled, the whole system struggled."*³²

24 Human Tissue Act 2004, section 18(a–c).

25 Witness transcript of Dr Graham Russell, consultant pathologist at the Trust, 1991–2022, Designated Individual, 2006–2010.

26 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

27 Response received from HTA during the Inquiry's Fairness Process.

28 HTA Inspection Report, 2007.

29 Witness transcripts of Ms Sharon Edwards, Lead APT, worked in Kent and Sussex Hospital mortuary, 2000–2011; N490, mortuary technician then APT, worked in mortuaries within the Trust, 1999–2011.

30 Witness transcript of N490, mortuary technician then APT, worked in mortuaries within the Trust, 1999–2011.

31 Ibid.

32 Witness transcript of Dr Gary Rushton, consultant pathologist working at the Trust since 2007, Clinical Lead for Pathology in 2009.

The Inquiry also heard evidence regarding the extent to which the senior executives at the Trust were aware of there being problems with the mortuary service in 2008. Ms Luffingham told the Inquiry that, at some point, soon after she had commenced her post as Chief Operating Officer, there had been an anonymous call made to a senior member of staff which alerted the executive team to problems in the mortuary:

"I remember going down to the mortuary with said associate director of ops and for the first time really, I hadn't been in post very long and not being ... and being concerned with some of the things we saw. So, milk in the [body] fridges. That type of thing."³³

Ms Luffingham reported that, although there was concern regarding what she and the Chief Nurse had found when they visited the mortuary, it was not sufficiently significant to close down the service:

"[I]t wasn't very clean, erm there didn't seem to be a lot of structure ... there was a lot of erm sitting around, it wasn't very tidy. And then we started to ask some questions around erm things in bags. Were they labelled? Were they not labelled? So we started to get a few alarm bells going on down there ... and then my colleague who was the Chief Nurse came in and did the erm search, in fact the whole hospital, everybody had to do. So she did that, making sure things were labelled erm there ... there was enough to alarm us. But nothing erm at that point, oh my god we need to stop everything going on here. There is enough to ask a lot of questions, put the ADO back down there erm ... ask to speak, you know ask to interview various people to say talk us through the processes that you have got."³⁴

Ms Luffingham was clear in her evidence that she would have reported her concerns about the mortuary to her line manager, Mr Glenn Douglas, the Trust Chief Executive from 2007 to 2017.³⁵ Indeed, Ms Luffingham thought that the call from the concerned staff member could have actually been received by Mr Douglas:

"I think it was a member of staff saying you need to go down and look at the mortuary. Now whether it came to me, whether it came to the ADO or whether it came to Chief Exec I can't remember, but I do know we hot footed it down there. I think he [Glenn Douglas] told me. I can't remember who told who what at that point."³⁶

The Inquiry is clear from Ms Luffingham's evidence that the executive team knew about the difficulties in the mortuary in 2008. We found limited evidence of these difficulties, or any actions taken to resolve them, being reported at Trust Board meetings, apart from mention of a Health and Safety Executive improvement notice being issued to the Trust.³⁷

The Inquiry heard evidence that in 2009 the Trust was experiencing significant financial challenges, having been placed in financial special measures. Mr Douglas told the Inquiry that both of the Trust's hospitals had been historically starved of investment

33 Witness transcript of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011.

34 Ibid.

35 Ibid.

36 Ibid.

37 MTW NHS Trust, Board papers, 2008.

and were under real pressure to make substantial financial savings.³⁸ The dire financial situation, in addition to the outbreak of the infection *Clostridium difficile*³⁹ (*C. difficile*), created a focus for the Trust Board that did not include a consideration of wider services. In addition to financial challenges and the high rates of *C. difficile*, there was the planning for the new Private Finance Initiative hospital at Tunbridge Wells. Mr George Jenkins OBE, Interim Trust Chair from 2007 to 2008, commented upon the extent to which the building of the new hospital distracted senior managers:

“And they were much focused on a new-build hospital [Tunbridge Wells Hospital] over at Pembury, which is on the edges of Tunbridge Wells, as opposed to managing that that they were tasked to manage and operate for the benefit of patients.”⁴⁰

The 2007 HTA inspection, which was carried out as part of the granting of the HTA licence to undertake PMEs, did acknowledge the age of the physical environment at the Kent and Sussex Hospital mortuary, but considered it to be fit for purpose.⁴¹

The view that the mortuary at Kent and Sussex Hospital was physically isolated and forgotten about by Trust management was something that the Inquiry heard consistently: *“The Kent and Sussex mortuary wasn’t in much, much better condition and so tucked away in the basement just off in the car park.”⁴²*

Dr Gary Rushton, a consultant pathologist, reflected on his experience of working in the Kent and Sussex Hospital mortuary during his interview with the Inquiry, commenting:

“I just think it was sort of a forgotten service to be honest. It was understaffed in terms of APTs and I think they very much worked along the lines of this is how we’ve always done it and this is how we do it, perhaps not buying into what needs to be done in order to conform to HTA practices. I think the mortuary manager at the time was struggling to get buy in and because I think the premises was quite old and dilapidating perhaps not fit for service it just struggled, the whole system struggled.”⁴³

Another consultant pathologist at the Trust, Dr David Fish, stated: *“[Y]ou know it’s bottom of the list of trust priorities I think in spending money on security in mortuaries.”⁴⁴*

We also heard that the difficulties experienced in the mortuary were reflected across the wider Trust culture at the time:

“It wasn’t a particularly pleasant culture going right through that hospital, just now from having worked in other places and I’m referring particularly to Maidstone, it was a general – right through the whole Trust from the kitchens and the porters right up to executives, chief executives level, there was just – it just seem to be a general

38 Witness transcript of Mr Glenn Douglas, Trust Chief Executive, 2007–2017.

39 *Clostridium difficile*, also known as *C. difficile* or *C. diff*. A bacterium that can infect the bowel and cause severe diarrhoea, bowel damage and even death. The infection most commonly affects people recently treated with antibiotics but can spread easily to others. Source: NHS Scotland website, 3 April 2023.

40 Witness transcript of Mr George Jenkins OBE, Interim Trust Chair, 2007–2008.

41 HTA Inspection Report, 2007, p.13, para. 28.

42 Witness transcript of N543, Security staff, 2005–2016.

43 Witness transcript of Dr Gary Rushton, consultant pathologist working at the Trust since 2007, Clinical Lead for Pathology in 2009.

44 Witness transcript of Dr David Fish, consultant pathologist at the Trust, 2005–2020.

culture of unfriendliness, backbiting, one-upmanship. You know, when I say, the Trust I'm working now, we'll have the chief exec and the [Chairman], they'll come down, not so much now but they come and see what's going on and it's all very friendly. Not there, it wasn't. It wasn't – you had to watch your back really.”⁴⁵

Mr Jenkins OBE, a previous Chair of the Trust, supported this view and told the Inquiry that staff were “totally demoralised” when he arrived at the Trust in 2007.⁴⁶

Following two Serious Untoward Incidents (SUIs), set out in Table 1, the HTA undertook an inspection in May 2009.

Table 1: Serious Untoward Incidents in the mortuary, 2009	
Year	Description of incident
2009 (January)	In November 2008 – release of the wrong body of a deceased child from the mortuary at Kent and Sussex Hospital. The error was detected by the funeral directors, who reported to staff working at the mortuary. This incident was reported to the Human Tissue Authority (HTA) in January 2009.
2009 (April)	The Designated Individual reported that human tissue from a post-mortem had been stored on unlicensed premises (Preston Hall, which was a Trust pathology facility). This was contrary to HTA requirements.

Source: HTA evidence supplied to the Inquiry, 18 March 2022.

The subsequent Inspection Report identified that the DI, Dr Russell, had failed to discharge his duty under section 18(b) of the Human Tissue Act 2004 in that he had not secured the use of suitable practices when carrying out a licensed activity.⁴⁷ The inspection also identified two breaches of the HTA Code of Practice relating to the consent to store human tissue and its storage. The conclusion of the HTA inspection is noteworthy in that it specifies the failing of the service very precisely:

“The HTA concludes that the issue is not one of governance of the activities carried out under the existing licences, but a failure in the governance framework that allowed a member of staff to (a) store relevant material from post-mortem examination on unlicensed premises after the authority of the coroner concluded, and (b) retain relevant material from post-mortem examination without consent from those in a qualifying relationship to the deceased.”⁴⁸

- The HTA Inspection Report in May 2009 identified that the failings related to a lack of oversight of processes and procedures and the competency of staff regarding knowledge of statutory procedures such as consent. The Inquiry considers such a finding to indicate a lack of supervision and oversight of the APT staff working in the mortuary.

45 Witness transcript of N490, mortuary technician then APT, worked in mortuaries within the Trust, 1999–2011.

46 Witness transcript of Mr George Jenkins OBE, Interim Trust Chair, 2007–2008.

47 HTA, Investigation Report for MTW NHS Trust, 5 May 2009, p.17.

48 HTA, Investigation Report for MTW NHS Trust, 5 May 2009, p.14, para. 69.

- The HTA Inspection Report also notes that the DI, Dr Russell, reported that the Mortuary Manager was overstretched, with the HTA commenting that the DI required more support.⁴⁹ The HTA required the DI to report to the regulator on a monthly basis regarding the progress being made in implementing the action plan. The Inquiry considers that this is significant, as it is evidence of a lack of supervision and oversight in relation to the mortuary service.

The Inquiry notes that the 2009 HTA Inspection Report was discussed at the mortuary service governance meeting of 22 July 2009. The minutes of the meeting note that Dr Russell had spoken with the Medical Director and the Deputy Chief Executive, who we have been informed was Ms Luffingham:⁵⁰

“GAR [Dr Graham Russell] has spoken to the Medical Director and Deputy Chief Executive who have also received copies of the report. He has advised them that he is only happy to continue as DI if they gave full support to the delivery of the action plan.”⁵¹

It is clear from these minutes that both the Deputy Chief Executive and the Medical Director were aware of the difficulties in the mortuary. The Inquiry can find no evidence of a discussion taking place at a Trust Board meeting regarding this inspection. We have also investigated the possibility of senior executives informing the Chair through informal discussions outside the formal Trust Board meeting. The evidence of the Chair at this time, Mr Anthony Jones,⁵² confirms that this inspection was not discussed with him.

- Not discussing a regulatory inspection at a Trust Board meeting, which resulted in further conditions on the Trust’s licence, demonstrates a lack of oversight and assurance in relation to the mortuary. This is discussed in more detail in Chapter 7.

The Inquiry has seen the action plan developed to address the shortcomings identified by the HTA. However, there is limited evidence of increased on-site managerial support for the Kent and Sussex Hospital mortuary to implement the action plan. In particular, the Inquiry notes Dr Russell’s comments recorded in the mortuary service governance meeting minutes:

“There is, therefore, currently no-one on the Kent & Sussex site. GAR [Dr Graham Russell] proposes that the new Mortuary Manager should be sited at Kent & Sussex.”⁵³

When the new Mortuary Manager, Mr Thomas Farrell,⁵⁴ was appointed in April 2010, he was based at the Maidstone Hospital site, although he had responsibility over both the Maidstone body store and the Kent and Sussex Hospital mortuary. Both the General

49 Witness transcript of Dr Graham Russell, consultant pathologist at the Trust, 1991–2022, Designated Individual, 2006–2010.

50 MTW NHS Trust, Response to Inquiry question as to who was the Deputy Chief Executive in 2009.

51 Mortuary service governance meeting minutes, 22 July 2009, p.4.

52 Witness transcript of Mr Anthony Jones, Trust Chair, 2008–2017.

53 Mortuary service governance meeting minutes, 22 July 2009, p.4.

54 Witness transcript of Mr Thomas Farrell, Mortuary Manager, 2010–2012.

Managers, Mr Withell⁵⁵ and Mr Leftley,⁵⁶ were based at Maidstone and, as Dr Russell had pointed out, there was no on-site management support for the mortuary at Kent and Sussex Hospital. Mr Withell informed the Inquiry that he had no part in the decision not to place Mr Farrell at Tunbridge Wells Hospital mortuary, and the decision would have been made by managers more senior than him.⁵⁷ We have not been able to identify who made the decision to base Mr Farrell at Maidstone Hospital or their reasoning for it.

- The Inquiry considers that it is significant that the extra on-site management support that had been identified as required at the Kent and Sussex Hospital mortuary was not forthcoming in 2009.

4.2.1 The Independent Review of Mortuary Services at the Trust, by Lowell and Johnson, 2009

Following the SUIs and the subsequent HTA inspection, an external review of the mortuary was commissioned, which took place in September 2009 (the Lowell and Johnson Report).⁵⁸ We have been unable to confirm who at the Trust commissioned this review. The review was undertaken by two senior managers from elsewhere in the NHS, Mr James Lowell and Mr Terry Johnson, a Senior Operations Manager and a Mortuary Manager respectively. This report provides evidence that there were serious issues with the delivery and the management of the mortuary service. The seriousness of the situation is succinctly set out by the report authors:

“The only conclusion that we can draw as a result of our visit is that Maidstone and Tonbridge [Tunbridge] Wells NHS Trust has a mortuary service with serious internal problems. Of real concern is the fact that some of the problems identified (i.e., the attitude of the staff) have the very real prospect of causing the Trust significant harm and with this in mind the Trust cannot afford to ignore them.”⁵⁹

The review identifies serious problems with the functioning of the mortuary service. In particular, the authors point out that mortuary staff failed to adhere to basic health and safety standards, such as wearing gloves when handling the deceased and failing to adopt proper processes and procedures:

“All of the mortuary staff seems to have a total disregard for the demarcation and infection control processes in the mortuaries. The aimless wandering in out of the PM [post-mortem] room at KS [Kent and Sussex Hospital] without at least putting on overshoes, not wearing gloves when handling bodies at both sites, not washing hands, boots that look as though they have not been washed for some time, not supervising visitors, and eating and drinking in what is in effect an extension of the

55 Ibid.

56 Witness transcript of Mr Nigel Leftley, General Manager Pathology, early 2000s–2011, Designated Individual, May–December 2010.

57 Response received from Mr Jim Withell during the Inquiry’s Fairness Process.

58 Witness transcript of Dr Rachael Liebmann, consultant pathologist at Kent and Sussex Weald NHS Trust, 1999, then Maidstone and Tunbridge Wells NHS Trust to 2014.

59 Mr James Lowell and Mr Terry Johnson, Independent Review of Mortuary Services, MTW NHS Trust, September 2009, p.17.

body store. All of these things coupled with the other issues raised in this section equate to a mortuary staff that have basically given up and seem to have lost all motivation and pride in their service.”⁶⁰

The authors identify that Mr Withell⁶¹ was having significant problems providing the APTs with sufficient management input:

“In conversation with Jim it is clear that he is trying his best to both engage with and support the APT staff. He is aware that the mortuary service has serious problems but as Cellular Pathology manager and working across split sites Jim does not have the time needed to micromanage the mortuary service and it is clear that he is getting little or no help from within the mortuary.”⁶²

The report not only identifies that the Mortuary Manager was overstretched but emphasises that the HTA had previously mentioned the same point: *“From the outside looking in it is blatantly obvious that Jim is seriously overstretched and this fact was identified by the HTA in their report.”⁶³*

The authors comment on the difficulties experienced by the DI and the lack of capability within the mortuary service to fulfil the role of Persons Designated:⁶⁴ *“What is clear is that at the moment there is no-one within the mortuary service capable of fulfilling this important role.”⁶⁵*

- The findings of the external review indicate a lack of senior management oversight of the mortuary service during this period. The Inquiry is also struck by the lack of interest and attention paid to the physical environment of the mortuary, as we see this as pertaining to a lack of interest in maintaining a secure physical environment.

Given that the report is highly critical of the mortuary service, it is of concern that Mr Leftley, who was the General Manager for Pathology at the time of the report, told the Inquiry that there were no issues in the mortuary during his tenure.⁶⁶ We were keen to understand what action the Trust took in response to the criticisms and recommendations set out in the Lowell and Johnson Report. The report was discussed in a closed discussion at the mortuary service governance meeting held on 26 October 2009. We identified from the minutes of the meeting that none of the APTs attended this meeting, with their apologies being minuted. This meeting presented an

60 Ibid., p.11.

61 Witness transcript of Dr Graham Russell, consultant pathologist at the Trust, 1991–2022, Designated Individual, 2006–2010.

62 Mr James Lowell and Mr Terry Johnson, Independent Review of Mortuary Services, MTW NHS Trust, September 2009, p.7.

63 Ibid., p.8.

64 Persons Designated assist the Designated Individual in ensuring compliance with HTA standards. Persons Designated can assist with developing procedures, as well as reporting incidents. There should be at least one Person Designated on each licensed site: see HTA website.

65 Mr James Lowell and Mr Terry Johnson, Independent Review of Mortuary Services, MTW NHS Trust, September 2009, p.8.

66 Witness transcript of Mr Nigel Leftley, General Manager for Pathology, early 2000s–2011, Designated Individual, May–December 2010.

opportunity to address the dysfunctional operation of the mortuary with the APTs, which was one of the harshest criticisms of the Lowell and Johnson Report. The Inquiry could find no evidence of this central issue being addressed with the mortuary staff. Had this been addressed, it might have presented an opportunity to improve the functioning of the mortuary.

The Inquiry was informed that the report was considered together with the HTA report and an overarching improvement plan was put in place. Ms Luffingham informed the Inquiry:

“There was an overarching Improvement plan that the team put in place following the L&J [Lowell and Johnson] and HTA reports. This was discussed at the pathology board and the operational board but it seems to no longer be part of Trust records. I recall this being discussed and RAG [Red, Amber, Green] rated and it being slow to be accepted by the more junior teams but that the board persisted. It was probably the most important thing they were tackling.”⁶⁷

Given the serious findings that this report set out, the Inquiry requested that the report be tracked, to understand how it was reported through the Trust governance structures. A full report did go to the Standards Committee in April 2010. The Standards Committee is described by the Trust Secretary as a subcommittee of the Quality Committee, which is a subcommittee of the Trust Board.⁶⁸ We note that the report to the Standards Committee does not appear to reflect the cultural issues identified in the Lowell and Johnson Report but rather focuses on equipment. There is comment on the newly appointed Mortuary Manager being focused on the development of SOPs.⁶⁹

The Lowell and Johnson Report was reported to the Quality Committee, a subcommittee of the Trust Board. However, the detail included was minimal:

“Pathology – there has recently been an independent review of the mortuary service at K&S [Kent and Sussex Hospital]. Actions resulting from the report findings are being considered.”⁷⁰

- The Inquiry considers that this record of the discussion indicates that the report made to the Quality Committee was of an extremely limited nature and did not provide those attending the Quality Committee with sufficient detail to allow them to understand the severity of the dysfunction being reported in a department responsible for undertaking regulated activity and thus draw it to the attention of the full Board.

67 Response received from Ms Nikki Luffingham, Chief Operating Officer, during the Inquiry's Fairness Process.

68 Written information provided by Mr Kevin Rowan, Trust Secretary since 2013, to the Inquiry, titled: 'Tracking the progress of the 2009 "Independent Review of Mortuary Services" by James Lowell and Terry Johnson through the Trust's governance process.'

69 Ibid., Appendix 2: Standards Committee, 14 April 2010.

70 MTW NHS Trust, Quality Committee meeting minutes, 11 November 2009, p.4.

- The Lowell and Johnson Report was never discussed by the Trust Board. We interviewed the Chair of the Trust for the relevant period, Mr Jones, and he reported that he had no recollection of ever discussing the Lowell and Johnson Report, either informally or at a Trust Board meeting.⁷¹ This was a failure of corporate governance.

In 2011, the *Daily Mail* included a quote from the Lowell and Johnson Report in an article about the mortuary at Kent and Sussex Hospital:

“Of real concern is the fact that some of the problems identified i.e., the attitude of the staff, have the very real prospect of causing the trust significant harm and with this in mind, the trust cannot afford to ignore them.”⁷²

This newspaper article publicly highlights, in clear terms, the risk to the Trust that was present in the mortuary. However, Mr Jones was emphatic that there was no discussion about this matter at Trust Board meetings.⁷³ The Inquiry considers that this article would have been known about by most, if not all, non-executive directors and executive directors, as it was a national newspaper article about the Trust. The information set out in the article had the potential to damage the reputation of the Trust. It is surprising that the contents of this article were not discussed at the Trust Board meetings, given that it referred to a serious incident and an external review of the mortuary service.

- Not discussing the Lowell and Johnson Report at a Trust Board meeting in 2009, and then when its contents appeared in the national press in 2011, was a missed opportunity for the Trust Board to question the safe functioning of the mortuary. The degree to which the Trust Board had oversight and assurance in relation to the mortuary issues raised in external reports is discussed in more detail in Chapter 7.

Little appears to have improved as a result of the Lowell and Johnson Report. This is illustrated by the HTA follow-up inspection in April 2010, which identified further shortfalls in compliance and placed a further seven conditions on the Trust’s HTA licence.⁷⁴ There is more detail about this inspection in Chapter 6. The HTA expressed surprise at the lack of progress since its last inspection, as it had warned the Trust it would be returning in April 2010.

- The limited improvement in the functioning of the mortuary by April 2010 indicates a continued lack of supervision from those with responsibility to ensure that the service was operating correctly and meeting its obligations.

71 Witness transcript of Mr Anthony Jones, Trust Chair, 2008–2017.

72 “Catastrophic impact” on family as baby is buried without brain because hospital staff left it on a shelf for FIVE months; *Daily Mail*, 3 September 2011.

73 Witness transcript of Mr Anthony Jones, Trust Chair, 2008–2017.

74 HTA Inspection Report, 2010.

Mr Farrell was appointed as Mortuary Manager in April 2010 at Band 8a, which is a senior management position in the NHS. He told the Inquiry that he found the mortuary at Kent and Sussex Hospital to be old-fashioned in its processes and procedures: *"[By] comparison from other mortuaries where I had been before I would say Maidstone or Maidstone Kent Hospital were a bit old-fashioned with the way they were doing things."*⁷⁵

Unfortunately, the appointment of Mr Farrell did not improve the functioning of the mortuary, and there was a further serious incident, relating to retained tissue, in December 2010. The Clinical Director of Pathology, Dr Mumford, was sufficiently concerned about the serious incident that she reported it to the Chief Executive:

*"I immediately went to see the Chief Executive and spoke to him about it. And we then went to the mortuary and did an audit of the paperwork to see if there was going to be some more surprises coming out of there and then we did fingertip searches and it was all a bit, really chaotic."*⁷⁶

The Inquiry interviewed the former Chief Executive referred to above, Mr Douglas. Mr Douglas was Chief Executive between 2007 and 2017. During his interview, he told the Inquiry:

*"[S]ounds really strange to say that, given what happened subsequently, but it was not an area I had any reason to have any concern about, and no concerns were directly raised in terms of the management of it. The only interaction, as I say, that ... of any consequence I had was around the reopening of the post-mortem service."*⁷⁷

This statement was also contradicted by Ms Luffingham's evidence to the Inquiry. She was clear that she kept Mr Douglas informed of all issues related to the mortuary that would cause concern, both in terms of formal reporting through the governance structures and informal reporting directly to the Chief Executive.⁷⁸

Following this serious incident, PMEs were temporarily stopped, and internal audits and disciplinary investigations were undertaken. The audits identified a lack of SOPs and found that, where they were in place, they were frequently not followed. One of the audits⁷⁹ identified chaotic record-keeping and a lack of knowledge among mortuary staff about SOPs, which supports our conclusion that little had improved as a result of a number of reports, namely the HTA 2009 inspection, the Lowell and Johnson Report and the subsequent HTA 2010 Inspection Report. One consultant pathologist told us:

*"[W]hat was done badly was probably just generally the whole services it was just so, at such a low point it was almost gone beyond being able to lift it back up again I think it just needed too much work done to it. And there was just one incident after another after another which created all these action plans and it just became too, it almost sort of self-destruction really that's how I viewed it to be honest."*⁸⁰

75 Witness transcript of Mr Thomas Farrell, Mortuary Manager, 2010–2012.

76 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

77 Witness transcript of Mr Glenn Douglas, Trust Chief Executive, 2007–2017.

78 Witness transcript of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011.

79 MTW NHS Trust, Internal audit of hospital mortuaries, December 2010.

80 Witness transcript of Dr Gary Rushton, consultant pathologist working at the Trust since 2007, Clinical Lead for Pathology in 2009.

There was a significant change in the leadership and management of the mortuary in 2011. Following the Lead APT, Ms Edwards, leaving the Trust, Mr Crossley became the Lead APT in 2011, operating without a senior APT. The Chair of the Trust, Mr Jones, informed the Inquiry that the only informal discussion he had had about the mortuary took place following a serious incident that had resulted in two staff being dismissed. Mr Jones informed the Inquiry that during this private discussion he was reassured by the Chief Executive, Mr Douglas, that the problems in the mortuary were down to mortuary leadership and a new Mortuary Manager would address the issues.

The Inquiry has not identified who made the decision to appoint Mr Crossley as Lead APT. However, we note that the 2009 Lowell and Johnson Report is scathing about Mr Crossley's knowledge and interest in the mortuary:

*"Following questioning of the APT (Ken) it is clear that he has no idea as to whether or not any of the above specifications is met or in fact whether the ventilation system is working at all."*⁸¹

"While Ken was showing us around the mortuary at KS we asked him various questions relating to the facility and operations. His responses give cause for concern; In the PM room he was asked if the ventilation was running – he did not know.

We asked where the incident book was – He did not know.

He was asked where the SOP file was and pointed to the window ledge in the office – the SOP file was not there.

We asked him if he knew what a quality system was – he did not know.

We asked him about CPD [Continuing Professional Development] and he did not know what we meant. When we explained he showed us Simons CPD portfolio (there was nothing in it) stating that his was at home.

*There was a major incident card on the wall of the body storage area but Ken did not know what the card was for and when asked if he had been involved in a major incident exercise it was apparent that he had not."*⁸²

*"Put this all together along with his constant reference to Maidstone and what you have is a very discontented individual who is unlikely to engage with the process of improving operating standards overall in this current environment."*⁸³

The Inquiry found no evidence that Mr Crossley's deficiencies were addressed through training or supervision, and we have seen a note of the Pathology Board meeting that states "Diploma APT Cse Oct 2010" against Mr Crossley's name.⁸⁴ Mr Crossley gave evidence to the Inquiry that, following his initial qualification, his training opportunities had been largely limited to the mandatory Trust training.⁸⁵ In addition,

81 Mr James Lowell and Mr Terry Johnson, Independent Review of Mortuary Services, MTW NHS Trust, September 2009, p.4.

82 Ibid., p.9.

83 Ibid., p.10.

84 Pathology Directorate Board meeting, 7 October 2010.

85 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

the Inquiry noted that a peer review of the mortuary conducted in 2021 commented that the Lead APT, Mr Crossley, had received no leadership training.⁸⁶

The Inquiry is concerned that, following the Lowell and Johnson Report in 2009 and Mr Crossley's subsequent appointment to Lead APT, once he had been awarded the APT Diploma in 2010, we did not find evidence that Mr Crossley took responsibility for improving his knowledge, skills and competencies regarding the requirements of the HTA. This would have enabled him to take a proactive role in implementing the required HTA standards and ensured that the mortuary service adhered to SOPs based on these standards. We consider that he should have taken steps to improve his ability to act effectively as a Lead APT and sought out relevant training.

The Inquiry finds it concerning that Mr Crossley was identified as the person to lead the mortuary out of the difficulties it was experiencing in 2010 and 2011. We note that the Mortuary Manager at the time Mr Crossley became the Lead APT, Mr Withell, and the General Manager for Pathology, Mr Holland, would have (or should have) both been aware of the Lowell and Johnson Report and the criticisms of Mr Crossley contained within it. The Inquiry considers that they should have paid due attention to these criticisms and ensured that Mr Crossley was provided with the opportunities to undertake the requisite training that might have enabled him to fulfil the requirements of the Lead APT role more effectively.

The Inquiry notes that Mr Holland commenced in post as General Manager for Pathology in December 2010, which was after the Lowell and Johnson Report was published.⁸⁷ We also note that he was the acting General Manager for Pathology from December 2010 until March 2011, when he became the Interim General Manager for Pathology until 2015. In April 2015, his post became substantive. Mr Holland continued in this role until 2022, when he became Head of Pathology following a management reorganisation.⁸⁸ The Inquiry accepts that Mr Holland did not hold the substantive post of General Manager for Pathology until April 2015; however, we consider that he held accountability for the mortuary from December 2010.

The Inquiry saw no evidence that Mr Holland either took steps or facilitated others, such as Mr Withell, to take steps to address Mr Crossley's deficiencies set out in the Lowell and Johnson Report. The Inquiry considers that, although Mr Holland did not take up his position as General Manager for Pathology until 2010, the Lowell and Johnson Report would still have been an important reference point for any new manager and should have been central to any action plan for the mortuary.

86 Report of peer review, 12 March 2021 (amended 26 March 2021), p.10.

87 Witness transcript of Mr Mark Holland, General Manager for Pathology, 2010–2022, then Head of Service for Pathology.

88 Ibid.

- In the absence of Mr Crossley undertaking the required training that would have enabled him to fulfil the role of the Lead APT effectively, robust management actions should have been taken by Mr Holland and Mr Withell that addressed the noted deficiencies. These would have provided both managers with assurance that Mr Crossley's knowledge and performance had improved and he was fulfilling his role effectively. The Inquiry could find no evidence that any action was taken by either manager to address Mr Crossley's identified deficiencies.
- It is of concern to the Inquiry that Mr Douglas, the Chief Executive, reassured the Trust Chair, Mr Jones, that assigning new leadership to the mortuary was the route to resolving the difficulties the mortuary service was experiencing, if he was referring to Mr Crossley. Mr Crossley was the Lead APT, rather than a Mortuary Manager of the appropriate grade, and his competence and engagement to lead the mortuary had been called into question. This illustrates the extent of the senior executive team's lack of understanding and oversight regarding the mortuary in 2011.

It is clear, from the evidence the Inquiry has seen, that in 2011 the management of the mortuary was in a state of flux. In addition to Mr Withell,⁸⁹ Mr George Taylor,⁹⁰ a biomedical scientist, was appointed to a general managerial position that included responsibility for the mortuary in mid-2011, prior to the move to Tunbridge Wells Hospital. In addition to Ms Edwards leaving and Mr Crossley becoming the Lead APT, there was significant downgrading of the Mortuary Manager's post during the period of Mr Farrell's employment with the Trust. The post was initially banded as NHS Agenda for Change Band 8a, but was downgraded in two successive restructuring events to a Band 5 between 2010 and 2011. This is a substantial downward grading of a post, and one that would have left a gap in the management and oversight of the mortuary. Mr Farrell terminated his employment with the Trust in 2012. Whatever the reason for the downgrading of the post, it is clear to the Inquiry that the introduction of the post of Mortuary Manager to increase professional leadership had not brought about the required improvements to the functioning of the mortuary service in 2010 to 2011:

"[B]ut again he didn't, he didn't erm, last very long ... he disappeared from the scene as well. So, I mean all, all along there were sort of undertones of problems at the mortuary. At Kent and Sussex mortuary. Erm, yeah and as I say culminated in the trust just er, wash, washing their hands of the service."⁹¹

A paper titled 'Report for the Divisional Operations Committee', written by Dr Mumford in April 2011, recommends that the Trust relinquish its HTA licence and stop undertaking post-mortems.⁹² In her evidence to the Inquiry in 2022, Dr Mumford discussed her retrospective view of this paper in detail, including that the mortuary was not operating safely:

89 Witness transcript of Mr Jim Withell, Cellular Pathology Service Manager, 2006–2017.

90 Witness transcript of Mr George Taylor, biomedical scientist, Mortuary Manager, 2011–2016.

91 Witness transcript of Dr David Fish, consultant pathologist at the Trust, 2005–2020.

92 Report for Divisional Operations Committee, April 2011.

“And the conclusion of that was a paper that we took to our clinical operations committee in April I think which, our contract was up for renewal for doing post-mortems and we took this paper ... and basically the mortuary wasn't safe ... it wasn't making any, it wasn't even breaking even financially. Kent County Council weren't willing to put any more money into doing post-mortems erm, and we felt that the best thing to do at that point because there was so much risk surrounding it we'd had three serious incidents in the preceding year, sorry a few years three years I think. And it just wasn't safe, and the best thing we could do was cancel the contract and send bodies for post-mortem elsewhere and they went to Greenwich. And then just work as a body store only until we get our house in order and we relinquished our HTA licence at that point because you don't need one if you're just running a body store you only need one if you're doing post-mortem activity.”⁹³

The Divisional Operations Committee was not a subcommittee of the Trust Board, but rather a management committee at the lower level of the Trust governance structure. This appears to be a relatively low-level committee to make a decision to relinquish a national licence for regulated activity. The Inquiry saw evidence indicating that the Medical Director, Dr Paul Sigston, completed the required documentation to relinquish the Trust's HTA licence.⁹⁴ The Inquiry notes that there is no record of any discussion of this decision at either the Quality Committee or the Trust Board. This omission is discussed in more detail in Chapter 7.

- The HTA licence was relinquished by May 2011 and the Kent and Sussex Hospital mortuary became a body store. This meant that it was not subject to the regulatory requirements of the HTA, including those related to security, and would not have been inspected. This action did not address the serious issues at the Kent and Sussex Hospital mortuary. The consequence of the Trust relinquishing its HTA licence was to reduce the level of external scrutiny of the mortuary. The decision meant that there was no longer the same impetus for senior Trust executives to address the serious problems that the service was experiencing.
- It is clear to the Inquiry that the difficulties experienced by the mortuary service were not given the required attention by senior management to allow effective resolution. There was an abundance of evidence available to senior management regarding the level of dysfunction in the mortuary service. The Inquiry heard evidence of action plans developed and management actions taken to resolve the issues, but these actions did not resolve the issues over time. In response to the ongoing difficulties, the Trust chose to relinquish the HTA licence, which meant that there was less oversight and less regulatory scrutiny.

93 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

94 HTA, Timeline of interactions between the Trust and the HTA.

- The context of the mortuary management arrangements and the functioning of the mortuary service is of critical importance in relation to David Fuller's offending. We consider that the compromised functioning of the service, lack of management supervision and oversight, and lax security arrangements, considered in Chapter 5, impacted on each other, and magnified the deficiencies of all three. It was within this environment that David Fuller was able to offend unnoticed.

4.3 The move to the new Tunbridge Wells Hospital site in May 2011

In May 2011, the maintenance team at Kent and Sussex Hospital, including David Fuller, transferred to the new Tunbridge Wells Hospital. From this point, David Fuller was an employee of Interserve (Facilities Management) Ltd. In September 2011, the mortuary service moved from Kent and Sussex Hospital to the new Tunbridge Wells Hospital. After the mortuary service had moved to the new Tunbridge Wells Hospital, David Fuller is not known to have offended again until 2012. His offending became increasingly prolific between 2012 and 2020, the details of which are in Chapter 2. When the mortuary service moved to the new hospital at Tunbridge Wells, the mortuary continued to be physically isolated from other services, on the basement level of the hospital. In addition, following the move, the Maintenance department in which David Fuller was based was situated next door to the mortuary.

4.4 The mortuary at Tunbridge Wells Hospital, 2011 to 2020

The Inquiry examined the management arrangements for the mortuary between September 2011 and 2020 to understand better how David Fuller was able to escape detection for so long. The general structure of the management of the mortuary remained the same, in that it was part of the Pathology Directorate. The Inquiry heard that there were two aspects to the management of the mortuary: general management, and clinical management through to the Medical Director. At the time of the move to Tunbridge Wells Hospital, the mortuary service was still a body store, as it had relinquished its licence earlier in the year. This means that it was not governed by the requirements of the HTA, including those to keep the premises secure. In 2014, the Trust successfully applied to restore its HTA licence.

4.4.1 The general management of the mortuary

As set out earlier in this chapter, the mortuary management arrangements in 2011 were subject to significant change. Mr Taylor, a biomedical scientist by profession, told the Inquiry that he was asked to assume managerial responsibility for the mortuary around mid-2011, when the mortuary was still at Kent and Sussex Hospital. Mr Taylor

remained as Mortuary Manager until 2016. Mr Taylor told us there was no formal appointment process, with no interview and no job description.⁹⁵

The Inquiry heard that, by 2012, Mr Taylor was confirmed as formally holding the post of Mortuary Manager. Although Mr Taylor was a biomedical scientist, a profession registered with the Health and Care Professions Council (HCPC), Mr Taylor did not perceive himself to have the professional leadership role for the mortuary service. Mr Taylor was clear that his role as Mortuary Manager did not include managerial responsibility for post-mortem work:

“So, my role was basically just overseeing the mortuary staff and helping them with their paperwork, erm, reporting procedures etc ... Erm, I don’t think I really took managerial responsibility for the actual post-mortem work.”⁹⁶

Mr Taylor also did not perceive himself as having responsibility for the body store at Maidstone. His reasoning for this is that, as a biomedical scientist, he did not have any mortuary qualifications and was not qualified to provide professional supervision: *“Because I wasn’t, I wasn’t qualified in anything, to do with anything like that.”⁹⁷*

Mr Taylor told the Inquiry that his main responsibility was to ensure that the Trust met the requirements of the HTA. We have seen a selection of mortuary service governance meeting minutes covering 2012 and 2013, and it is clear that there was significant work being undertaken to develop SOPs, and the Trust did successfully reapply for its HTA licence in 2014. However, in placing Mr Taylor in the role of Mortuary Manager, the Trust did not recognise the importance of having senior leadership from someone with the required professional skills.

- By 2011, there was no professional leadership or oversight of the APTs and how they performed their duties when delivering the mortuary service. The Mortuary Manager at the Trust did not have the necessary APT skills to provide appropriate levels of supervision and oversight to ensure that the mortuary staff complied with SOPs being developed and agreed at the various governance forums.

When Mr Taylor retired in 2016, Mr Peter Deal became the Mortuary Manager and held this position until after David Fuller’s arrest. Mr Deal was also a biomedical scientist, registered with the HCPC. Mr Deal told the Inquiry that, before he became the Mortuary Manager, he was a Pathology Manager and he maintained this role and all its responsibilities once he was appointed to the position of Mortuary Manager. The Inquiry is mindful that this created the same situation that had seen the mortuary struggling so much between 2009 and 2011. The manager responsible for the mortuary had a broad range of responsibilities, was not an APT and was not situated on the site where PME’s were undertaken. Mr Deal told the Inquiry that he had some previous experience in managing a mortuary service for a short time in 2002 but

95 Witness transcript of Mr George Taylor, biomedical scientist, Mortuary Manager, 2011–2016.

96 Ibid.

97 Ibid.

acknowledged that, with the advent of the HTA legislation, there had been significant changes to mortuary services since that time.⁹⁸

Mr Deal told the Inquiry that he had only visited the mortuary at Tunbridge Wells Hospital on a monthly basis during a four-year period.⁹⁹ However, the Inquiry notes that Mr Deal told the police in February 2021 that he had visited the mortuary on only a handful of occasions and that he had not seen the new fridges that were installed in November 2020.¹⁰⁰ In other words, he had not visited the mortuary for at least four months. The Inquiry also notes that N131, an APT, told the Inquiry that Mr Deal did not visit the mortuary at Tunbridge Wells Hospital more than twice.¹⁰¹ When the Inquiry asked Mr Deal about the frequency of his visits to the mortuary at Tunbridge Wells, he agreed that they were infrequent.¹⁰² The Inquiry acknowledges that the COVID-19 pandemic did place operational restraints on cross-site visits. However, we consider that even prior to the pandemic, it is likely that Mr Deal was an infrequent visitor to the Tunbridge Wells Hospital mortuary.

Mr Deal informed us that he had relied upon the Lead APT to manage all aspects of the mortuary, both professional and service delivery.¹⁰³ The Lead APT, Mr Crossley, contradicted Mr Deal regarding this matter in response to questions asked during his interview with the Inquiry:

“Q: Did they confer to you any supervisory role at all in your role as lead APT for staff in the mortuary?”

A: For the training of the junior APTs and assisting at post-mortems and what have you. Not so much the managerial side, no.

Q: No? And as lead APT, were you ... did you have any role in supervising that people were there on site, that it was staffed? Did the mortuary manager look to you ...

A: No.”¹⁰⁴

Mr Crossley also commented that “*management*” would be the people to draw up an action plan following any incident occurring in the mortuary.¹⁰⁵ He also told the Inquiry that “*management*” would be involved in monitoring any actions that arose from an HTA inspection.¹⁰⁶ This is consistent with Mr Crossley’s view expressed to Lowell and Johnson in 2009. It is clear to the Inquiry that Mr Crossley did not consider himself to have any role in the management of either the mortuary service or the APTs.

The two other APTs at Tunbridge Wells Hospital confirmed this view, reporting that they were a team of three and not distinguishing Mr Crossley as a manager performing

98 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

99 Ibid.

100 Officer’s report following interview with Mr Peter Deal, 5 February 2021.

101 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

102 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

103 Ibid.

104 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

105 Ibid.

106 Ibid.

an oversight role for them.¹⁰⁷ N130, APT at the Trust from 2014 to 2023, commented: *"We had no management structure at all really."*¹⁰⁸ N130 also commented upon the way in which the lack of management support impacted on the APTs:

*"[F]or example, equipment or PPE erm, to do our job, really. We'd keep asking for equipment or things and it will, will just never get delivered really, because of the budget. Or it was just we put an order in and you just didn't happen."*¹⁰⁹

N130 told the Inquiry that, even when the APTs kept asking about personal protective equipment (PPE), there was no response: *"Er, you just keep asking, and then eventually, you keep asking and you just get fed up because nothing happens."*¹¹⁰

It is difficult to understand how APTs were able to undertake their responsibilities and activities without adequate PPE. It is clear from the evidence that there were limited management processes in place to action important day-to-day functions of the mortuary service.

N131, an APT who began working at Tunbridge Wells Hospital in 2012 as a mortuary technician before qualifying as an APT in 2016, reported similar views about their experience of being managed in the mortuary: *"We had a management structure on paper, but I don't feel like I've ever been managed at that level before, no."*¹¹¹

- The Inquiry considers that the lack of management action and support for the APTs created a feeling of powerlessness for the mortuary staff. The Inquiry also considers Mr Deal's admission that he left the management of both the mortuary service and the APTs to Mr Crossley to be a derogation of his management responsibilities for the mortuary. Mr Deal's evidence indicates an absence of oversight, supervision and management attention being given to the mortuary service.
- The Inquiry has heard of the poor working practices that were considered commonplace in the mortuary, such as leaving the deceased on a mortuary table overnight and allowing maintenance staff to enter the mortuary when the deceased was laid out on the mortuary table. The Inquiry considers that the occurrence of these practices was directly related to a lack of management oversight and an absence of strong professional leadership.

Mr Deal did detail the challenges of managing the breadth of his role in his appraisal in 2020, referring to *"diverse departmental requirements"* and stating that a *"significant issue is having to rapidly change departments"*.¹¹² We note that he was envious of managers with only *"one point of focus"*.¹¹³ In her response, Ms Theresa Welfare, the Head of Biomedical Services, said Mr Deal was managing the diverse challenges well

107 Witness transcripts of N130, APT, worked in mortuaries at the Trust, 2014–2023; N131, APT, worked in mortuaries at the Trust since 2012.

108 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

109 Ibid.

110 Ibid.

111 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

112 Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021, appraisal 2020.

113 Ibid.

but made no mention of how she could support with these challenges.¹¹⁴ The Inquiry notes that Ms Welfare did not respond to Mr Deal's concerns and did not attempt to address the issues raised by him. We consider that, up to David Fuller's arrest in December 2020, Ms Welfare did not engage with the management of the mortuary in any depth.¹¹⁵ For example, the Inquiry heard that Ms Welfare was aware that the practice of deceased people being 'doubled-up' in fridges, as a way of managing capacity, was taking place.¹¹⁶ This practice is not in line with HTA guidelines.

It is of significant interest to the Inquiry that Mr Deal was an infrequent visitor to the mortuary. This absence of interest in the mortuary is echoed in the evidence of other senior staff. Mr Douglas only visited the mortuary once when it was at the Kent and Sussex Hospital site and on a further two occasions when it was sited at Tunbridge Wells,¹¹⁷ one of these being when it re-opened for post-mortems.

Ms Avey Bhatia, the Chief Nurse between 2013 and 2017, told us that she did visit the mortuary but not the post-mortem room, and that the focus of her attention was the support of the bereaved rather than the deceased, and the correct tracking of transfer of the deceased in and out of the mortuary.¹¹⁸ Another former Chief Nurse, from February 2017 to June 2021, Ms Claire O'Brien, told the Inquiry that, with regard to the mortuary, her focus was on the quality of care given to recently deceased patients as part of their End of Life pathway and the treatment of the bereaved. She did not visit the mortuary regularly, perhaps three to four times during her tenure, and, when she did, it was usually to see staff or for a specific purpose. Ms O'Brien commented that she had a limited role in relation to assuring the mortuary met the required HTA standards.¹¹⁹ The Trust Board relationship with the mortuary is discussed in more detail in Chapter 7.

The lack of visibility of the senior management team was noted by the APTs. N130 responded to questions from the Inquiry:

"Q: And do you ever see any of the senior leadership team or any of the execs in the mortuary?"

A: Erm, not really, nope. I think he, Miles Scott came down once when he started."¹²⁰

N131 supported this view:

"Q: You said that since the David Fuller incident you've seen Miles more often. Prior to that did any of the execs or senior leadership every [sic] come to the mortuary at all?"

A: No."¹²¹

114 Ibid.

115 Witness transcript of Ms Theresa Welfare, Head of Biomedical Services, and line manager to the Mortuary Manager since 2016.

116 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

117 Witness transcript of Mr Glenn Douglas, Trust Chief Executive, 2007–2017.

118 Witness transcript of Ms Avey Bhatia, Chief Nurse, 2013–2017.

119 Witness transcript of Ms Claire O'Brien, Chief Nurse, 2017–2021.

120 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

121 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

Both N130 and N131 reported a feeling of isolation from the Trust management structure. N130 commented, “[H]igher up the management chain, you know. Erm, I feel like for years we’ve just been ignored.”¹²² N131 commented, “I don’t – I just felt like there wasn’t really any communication over and above our little department to be honest.”¹²³

- The Inquiry considers that the mortuary service, and the APTs delivering the service, were not given the required level of management oversight to support them in delivering the service in line with the SOPs. The lack of visibility of the senior executive team created a sense of isolation for the mortuary service. This isolation created a sense of powerlessness for APTs. The Inquiry has found that following the move of the mortuary service to Tunbridge Wells Hospital, senior management supervision, oversight and assurance of the mortuary service was almost non-existent.

4.4.2 Professional management of the anatomical pathology technologists

The mortuary is staffed by APTs. To become an APT, an individual must undertake academic and practical training.¹²⁴ APTs are not regulated health professionals, and do not need to be registered with a health professional regulator or hold a licence to practise. This means that they are not governed by a regulatory framework that sets out professional standards and fitness to practise requirements to which all APTs must adhere. Therefore, APTs are not subject to any professional regulatory scrutiny or professional disciplinary process should their fitness to practise be questioned. There is an Association of Anatomical Pathology Technology (AAPT) that oversees the standards of the qualifications for APTs. However, membership of this body is on a voluntary basis only. The Inquiry considers that the professional leadership and oversight provided at the Trust was very limited until after David Fuller’s arrest.

A key aspect of maintaining and developing professional practice is access to Continuing Professional Development (CPD) opportunities. All the APTs we spoke to reported very limited access to CPD opportunities once they had achieved their initial professional qualification. N130 told the Inquiry that, apart from one course in 2021, they had not been on any further training courses since gaining their qualification.¹²⁵ N131 told the Inquiry that they had not been encouraged to undertake CPD prior to the appointment of the new Mortuary Manager in 2021.¹²⁶ Mr Crossley also told the Inquiry that, apart from a disaster identification course, he had not been on any courses. N131 and N130 were clear with the Inquiry that they would both have liked to have had more CPD, but they were not able to because of a lack of staff to cover their absence. N131 and N130 also commented that, although they both had annual

122 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

123 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

124 AAPT, ‘APT Careers’, AAPT website.

125 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

126 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

appraisals, they did not find them helpful, as they were not encouraged to undertake the development identified as part of the process.¹²⁷

The Trust engaged the AAPT to undertake a peer review of the mortuary in 2021, following David Fuller's arrest.¹²⁸ We consider that this peer review is relevant to the Inquiry, as it informs us about the professional practice and professional leadership arrangements that were in place during the period in which David Fuller was offending. The peer review identified that:

*"The practices in place in the PM room fall short of Level 3 standards and need addressing. There are health and safety concerns due to old style practices still being carried out. This would be easier to implement and more sustainable with an APT-qualified manager highlighting potential changes, rather than the DI or Mortuary Lead who do not have mortuary service experience."*¹²⁹

- Given the evidence we have seen, the Inquiry considers that there was an absence of professional oversight for APTs, as there was no APT who was sufficiently senior to provide that leadership and oversight.

The biomedical scientists who did have responsibility for the mortuary, such as Mr Withell and Mr Deal, were registered with the HCPC, but their roles did not involve clinical oversight of the APTs.

The Inquiry heard that there was another clinician with responsibility for the mortuary, Dr Mumford. Between 2010 and 2018, Dr Mumford reported through to the Trust Board via the Medical Director. Dr Mumford was the line manager for Dr Chambers, the DI at the Trust from 2014.

The Inquiry was struck by the increasing breadth of Dr Mumford's role from 2007 to 2018, when she became Deputy Medical Director.¹³⁰ When Dr Mumford was appointed to her consultant position in the Trust in 2007, she also held the position of Director of Infection Prevention and Control (DIPC) for the Trust, which is a statutory position of some importance, especially given the Trust's history with high rates of *C. difficile* infection. Dr Mumford told us that she was recruited to deal with this particular challenge:

*"I came into the Trust to sort out a massive C. diff outbreak and I was brought in specifically to manage that and to deal with it and to put things right, and that was a hugely challenging time."*¹³¹

In 2010, Dr Mumford was appointed to the position of Clinical Director for Pathology, which includes clinical responsibility for the mortuary. In 2012, her role was further expanded by the Trust to become Clinical Director for Diagnostics, Therapies and Pharmacy. In addition to the expanded Clinical Director role, Dr Mumford held the role

127 Witness transcripts of N130, APT, worked in mortuaries at the Trust, 2014–2023; N131, APT, worked in mortuaries at the Trust since 2012.

128 Report of peer review, 12 March 2021 (amended 26 March 2021).

129 Ibid., p.10.

130 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

131 Ibid.

of Associate Director for Clinical Operations between 2017 and 2018. This required her to report directly to the Chief Operating Officer and was a challenging role in a busy acute hospital. Dr Mumford has always held the position of DIPC along with her Clinical Director roles.

The Inquiry is aware that, in addition to Dr Mumford's expanded management responsibilities in 2012/2013, there was a merger with another local Pathology department, which would have required attention and management. The Inquiry has reviewed an external report produced in 2013 by Verita, a management consultancy that was commissioned by the Trust to investigate the relationships between its histopathologists.¹³² The report describes challenging professional relationships existing between some histopathologists. The report also identifies that both the clinicians and the managers in histopathology had a significant clinical backlog to tackle. The report contains a long list of recommendations that would have fallen within the remit of Dr Mumford to address, as the Clinical Director for Diagnostics, Therapies and Pharmacy. It is likely that these additional and new responsibilities would have absorbed the attention of Dr Mumford over and above the mortuary service. The management of medical staff became integrated into the overall management structures at the Trust in 2018.¹³³ This should have created a greater focus on services such as the mortuary, but the Inquiry could find no evidence that this was the case.

The Inquiry notes that Dr Mumford was able to provide focus and direction to the team when she first assumed her responsibility for the mortuary. This is illustrated by the detailed evidence she was able to give about her response to serious incidents occurring in the mortuary in 2010 and 2011. However, speaking about the period after her role and responsibilities at the Trust had increased, her evidence and knowledge about the mortuary service became markedly less detailed. This is illustrated by her lack of knowledge about the poor morale among mortuary staff, the working practices of the APTs and the limited management oversight that was provided to the mortuary.

- The Inquiry considers that Dr Mumford, as the Clinical Director with responsibility for the mortuary, did not demonstrate the required level of engagement with the mortuary service. Such engagement could have contributed to the resolution of the persistent problems the mortuary experienced following restoration of its licence in 2014.
- The mortuary did not adhere to the agreed SOPs, which reflected HTA requirements; while Dr Mumford was aware that this was the case in 2010/2011, the Inquiry has not seen evidence that she retained this focus once the licence was restored in 2014.

132 An independent review of the Histopathology department at MTW NHS Trust, December 2013.

133 Witness transcript of Mr Kevin Rowan, Trust Secretary since 2013.

4.5 Role of the Designated Individual at Maidstone and Tunbridge Wells NHS Trust

The statutory role of the DI is considered in more detail in Chapter 6. In this section, we deal with the impact of the DI post at the Trust. We interviewed three individuals who had held the position of DI: Dr Russell (2006 to 2010), Mr Leftley (May to December 2010) and Dr Chambers (2014 to present). In addition to these three individuals, the former Medical Director, Dr Sigston, held the position for a short time in 2011, prior to the Trust relinquishing its HTA licence.¹³⁴ The Inquiry heard consistent evidence regarding the difficulties experienced by DIs as they attempted to ensure that the service was delivered in line with HTA requirements.¹³⁵ Dr Russell told the Inquiry that he found the role to be particularly challenging and that he did not consider he had control of the issues for which he was responsible:

*"[T]he HTA role I erm found pretty challenging and I ... it was vastly more time consuming than I thought it was going to be and as we sort of hinted up, I didn't feel I had actually control of all of the issues or control of all of the steps on a pathway of for example the tissue retention pathway, you know it was there and defined but actually it didn't seem to be working terribly well."*¹³⁶

For a very short period, General Manager for Pathology, Mr Leftley, held the position of DI but found it equally challenging and told the Inquiry that it was pushed upon him: *"Unfortunately, yes and I say unfortunately because I felt I was really pushed into it because no one else would take the role on."*¹³⁷

Mr Leftley told the Inquiry that he did not consider himself responsible for or able to influence service delivery or adherence to the required standards. He did not ensure that the mortuary staff adhered to the required SOPs during the six years he was General Manager for Pathology and during his short tenure as DI.¹³⁸

In his evidence to the Inquiry, Dr Chambers, the DI from 2014 to present, appeared keen to distance himself from responsibility for managing the mortuary. Dr Chambers told the Inquiry that his role was to provide oversight, rather than management, for the mortuary service.¹³⁹ He also told the Inquiry that, although the HTA legislation gave him the responsibility for supervising regulated activities, he was allowed to delegate that responsibility but could not remember the person to whom he was able to delegate. He was, however, clear that he did not have responsibility for the day-to-day running of the service and attended on a weekly basis only:

"No, I was not, I was not the day-to-day manager. I did not oversee every individual activity."

134 Witness transcript of Dr Paul Sigston, Medical Director, 2010–2017.

135 Witness transcript of Dr Graham Russell, consultant pathologist at the Trust, 1991–2022, Designated Individual, 2006–2010.

136 Ibid.

137 Witness transcript of Mr Nigel Leftley, General Manager for Pathology, early 2000s–2011, Designated Individual, May–December 2010.

138 Ibid.

139 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

I was only ever really there one day a week and then plus, plus any mortuary mana, any erm, mortuary governance meetings.”¹⁴⁰

- It is clear to the Inquiry that the position of DI at the Trust did not enhance the support for the day-to-day management of the mortuary.
- The DI, Dr Chambers, told the Inquiry that he was not responsible for the day-to-day management of the mortuary. This position does not acknowledge the importance of HTA standards underpinning the daily activity of the mortuary. Dr Mumford should have been concerned about Dr Chambers’ understanding of his role.
- The HTA legislation places the responsibility for compliance with the standards in the hands of the DI. The Inquiry found that none of the DIs we interviewed felt able to influence whether the mortuary delivered its service in accordance with the standards and procedures required by the relevant legislation.
- It is of serious concern to the Inquiry that none of the DIs demonstrated awareness of the extent of the legal obligations of their role or felt able to exert the required level of influence to ensure adherence to the standards set out in the legislation.

In the case of Dr Chambers, the Trust told the Inquiry that it had supported him to undertake two leadership courses (ten days in total) in 2017 and to attend a Royal Society of Medicine conference in 2016.¹⁴¹ This did not appear to increase his understanding of the role.

We consider that the successive teams of senior management at the Trust knew the difficulties that existed in the mortuary service. Dr Rachael Liebmann, a consultant pathologist who worked at the Trust, told the Inquiry that she had raised concerns regarding the running of both the Maidstone and the Kent and Sussex Hospital mortuaries with Ms Rose Rees (formerly Gibb), who was the Trust Chief Executive between 2003 and 2007.¹⁴² Dr Liebmann told the Inquiry that it had taken a lot of courage for her to raise her concerns with Ms Rees. Yet, when the Inquiry spoke with Ms Rees, she told us that she had no recall of anyone raising problems about the running of the service.¹⁴³

The problems with the running of the mortuary that Dr Liebmann had identified continued through to 2009, as described by the Lowell and Johnson Report.

- The Inquiry has seen consistent evidence that the same cultural and service problems existed across the whole period within the Inquiry’s consideration.

140 Ibid.

141 Response received from MTW NHS Trust during the Inquiry’s Fairness Process.

142 Witness transcript of Dr Rachael Liebmann, consultant pathologist at Kent and Sussex Weald NHS Trust, 1999, then Maidstone and Tunbridge Wells NHS Trust to 2014.

143 Witness transcript of Ms Rose Rees (formerly Gibb), Trust Chief Executive, 2003–2007.

- The same issues with lack of adherence to SOPs and competencies that had been reported in 2009 were reported in the peer review of 2021. The Inquiry considers that it is significant that we found limited evidence that these issues had ever been resolved during that 12-year period. There was a lack of management oversight and supervision from 2005 to 2020.

The following section identifies the impact of the inadequate supervision and oversight and how this contributed to creating opportunities for David Fuller to commit the offences he did over such an extended period of time.

4.6 Impact of inadequate management oversight of the mortuary at Tunbridge Wells Hospital

The inadequate management and supervision that we have set out in this chapter created the environment in which David Fuller was able to offend in the mortuary at Tunbridge Wells Hospital. We heard of mortuary working practices that were in direct contradiction to the HTA Codes of Practice and the Trust's mortuary SOPs. The Inquiry was told about the practice of leaving the deceased out overnight in the post-mortem room, prior to a PME the following morning. We also heard that the deceased were left out in the post-mortem room when maintenance staff came into the mortuary to undertake tasks unaccompanied. Both practices are discussed in detail in Chapters 2 and 3. David Fuller exploited these gaps between policy and practice for his own sexual gratification.

The Inquiry considers that senior managers with responsibility for the mortuary ought to have known these practices were occurring. Inadequate supervision and oversight of the mortuary enabled these disrespectful practices to continue unchecked. In his evidence to the Inquiry, David Fuller told us of three instances where he had committed offences against deceased people left out in the mortuary, as set out in Chapter 2.

The Inquiry heard that mortuary staff continued to feel isolated after the move to Tunbridge Wells Hospital. The mortuary staff reported that, prior to David Fuller's arrest, they did not see senior managers and there was no communication outside of the Mortuary department.^{144,145} A report of a peer review carried out in March 2021, after David Fuller's arrest, identified that mortuary staff had little face-to-face engagement with anyone other than the DI, Dr Chambers.¹⁴⁶

We also heard of disorganised working practices in relation to when the mortuary was staffed. We were told that, as a result of being short-staffed, the APTs frequently worked over their contracted hours.¹⁴⁷ This required staff to take time off in lieu on a regular basis:

¹⁴⁴ Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

¹⁴⁵ Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

¹⁴⁶ Report of peer review, 12 March 2021 (amended 26 March 2021).

¹⁴⁷ Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

*"I would leave at half-past three, if I happened to miss my lunch break, which is 30 minutes. We acquired a lot of over ... 'cause there was only three of us, it was a lot of overtime and time in lieu. And we were instructed by Pete Deal to just manage that as ... amongst ourselves."*¹⁴⁸

The Inquiry was told that, in 2014, after the Trust successfully reapplied for its licence, the APT workload increased and a system of taking time back in lieu was introduced.¹⁴⁹ We heard that the system for taking time back was that, if it was a small amount of time, the APTs would agree between themselves. If it was as much as a day, they would email the Mortuary Manager to ask for permission.¹⁵⁰ Mr Deal also provided the Inquiry with an account of how time in lieu had been managed until 2019:

*"[W]hen George Taylor handed over to me, he said that there was a situation where, if they came in early, the Trust wouldn't pay them money for overtime, and that they may accrue lieu time, and Ken looked after that. So, Ken would deal with the lieu time, and I think they all kept their own records, and they would email me and say, you know, 'Is it all right? I need to take half an hour.' But it wasn't very common, put it that way."*¹⁵¹

Mr Deal told the Inquiry that there was very little time in lieu after an electronic health roster was introduced in 2019.¹⁵² However, the reports from the APTs indicate that this was not the case. This leads the Inquiry to conclude that there was a lack of oversight of working practices in the mortuary up until David Fuller's arrest.

The peer review carried out in 2021, after David Fuller's arrest, identified that there were staffing pressures due to increased workload.¹⁵³ The identification of when staff were working in the mortuary was important to the Inquiry, as we know that David Fuller offended during the mortuary's working hours. We consider that the lack of supervision of working practices created opportunities for him to offend during these times. Time in lieu is also discussed in Chapter 2.

We also noted a series of breaches of security in 2013, where the mortuary fire exit door was found open, having been locked the night before.¹⁵⁴ We found that these breaches were subject to limited investigation, although they were reported by mortuary staff. Senior staff made the assumption that it was porters leaving the doors open, but we could see no evidence upon which to base this assumption and note that minimal action was taken to improve security.

The Inquiry heard numerous examples of a lack of management oversight of the mortuary. The Inquiry notes that Mr Holland, General Manager for Pathology, told the Inquiry that he took assurance regarding compliance with the mortuary SOPs from the Quality Manager and the Mortuary Manager. Mr Holland also told the Inquiry that he took assurance regarding the SOPs from the compliance process itself:

148 Ibid.

149 Ibid.

150 Response received from N131 during the Inquiry's Fairness Process.

151 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

152 Ibid.

153 Report of peer review, 12 March 2021 (amended 26 March 2021).

154 MTW NHS Trust, Incidents reported by mortuary staff, 2011–2020.

"[M]y assurance will come from the Quality Manager and the Mortuary Manager. I wouldn't necessarily read every, all that was done. I think if they were giving me assurance that everything was okay, then that would be, you know, we would say 'Has it been done?'; I would be taking my guidance from, well, when we next get ISO assessed or accredited, or when we next get HTA reviewed, that would then give me my final – the feeling whether what they said was actually happening."¹⁵⁵

The Inquiry considers that Mr Holland's statement is an example of both the isolation of the mortuary service and its lack of management oversight. It is clear from his evidence that Mr Holland did not consider himself responsible for such matters as mortuary SOPs, even though they were governed by regulation and legislation. The Inquiry considers that Mr Holland did not take the required level of management responsibility to ensure that the mortuary was adhering to SOPs and fulfilling HTA requirements.

- The Inquiry considers that the mortuary management arrangements between 2011 and 2020 did not provide the required level of supervision and oversight to the mortuary service. David Fuller is responsible for his crimes against the deceased resting in the mortuary. However, the lack of effective managerial oversight and supervision of mortuary working practices supported the circumstances in which David Fuller was able to offend without being discovered.

What we have found

- The mortuary management arrangements at the Trust between 2005 and 2020 were not sufficient to ensure the running of the service according to the requirements of the Human Tissue Authority (HTA). Although the mortuary changed site during this period and was also subject to changes in management personnel, the problems with the mortuary service persisted. Practices were adopted that suited the convenience of mortuary staff rather than adhering to the requirements of the HTA guidance. The Inquiry heard that there was virtually no on-site supervision, limited oversight and limited assurance. The Inquiry considers that the lack of oversight allowed a culture to develop in the mortuary where Standard Operating Procedures were routinely not followed, and security breaches were not thoroughly investigated. We were unable to find any evidence that these issues were resolved over the period we were reviewing. This culture created the environment in which David Fuller offended.

155 Witness transcript of Mr Mark Holland, General Manager for Pathology, 2010–2022, then Head of Service for Pathology.

- By 2009, the senior management team at the Trust were aware that the mortuary management arrangements were not able to deliver the service to the standard required by the HTA. They had also been warned that there was a risk of serious harm unless action was taken. This warning was reiterated publicly in a *Daily Mail* article in 2011. The Inquiry heard that actions were taken which included changing leadership and strengthening governance arrangements, but these actions were not supported in the long term. Even when there was clear evidence of the poor running of the service, and senior managers had concluded that there were significant problems with the mortuary service, the most notable long-term action taken was to remove the mortuary from external scrutiny by relinquishing the Trust's HTA licence.
- The Inquiry found that, even when the lack of on-site management support had been identified in 2009 by both the HTA and the Lowell and Johnson Report, the required level of management support at the Kent and Sussex Hospital mortuary was not forthcoming.
- From the time when the service moved to the Tunbridge Wells Hospital site in 2011 until David Fuller's arrest in 2020, the mortuary management arrangements again did not provide the necessary supervision and oversight to ensure that the service adhered to its own policies and procedures. The leadership of anatomical pathology technologists (APTs) continued to be inadequate, and APTs adopted working practices that were not in line with HTA requirements.
- Mortuary staff felt isolated from the rest of the Trust, received minimal supervision, did not have access to Continuing Professional Development and felt that senior management ignored them. We heard consistent evidence from staff and saw evidence in a number of reviews that there were deep cultural problems within the mortuary. We saw no evidence that these cultural problems were ever addressed by senior management at the Trust.
- It is clear to the Inquiry that members of the executive team knew about the problems with the mortuary service as early as 2008. However, we were unable to identify any evidence that these issues were discussed in any detail at Trust Board meetings. The Inquiry considers the failure to keep the Trust Board fully informed of the problems in the mortuary to be a significant failure of corporate governance on the part of the successive executive teams.

Chapter 5:

Security arrangements at Maidstone and Tunbridge Wells NHS Trust

In this chapter, we review the security arrangements that were in place at Maidstone and Tunbridge Wells NHS Trust (the Trust). This includes the management and oversight arrangements of the mortuary service between 2005 and 2020. We consider the adequacy of these arrangements – in particular, CCTV coverage and the monitoring of swipe card access to restricted areas. We also consider the wider security arrangements at Maidstone and Tunbridge Wells NHS Trust, because the security of the mortuaries is not completely under the control of the mortuary service and its staff.

5.1 Management arrangements for security services through to the Trust Board

Maidstone and Tunbridge Wells NHS Trust has had a complex arrangement for the provision and management of security and security systems. From 2005, a private company has provided and operationally managed a security service for the Trust, with the Trust retaining responsibility for the systems of security monitoring and control, and the oversight of security provision.¹ Consistent evidence given to the Inquiry indicates that there was a very limited security function at the Trust until the appointment of a Local Security Management Specialist (LSMS) in 2006.² This post was also known as the Trust Security Manager. The provision that was in place focused upon car parking arrangements.³ The security function was managed through the Estates department. However, the management of the Estates function has been subject to changes in terms of the person accountable to the Trust Board for the function between 2005 and 2020.

The Trust provided the Inquiry with evidence that the post of Chief Operating Officer was the accountable officer to the Trust Board for the Estates function until 2018, when a decision was made by Mr Miles Scott, the Chief Executive since 2018, to remove this responsibility from the Chief Operating Officer's portfolio. However, Ms Angela Gallagher, Chief Operating Officer between 2001 and 2018, told the Inquiry that she

1 Witness transcript of N525, Security Manager, 2016–2020.

2 Witness transcripts of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011; N526, Security Manager, 2006–2015.

3 Witness transcript of Mr John Weeks, current Director of Emergency Planning and Response, various roles, 1992–present.

only assumed responsibility for the Estates function around 2014 or 2015, following the departure of the Director of Finance.⁴ The Inquiry notes that Ms Nikki Luffingham, the Chief Operating Officer before Ms Gallagher, told the Inquiry that the Estates function was in her management portfolio.⁵

In 2006, the Trust introduced the post of the LSMS. This was part of a national initiative following an NHS directive that year, which created the post of LSMS as a requirement for all NHS trusts in England.⁶ The underpinning principles of the directive were to protect NHS staff from injury and ensure that NHS assets were securely maintained.

The Trust provided the Inquiry with evidence in relation to the management arrangements for the LSMS at the Trust.⁷ We were informed that, when the Trust introduced the position of LSMS in 2006, it was initially managed by the General Manager for Facilities Contracts, Mr Stuart Hoile, and then the Assistant Director of Estates and Facilities, Mr Steve Wedgwood. Both positions were managed by the Director of Estates and Facilities, Mr Derek Shaw, who reported to the Chief Operating Officer.⁸ The Chief Operating Officer from 2008 to 2011 was Ms Luffingham. As stated previously, the Trust was clear that Ms Gallagher, who was appointed Chief Operating Officer in 2011 after Ms Luffingham's departure,⁹ assumed executive director responsibility for security through the Estates function.¹⁰ In 2018, on Ms Gallagher's retirement as Chief Operating Officer, the reporting line for the Estates function changed, with the Director of Estates reporting directly to Mr Scott, the Chief Executive. Mr Scott assumed direct responsibility for the whole of the Estates portfolio, which included the security function.¹¹ This situation continued until after David Fuller's arrest.¹²

The Inquiry was told by N526, the Trust Security Manager who was in post from 2006 to 2015, that at some point during their tenure, Mr John Sinclair, Head of Compliance, became their line manager.¹³ This is different from the evidence supplied by the Trust. The Inquiry is satisfied that Mr Sinclair (now deceased) did assume line management responsibility for the Trust Security Manager. N526 was credible in their account of the difficulties this change created for them. Mr Sinclair becoming responsible for security meant that the post of LSMS had four layers of management to the Trust Board, which may have made it difficult for the Trust Board to gain adequate oversight of the security function.

From the information supplied to the Inquiry by the Trust Secretary, Mr Kevin Rowan, when a new LSMS, the Trust Security Manager N525, was appointed in 2016, there were only three layers of management from the LSMS to the Trust Board. However, at some point during the tenure of the new LSMS, another management layer was introduced once again.

4 Witness transcript of Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

5 Witness transcript of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011.

6 Department of Health, Letter to NHS bodies, Secretary of State Directions on NHS Security Management Measures, 24 March 2004.

7 Paper provided by Mr Kevin Rowan, Trust Secretary since 2013, in response to Inquiry question, 24 April 2023.

8 Mr Derek Shaw, Director of Estates and Facilities, 2010–2013.

9 Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

10 Paper provided by Mr Kevin Rowan, Trust Secretary since 2013, in response to Inquiry question, 24 April 2023.

11 Ibid.

12 Ibid.

13 Witness transcript of N526, Security Manager, 2006–2015.

- The Inquiry considers that between 2005 and 2020, the Trust Board oversight of security was obscured through an overly long chain of management accountability. This may have made it difficult for the Trust Board to see how effectively the security function was operating.

In her evidence to the Inquiry, Ms Gallagher stated that, although she did not directly manage the LSMS post, she did directly liaise with the LSMSs to discuss the security assessment and plan.¹⁴ Neither of the LSMSs mentioned this happening during their evidence to the Inquiry. The Inquiry accepts that this does not mean it did not happen but considers that this liaison was not at the forefront of the LSMSs' minds when giving evidence to the Inquiry.

In 2018, the reporting line for the Estates function changed, with the Director of Estates reporting directly to the Chief Executive, Mr Scott, which reduced a layer of management in terms of the security function's reporting arrangements. However, the decision did not improve the visibility of the security function for the Trust Board, as the Director of Estates was not a voting member of the Trust Board and only attended Board meetings when invited for a specific purpose.¹⁵ Given this, the Trust Board would have been dependent upon the governance reporting systems to hear about the challenges the security function faced. The Inquiry was told that the Health and Safety Committee was the governance forum into which the security function reported.¹⁶

5.1.1 The Health and Safety Committee

The Trust's Health and Safety Committee was a management committee set up by the *"Trust Management Executive Committee to ensure the implementation and management of the operational aspects of health, safety and risk"*.¹⁷ In 2020, the Health and Safety Committee became a subcommittee of the Quality Committee, which was its reporting route up to the Trust Board in the Trust governance framework.

The LSMS attended the Health and Safety Committee from 2008.¹⁸ Part of the scope of the Health and Safety Committee was to review arrangements for the security of premises and to monitor the implementation of security policies and action plans from risk assessments. Mr Scott told the Inquiry that the Health and Safety Committee had an oversight function. This would have included ensuring that the appropriate policies were in place and audits were being undertaken within the security function, and were also being reported through the governance framework to the Trust Board.¹⁹

We reviewed the minutes provided to us from the Health and Safety Committee meetings held between 2008 and 2020. There are limited references to security breaches at either the Kent and Sussex Hospital mortuary or the Tunbridge Wells

14 Witness transcript of Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

15 Witness transcripts of Ms Jeanette Batten (formerly Rooke), employed with Trust predecessor organisations since 1988, Associate/Deputy Director of Estates and Facilities Management, 2011–2013, Director of Estates and Facilities Management, 2013–2019; Mr Douglas Ward, Director of Estates, 2019–2022.

16 Witness transcript of Mr Miles Scott, Trust Chief Executive since 2018.

17 Terms of Reference for the Health and Safety Committee, 2008–2018.

18 Health and Safety Committee Terms of Reference, 2014–2020.

19 Witness transcript of Miles Scott, Trust Chief Executive since 2018.

Hospital mortuary in the meeting notes. This is despite the fact that the Inquiry saw evidence of three security breaches over a two-month period in 2013, when mortuary staff reported coming into work and identifying that the fire exit door had been found open when it had been closed the previous evening. These security breaches were reported by the staff as incidents on the Trust's reporting system, but the Inquiry could not identify any evidence that they were discussed at Health and Safety Committee meetings. We did, however, see evidence of other security breaches discussed by this committee, such as assaults on staff.²⁰

The Inquiry notes the wide brief of the Health and Safety Committee, which included operational and clinical issues related to health and safety.

- Given the breadth of the Health and Safety Committee's focus, it is difficult to see how the Committee could have provided the level of oversight that was expected of the security function. In addition, given the complexity of the governance framework, it is also difficult to see how pressing security issues would have found their way up to the Trust Board.
- The Inquiry notes that the security function was managed through three or four layers of management for the period 2006 to 2020. In addition, there was a complex governance framework that was in place at the Trust. Acting together, these two factors meant that it was very difficult for the Trust Board to have adequate oversight of security matters as the reporting routes obscured information.

The Trust governance arrangements are discussed in detail in Chapter 7.

5.1.2 Trust Security Managers/Local Security Management Specialists, 2006 to 2022

In 2006, the Trust appointed its first Trust Security Manager who also held the title of LSMS. The Inquiry heard that, at the Trust, this post only provided strategic advice to the Trust Board regarding security. The post did not have operational responsibility for the delivery of the service: *"On security we did not have any operational management responsibility. It was purely advisory."*²¹

We also heard that the Trust managed the relationship with the private provider of security services:

*"There was never a Trust security team, we was the Trust team, we was the team, there wasn't a Trust team at all. There was only the Trust, our managers who obviously ... they oversaw all the contract there was never a Trust security team."*²²

There have been four Trust Security Managers since 2006.²³ However, one of these appears to have been in place as an interim measure between December 2015 and

20 MTW NHS Trust, Health and Safety Committee meeting minutes, 7 January 2013.

21 Witness transcript of N548, Associate Director of Estates, 2005–2011.

22 Witness transcript of N543, security staff, 2005–2016.

23 Paper provided by Mr Kevin Rowan, Trust Secretary since 2013, in response to Inquiry question, 24 April 2023.

May 2016, as they were previously the Fire and Compliance Officer and we saw no evidence that they were suitably qualified for the position of LSMS.

The Inquiry was told that the scope of the responsibilities of the Trust Security Manager was considerable but that they had limited budget to respond strategically to the security needs of either the Trust or individual services.²⁴ The Inquiry did not see any detailed breakdown of expenditure, and is not in a position to comment on the adequacy of the budget. The Inquiry heard that the Trust retained responsibility for the majority of the security infrastructure:

“Trust security is for the maintaining of the infrastructure, CCTV, computers, etc. We are mostly involved with general patrolling, CCTV monitoring, monitoring access control, scheduling.”²⁵

The operational responsibility for the security service has remained with a private provider and this provider changed on a number of occasions between 2005 and 2022.

5.2 CCTV at Maidstone and Tunbridge Wells NHS Trust, 2005 to 2020

When interviewed by the Inquiry, David Fuller commented that one of the measures that would have prevented him from committing his offences was the presence of CCTV in the post-mortem room of the mortuary. The Inquiry has no way of knowing if this would have been the case, or whether David Fuller would have found another route to gain access to the deceased. However, it is reasonable to assume that the presence of CCTV in the post-mortem room, capturing activity at the body fridges, would have presented a barrier to David Fuller committing offences in the way he did. For this reason, the Inquiry reviewed the presence of CCTV at both the Kent and Sussex Hospital and Tunbridge Wells Hospital mortuaries. We also reviewed decisions made about the installation of CCTV and the monitoring of CCTV between 2005 and 2020.

5.2.1 CCTV at the Kent and Sussex Hospital mortuary

The Inquiry was informed that there was limited CCTV across the whole of the Kent and Sussex Hospital site and no CCTV covering the mortuary. We were told by N526, a former Trust Security Manager, that there were approximately six cameras at Kent and Sussex Hospital, but that there was no strategic approach to the installation of these cameras:

“I think half a dozen cameras at Kent and Sussex. Again, sort of bit-buys. ‘Oh yeah, that’s cheap, let’s buy two of those,’ and all that. There is nothing consistent throughout the Trust.”²⁶

N526 recognised that the CCTV coverage was not sufficient for the Trust and instigated a review of CCTV across the Trust, prior to the move to the new Tunbridge Wells

24 Witness transcripts of N525, Security Manager, 2016–2020; N526, Security Manager, 2006–2015.

25 Witness transcript of N533, security staff from 2018.

26 Witness transcript of N526, Security Manager, 2006–2015.

Hospital site, “saying to the Director, ‘we have to put CCTV in place, and it has to be a lot better than it is now’”²⁷

The review lasted three weeks, with recommendations being provided to senior Trust management. We were informed by N526 that “it was a case of, ‘thank you very much for that, but we haven’t got the money for it, so don’t bother’”²⁸ They told us that they found the decision disheartening knowing how important CCTV is in a hospital. We were unable to find any evidence of where the decision not to implement the recommendations from the review was made.

The Inquiry saw evidence that the installation of CCTV in the Kent and Sussex Hospital mortuary was identified in an action plan to support the Human Tissue Authority (HTA) licensing activity in 2007.²⁹ From reviewing minutes of the mortuary service governance meetings, we also identified two occasions when the installation of CCTV was discussed for the Kent and Sussex Hospital mortuary. The first occasion occurred at the April 2008 meeting, where it was agreed that CCTV should be installed. We also saw the minutes of a mortuary service governance meeting held on 22 July 2009, which record: “The most recent incident at the Maidstone body store has been investigated and the MTOs [mortuary technical officers] were not at fault. CCTV will now be installed on both sites.”³⁰

We know that CCTV was not installed at either of the sites in 2009. The mortuary staff and managers recognised that CCTV was a way of ensuring that the mortuary was secure, but the importance of securing the mortuary does not seem to have been appreciated by senior management at the Trust. Ms Luffingham, the Executive Director with responsibility for security at the time, told the Inquiry that, although she was aware that it had been identified as a gap in the mortuary action plan, the prospect of the new hospital build reduced the possibility of spending money on the existing hospital buildings:

“[I]t didn’t seem to be the ... erm appetite to spend any money on a hospital that was being closed down. And erm I don’t believe it was ever ... despite our best attempts, ever agreed there would be any CCTV in you know you may have found they had put some in, but I ... it was quite a struggle.”³¹

- The Inquiry recognises that the Trust would have been focused on the build of the new hospital and that it would have been a difficult decision to fund expenditure on a hospital that was soon to be closed down. However, the Inquiry considers that, as CCTV was identified as a route to a more secure mortuary by mortuary staff and Dr Graham Russell, who was the Designated Individual at the time, with statutory responsibility for the mortuary licence, senior executives should have given greater consideration to the installation of CCTV in the mortuary at Kent and Sussex Hospital. Alternatively, in the absence of the installation of CCTV, they should have considered how to mitigate the risk that not having CCTV presented.

27 Ibid.

28 Ibid.

29 MTW HTA action plan.

30 Mortuary service governance meeting minutes, 22 July 2009, p.6.

31 Witness transcript of Ms Nikki Luffingham, Chief Operating Officer, 2008–2011.

- The Inquiry has not been able to identify any risk analysis around not installing CCTV in the mortuary at this time, and therefore has not been able to understand the rationale for not installing it, beyond that offered by Ms Luffingham. Neither have we been able to identify who was responsible for making the decision, even though we have reviewed a wide number of minutes from various governance forums.
- The Inquiry regards the decision not to install CCTV in the mortuary in 2009 as a missed opportunity to strengthen the security of the mortuary and create a barrier to David Fuller entering the mortuary unchecked and thus reduce his opportunities to offend.

5.2.2 CCTV at the Tunbridge Wells Hospital mortuary

The Tunbridge Wells site had a full system of CCTV installed prior to the hospital opening in 2011 as part of the Private Finance Initiative (PFI) contract. This did not include CCTV inside the mortuary. We know that CCTV was only installed inside the mortuary at Tunbridge Wells Hospital in 2020, and it was in the receiving room but not in the post-mortem room.³²

The CCTV system was operated by the private security company that was providing operational security services to the Trust. However, this is at odds with the Trust's CCTV Policy, which states that the Trust retained responsibility for the ownership and operation, and for compliance with statutory and regulatory standards for CCTV.³³

The Inquiry heard contrasting views on the adequacy of the CCTV implementation at this site. Mr John Weeks, the current Director of Emergency Planning and Response, told the Inquiry that when the hospital was opened there was an investment in security, which included "a security control room with lots of CCTV, which we never had before".³⁴ Mr Weeks also commented that these CCTV cameras were placed "on pretty much every entrance and exit to the hospital and in areas, flashpoint areas, like A&E and those kind of places".³⁵

N525, another former Trust Security Manager, gave a contrasting perspective on the effectiveness of the CCTV placement, telling the Inquiry that the design of the CCTV installation and coverage concerned them:

*"[W]e had no CCTV in our A&E majors' area which was, you know, which was our key area for violence. And that pretty much remained the situation for the four years that I was there. And I feel that that, if that paints a picture of what I came into ... So, on my arrival at both sites but Pembury [Tunbridge Wells Hospital] in particular being new, I think it was a fairly poorly executed security installation."*³⁶

32 Email, Mr Peter Deal (biomedical scientist, Mortuary Manager 2016–2021) to Brook Security, 6 May 2020, 16:53.

33 MTW NHS Trust, CCTV Policy and Procedure, for the years 2009–2021.

34 Witness transcript of Mr John Weeks, current Director of Emergency Planning and Response, various roles, 1992 to present.

35 Ibid.

36 Witness transcript of N525, Security Manager, 2016–2020.

They also stated: *“The CCTV coverage definitely was lacking and was out of date and, as I said, was unable to be replaced if a certain component of it failed.”*³⁷

Following David Fuller’s arrest, a review of the strategic and operational functioning of Trust security was undertaken in December 2021 and reported in January 2022.³⁸ Even though the report was published after David Fuller’s arrest, since the review illustrated the quality of the security arrangements in place around the time of his arrest, the Inquiry reviewed this report. The report comments that, although the CCTV was fit for purpose in terms of image quality, capture rates and data retention, there were a number of blind spots within the building and externally. The report cites the Emergency Department as an example of where CCTV coverage is insufficient to be of real value in terms of evidence of wrongdoing and monitoring movement and activities. The report also recommends a strategic review of the CCTV locations and points out that this would complement the small security team and provide a visual deterrent to wrong-doing. The Inquiry considers that the report of January 2022 supports the former Trust Security Manager’s view, which they held from 2015 until they resigned in 2020.

Opportunities to install CCTV in the Tunbridge Wells Hospital mortuary

There were occasions when the installation of CCTV in the mortuary was considered, following the move to the new Tunbridge Wells Hospital site. We were informed by a former Trust Security Manager, N525, that they were contacted by Mr Peter Deal, the Mortuary Manager at the time, in relation to installing CCTV in the mortuary, as a result of concerns about the treatment of the deceased by porters at the Maidstone Hospital site. N525 thought that this was around 2017 but could not be sure. N525 suggested that a small, localised CCTV system be introduced.³⁹ This CCTV system was to cover external areas of the mortuary, such as the external door, and fridge areas. N525 told us that, although they consulted with a supplier and drafted a proposal, they believed it was not installed because the development had to be funded from the Pathology department budget. We saw email evidence that Mr Deal did request a quote for the installation of CCTV in May 2016.⁴⁰ Mr Deal told the Inquiry that the CCTV system was not implemented because the funding for it would have had to come out of the Pathology budget: *“That fell through in about 2017 when I found it would have to come out of my budget.”*⁴¹

The Inquiry saw a long email trail from Mr Deal, starting in March 2018, requesting support for a quote for the installation of CCTV.⁴² Mr Deal eventually received a quote for the CCTV via email in November 2018.⁴³ The cost of installing CCTV in the mortuary at Tunbridge Wells Hospital in 2018 would have been £2,295.00 + VAT.

37 Ibid.

38 The Security Management Report, January 2022.

39 Witness transcript of N525, Security Manager, 2016–2020.

40 Internal email, Mr Peter Deal (biomedical scientist, Mortuary Manager, 2016–2021), 6 May 2016, 09:49.

41 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

42 Email, Mr Peter Deal (biomedical scientist, Mortuary Manager, 2016–2021) to Dr Dominic Chambers (consultant histopathologist, Designated Individual since 2014).

43 Email, Brook Security to Mr Peter Deal (biomedical scientist, Mortuary Manager, 2016–2021), 13 November 2018, 12:31.

It is clear that CCTV had not been installed by the time of the inspection by the HTA in November 2018, as the HTA made a recommendation that CCTV should be installed in the Maidstone Hospital body store to support lone working.⁴⁴ We were told that, following the HTA recommendation, the original paper requesting funding for CCTV was revived:

"[B]ecause of the timing of the HTA report, when we got to, it didn't come out until the January [actually November] 2018, which meant the 2017/18 money had gone and the 2018/19 money had already been allocated previously. So, I put in the business case, it was approved, and it went into the 2019/20 year."⁴⁵

The Inquiry understands that CCTV was installed in the Tunbridge Wells Hospital mortuary in May 2020.⁴⁶ The Inquiry was not able to confirm Mr Deal's assertion that the delay in installing CCTV was down to finances and funding cycles. This is because we were unable to identify where the decision was made as to whether the proposal should go forward for funding. However, we have no reason to doubt the explanation Mr Deal has given to us. The Inquiry considers that the delay in installing the CCTV, even after it was raised by Mr Deal as a priority following the 2018 HTA inspection, demonstrates that effective security was not considered a priority by senior managers. From the evidence the Inquiry has seen, it appears that Mr Deal was left to progress the issue alone, without support. There was no involvement from his line manager, Ms Theresa Welfare, Head of Biomedical Services since 2016. Even when Mr Deal was absent from work for six weeks, this matter was not progressed by anyone else and left in abeyance until his return.⁴⁷

- The Inquiry considers that the delay in installing CCTV in the Tunbridge Wells Hospital mortuary until 2020, even after it was raised by Mr Deal as a priority, illustrates a lack of understanding of the importance of security in the mortuary at a senior management level.

We were unable to identify who, or which forum, made the decision not to fund CCTV in the mortuary until 2020 but accept that it was a financial decision made at a departmental level.⁴⁸

The relative cost of the installation of CCTV was small for the organisation as a whole, but burdensome for the Pathology department. The Inquiry saw an email to N525, the Trust Security Manager at the time, which gives a quote for CCTV improvements at Maidstone Hospital that was more than £20,000.⁴⁹ The Tunbridge Wells Hospital mortuary CCTV installation would have made a small difference to this amount. However, for the Pathology department, the relatively small amount of money required was beyond its budget. In the Inquiry's view, this situation meant that the executive

44 HTA Inspection Report, 2015; HTA Inspection Report, 2018.

45 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021. Mr Deal gives the wrong date for the HTA 2018 report, which was actually produced in November 2018. Mr Deal's point stands, as it would have missed the funding rounds.

46 Email, Mr Peter Deal (biomedical scientist, Mortuary Manager, 2016–2021) to Brook Security, 6 May 2020, 16:53.

47 Email, Mr Peter Deal (biomedical scientist, Mortuary Manager, 2016–2021) to Brook Security, 24 October 2019.

48 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

49 Email, Brook Security to N525 (Security Manager, 2016–2020), 12 June 2019, 12:01.

team lost sight of what was happening at a local level in relation to security at the mortuary. The principle of local decision-making may have been sound, but there appears not to have been the ability to escalate where necessary.

- The Inquiry recognises that the Trust was experiencing significant financial pressures during this period and that difficult decisions had to be made. However, earlier installation of CCTV at the Tunbridge Wells Hospital mortuary, providing the correct coverage and operated with trained staff who were monitoring it, would have provided a significant barrier to David Fuller's offending.

The decision not to install CCTV in the post-mortem room

When the decision was taken to install CCTV, it was decided that it should only be installed in the receiving room and in the corridors of the mortuary, and not in the post-mortem room. The Inquiry heard that this was done to protect the dignity of the deceased. When David Fuller gave evidence to the Inquiry, he told us that when the cameras were being installed, he knew that they were being installed in the wrong direction to pick up his offending in the post-mortem room of the mortuary.

We heard that CCTV was not installed in the post-mortem room to protect the dignity of the deceased.^{50,51} We appreciate that the issue of CCTV in areas where there are deceased people is a matter of judgement and raises its own security issues.

- The Inquiry recognises that the decision about CCTV was made with the best intention to preserve the dignity of the deceased. However, consideration was not given as to how the installation of CCTV would prevent illegitimate access to deceased people in the post-mortem room.

The Inquiry also heard that, when the CCTV was installed, it did not comply with the requirements of the Trust's own CCTV Policy.⁵² For this reason, it was removed by the current Trust Security Manager, N266.⁵³ The Trust CCTV Policy required staff viewing the images to be trained in viewing them, which is a legal requirement. The policy also required that there should be CCTV management and a log of those trained to view the CCTV.⁵⁴ We were told that mortuary staff, who were expected to operate the CCTV system in the mortuary, were not trained in how to use the system or how to monitor the footage, with the reasoning that it was "fairly intuitive".⁵⁵ Mortuary staff told us that they did not monitor the CCTV footage: "**Q:** Did you ever used to look at it [CCTV]? **A:** No, it was just up in the corner."⁵⁶

It is clear that the CCTV, as installed, did not present a barrier to David Fuller offending.

50 Witness transcript of Ms Ritchie Chalmers, Chief of Service for Core Clinical Services Division since 2020.

51 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

52 MTW NHS Trust, CCTV Policy and Procedure, for the years 2009–2020.

53 Witness transcript of N266, Security Manager since 2020.

54 MTW NHS Trust, CCTV Policy and Procedure, for the years 2009–2020.

55 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

56 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

5.3 Monitoring access to the mortuary

The Inquiry heard that the mortuaries at the Trust were consistently identified as restricted areas, for which access was controlled. The Inquiry reviewed the extent to which access to the mortuary, as a restricted area, was monitored by the Trust between 2005 and 2020. We looked at the arrangements for Kent and Sussex Hospital and Tunbridge Wells Hospital separately.

5.3.1 Mortuary access arrangements at Kent and Sussex Hospital, 2005 to 2011

We heard consistent evidence from witnesses regarding the security arrangements for the mortuary at Kent and Sussex Hospital and all were aware of the restrictions in place to access the mortuary.⁵⁷ We requested Standard Operating Procedures (SOPs) and mortuary policies for the mortuary service at Kent and Sussex Hospital; however, we were informed by the Trust that they were not available. The Trust was unable to explain what had happened to them or if there had been a policy governing access at Kent and Sussex Hospital. We would have expected the Trust to have policies in place to address security arrangements for the mortuary.

The Inquiry heard that access to the mortuary at Kent and Sussex Hospital was restricted by a key and a digital keypad, and that all mortuary staff had a key.⁵⁸ During the day, access for all other staff was gained via ringing a bell and waiting for mortuary staff to answer the door: “[T]here was a bell on the door, and you just rang the bell and waited for someone to let you in.”⁵⁹

The Inquiry heard contradictory evidence about access to the Kent and Sussex Hospital mortuary outside mortuary working hours. We were told that porters had to sign keys out from the hospital switchboard when they required mortuary access to transfer the deceased.⁶⁰ However, we note that the 2007 HTA Inspection Report of the Trust contains the following comments:

“Out of hours access to the mortuary requires consideration. The current arrangement allows undertakers and portering staff to access the mortuary unaccompanied, using a keypad code to gain entry. The firm of funeral directors, Dignity Care, works under contract to the Coroner and staff have key access and instructions to disable and reset the alarm.”⁶¹

The Inquiry saw evidence that the system for access for porters during out of hours was identified as an issue by the HTA following its 2007 inspection.⁶² From this point onwards, we believe that the system was put in place where the mortuary key was kept at the switchboard, and porters and maintenance staff would have to sign the key out

57 Witness transcripts of N160, N315, N317, N318 and N534.

58 Witness transcript of Mr John Weeks, current Director of Emergency Planning and Response, various roles, 1992–present.

59 Ibid.

60 Witness transcripts of N160, N315, N317, N318 and N534.

61 HTA Inspection Report, 2007, p.10.

62 MTW action plan for HTA inspection October 2007.

from the switchboard if they required access to any restricted area, including the mortuary, out of hours:

*"It had a key and a digi lock to it. So during the daytime, when the mortuary staff were there, it was just a digi lock. And then at night, it was also locked with a key, which you had to get from the switchboard and sign out."*⁶³

The Inquiry heard that, with this system, switchboard staff knew who had the keys and how long a set of keys were signed out for and that this was recorded in a logbook. We asked for these logbooks, but they have not been retained by the Trust. We are therefore unable to assess how robustly staff adhered to this system. In light of the lack of documentary evidence on the matter, the Inquiry considers that it is more likely than not that access to restricted areas was not being monitored by the Trust.

David Fuller's access to the Kent and Sussex Hospital mortuary

The Inquiry heard that, as an electrical maintenance supervisor, David Fuller had a key to the hospital mortuary, as this was the practice at the time.⁶⁴ We heard that maintenance supervisors were given master and submaster keys to all restricted areas in the hospital, in order that they could access them in the event of a maintenance issue occurring out of hours. The evidence of N546, a former Operations Estates Manager at the Trust, on this matter was as follows:

*"Being in engineering, we had access to all places within the hospital. We had had to have keys we had a master key, submasters and ordinary keys."*⁶⁵

In 2002, David Fuller was promoted to supervisor, so he would have legitimately held a key to the mortuary from this point onwards and would not have been reliant on the keys held at the switchboard for access to the mortuary. This is supported by evidence we heard from porters, maintenance staff and the Trust helpdesk coordinators. In his evidence to the Inquiry, David Fuller told us that he had a key to the Kent and Sussex Hospital mortuary.

We were unable to confirm that giving David Fuller full access to the mortuary was in line with any mortuary policy, as we have not seen a policy governing access to the Kent and Sussex Hospital mortuary. We consider it likely that the mortuary did not have a policy governing access. A set of mortuary service governance meeting minutes in 2008 state:

"Model Rules for visitors

*JW had drafted a document – 'Model Rules for Visitors' because currently there is no protocol for security etc. The rules suggest having a signing in book for all visitors – this was discussed and agreed that this would not be practical and that CCTV would be the best form of security. JW to take forward."*⁶⁶

63 Witness transcript of Mr John Weeks, current Director of Emergency Planning and Response, various roles, 1992–present.

64 Witness transcript of N546, Operations Estates Manager, 2008–2012.

65 Ibid.

66 MTW NHS Trust, Mortuary service governance meeting minutes, 21 April 2008, p.4.

- These minutes provide evidence in relation to three important matters: there was no policy governing access to the mortuary for non-mortuary staff; there was no local record of who was accessing the mortuary; and CCTV was being discussed in relation to the mortuary in 2008.
- The Inquiry considers it to be a failure of governance that the Trust did not have a policy in place setting out mortuary access arrangements for non-mortuary staff at Kent and Sussex Hospital.

Control of access to the Kent and Sussex Hospital mortuary keys

We saw no evidence that there was any control of access to the mortuary keys, beyond placing them at the hospital switchboard and signing them in and out in a logbook. We requested the logbooks for review, but we were informed that the Trust was not able to find them. In addition, as there was no CCTV installed at the Kent and Sussex Hospital mortuary, it would be unlikely that someone who held a key would be noticed accessing the mortuary out of working hours.

Given that there was no system of monitoring access for those who legitimately held a key to the mortuary, it is likely that inappropriate access would only have been identified through mortuary staff noticing that something was amiss. The mortuary service was experiencing significant problems, as set out in Chapter 4, and the Inquiry considers that access to the mortuary out of hours would have gone unnoticed. This is supported by the fact that the Inquiry saw evidence that property went missing in the mortuary and no action was taken to discover how this had happened. The notes from the 2007 HTA inspection identified that:

“There has been at least one incident where personal property belonging to a member of the mortuary staff was stolen, during a period when no bodies had been delivered.”⁶⁷

We also saw minutes of the mortuary service governance meeting in July 2009, recording that a digital camera had gone missing:

“AB advised that the missing mortuary digital camera does have photographs on it as they had not yet been downloaded, however, they were non-identifiable.”⁶⁸

The Inquiry requested reports of all incidents in the mortuary or that mentioned the mortuary from the Trust’s central reporting system. While we did see evidence that the central reporting system was used by mortuary staff, neither of these incidents were reported by any staff working in the mortuary. We consider that the disappearance of a digital camera containing photographs of the deceased is a breach of security and should have been reported by either the lead anatomical pathology technologist (Lead APT) or the Designated Individual at the time, and then fully investigated. We note that the camera was recorded as found, in the minutes of the mortuary service governance meeting, six months later. The lack of reference to these incidents illustrates that

67 HTA Inspection Report 2007, p.10.

68 MTW NHS Trust, Mortuary service governance meeting minutes, 22 July 2009, p.6.

security breaches at the mortuary were not effectively reported by mortuary staff, including consultant pathologists, between 2005 and 2011.

- This lack of concern about security breaches suggests that there was little appreciation at senior management level and above of the importance of robust security procedures to protect the safety and dignity of the deceased in the mortuary.

Requests for extra mortuary keys at Kent and Sussex Hospital

The Inquiry found that David Fuller had a key to the Kent and Sussex Hospital mortuary from 2002. We also heard that there was a lax approach to the security of keys to the mortuary. Kent Police provided us with evidence that confirmed they had found a master key for the Kent and Sussex Hospital mortuary in David Fuller's possession. A work docket from Kent and Sussex Hospital, dated 2 February 2011, was also found by the police during a search of his home. The docket was a request for further copies of the mortuary master key to be cut. The Inquiry considered it important to understand why this request was made, as the cutting of extra keys to a restricted area compromises the security of that area. We were unable to speak with the employee whose signature was on the request as we were informed that they had died some years ago. From the evidence available to us, we understand that that employee did not work in the mortuary in 2011, having left in 2000.

The Inquiry interviewed N571, the employee on the helpdesk who issued the request to the Maintenance department.⁶⁹ N571 did not comment on this specific request but confirmed that it was not unusual for there to be requests for extra mortuary keys to be cut. Indeed, their recollection was that, on average, mortuary staff requested new keys about twice a month, which was more than any other department. However, we heard no other evidence that keys were being frequently cut for the mortuary.

The Trust's Security Policy and Procedure from 2011 states that master keys would not generally be available.⁷⁰ The Inquiry heard that at Kent and Sussex Hospital some new keys were cut in David Fuller's workshop, as long as they were not master keys, which we were told had to be sent away to a specialist supplier to be cut.⁷¹ This was confirmed by the helpdesk coordinator. The Trust was unable to explain to us why these additional keys were required. The current Lead APT, Mr Kenneth Crossley, who has worked in mortuaries at the Trust since 1994, informed the Inquiry that he had never requested a mortuary key to be cut and was not aware of the process for requesting extra keys.⁷²

David Fuller gained access to the Kent and Sussex Hospital mortuary through a key given to him, legitimately, in his role as an electrical maintenance supervisor. However,

69 Witness transcript of N571, Kent and Sussex Hospital helpdesk employee from 2006, Interserve manager, 2011–2017.

70 MTW NHS Trust, Security Policy and Procedure, 2011, p.13.

71 Witness transcript of N315, porter since 1992.

72 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

the cutting of extra mortuary keys was of interest to the Inquiry because of the compromise it presented to the security of the mortuary. We were unable to identify why these extra keys were requested with the frequency that has been reported or confirm who had requested them.

- In summary, the docket requesting the cutting of the mortuary key was found by the police in David Fuller's belongings, along with a mortuary key. This request was dated 2011, by a lead mortician who had left the mortuary in 2000. The Inquiry has not been able to establish how this was possible. We heard conflicting evidence about the regularity of keys being cut for the mortuary. However, the Inquiry considers that the presence of the docket requesting a mortuary key be cut in David Fuller's possession demonstrates that there was poor control over mortuary keys and is consistent with other evidence we heard about a lax approach to security in the mortuary.

5.3.2 Access arrangements on transfer to Tunbridge Wells Hospital in 2011

The Inquiry heard that access arrangements to restricted areas were chaotic from the beginning of the transfer to the new hospital site. N526, a Security Manager who worked at the Trust between 2006 and 2015, told the Inquiry that, when it came to the transition to the new Tunbridge Wells Hospital, they were conscious of not wanting to make the same mistakes as at Kent and Sussex Hospital, in terms of poor controls over restricted access.⁷³ They told the Inquiry that they developed a plan to issue forms to all managers in the hospital, requesting that they tick access requirements for each individual member of their team. This form was to be returned to the security team who planned to implement the controls according to the access requirements requested. The Inquiry heard that the senior managers responsible for the transition did not implement this plan:

*"And when the forms went out, I think of the 70 or 80 that we sent out, we got four or five back. So, of course, when Day One came and the hospital opened, the whole of the maternity unit opened first. And that was massive, and it was a case of, 'oh, just give everybody a card, and then we can sort out their access control afterwards.'"*⁷⁴

The Inquiry heard that there was confusion about access controls and swipe cards during the first year at the new hospital:

*"And on a number of occasions, we had systems switched off. So that everybody that is getting access to places they shouldn't have got access to, and that would come in the form of complaints. Saying, 'what the hell is this guy doing in here?'; 'what is this woman doing in here? How did she get in, what's the access control?' 'No, the doors are open'. And then you would have systems where they have shut them down, and people can't get access."*⁷⁵

73 Witness transcript of N526, Security Manager, 2006–2015.

74 Ibid.

75 Ibid.

“But they were literally just issuing cards when people came in, issue my card. I think the pay office used to issue cards at Maidstone . . . And they were losing cards. They actually lost, in the first year of access control cards, they lost over 90 cards that they couldn’t account for.”⁷⁶

The Inquiry heard that, during this period, swipe cards were only blocked once they were identified as missing and that this could take some time to do. N526, the Trust Security Manager at the time, told us that they introduced a system that meant that, if swipe cards were not used in a three-month time period, their access rights would be deleted centrally.⁷⁷

- The control of access to restricted areas during the transition to the new Tunbridge Wells Hospital was chaotic and did not follow the pre-arranged plan. Given the evidence that we heard about what happened during the transition, the Inquiry considers that the management of the controlled access to restricted areas was inadequate during the transition phase of the move to the new hospital.

5.3.3 Mortuary access arrangements at Tunbridge Wells Hospital, 2011 to 2020

David Fuller entered the mortuary 444 times between December 2019 and December 2020. There is no record of jobs allocated to him during this time, so attending to reactive maintenance tasks does not explain his presence in the mortuary. There is no other record of David Fuller using his swipe card to enter the mortuary, as swipe card data is deleted after one year. However, given that it is established that he offended 116 times between 2012 and 2020 in the mortuary at Tunbridge Wells Hospital, we examined in detail how access to the mortuary was permitted and monitored.

Control of access to restricted areas

The Inquiry heard evidence from 72 witnesses about access to the mortuary and other restricted areas at Tunbridge Wells Hospital. The Inquiry heard that, when services were transferred to the new Tunbridge Wells Hospital site, the mortuary was identified as an area where access should be restricted, in the same way that access was restricted to other areas of the site, such as pharmacy and IT.⁷⁸ There was video phone access at both mortuary entrances (see Figure 1 in Chapter 2). The Inquiry was told that, to access the mortuary during normal working hours, non-mortuary staff would ring a buzzer at the mortuary door and wait to be let in through the internal door. Outside working hours, the Inquiry was told that the only non-mortuary staff who needed to access the mortuary were porters and maintenance staff, who did so using a swipe card.

76 Ibid.

77 Ibid.

78 Witness transcript of Ms Jeanette Batten (formerly Rooke), employed with Trust predecessor organisations since 1988, Associate/Deputy Director of Estates and Facilities Management, 2011–2013, Director of Estates and Facilities Management, 2013–2019.

There were two entrances to the Tunbridge Wells Hospital mortuary: an internal entrance and an external entrance. Areas of restricted access at the hospital had doors with magnetic locks that required an electronic swipe card to deactivate the lock.

The mortuary as a restricted area compared with other restricted areas

The Inquiry heard that, although the mortuary was designated a restricted area, it was not treated in the same way as other restricted areas, such as maternity or pharmacy. We were told that, while maintenance engineers were given access to the mortuary, they were not given access to other restricted areas, such as IT, pharmacy and children's service areas.⁷⁹

We note that, in the Trust's Annual Security Report 2009, authored by the LSMS, the following priority areas were identified:

*"The LSMS has four **PRIORITY AREAS OF ACTION** to work towards, under which there are seven **GENERIC AREAS OF RESPONSIBILITY**. These will all be explained later in this Report. The four **Priority areas** are:*

*The prevention of violence and aggression to staff
preventing the loss and malicious damage of Trust assets
the security of drugs, prescriptions, pharmacies and hazardous materials, and
the security of maternity and other paediatric facilities around the sites."*⁸⁰

- The Inquiry considers that, even though the mortuary was identified as a restricted area, it was not protected with the same level of security as other restricted areas, such as pharmacy.

The Trust's Standard Operating Procedures and mortuary policy

The security procedures governing access to the mortuary are found in the SOPs, as part of the Mortuary General Policy and Procedures.⁸¹ The SOPs include the mortuary security policy, which sets out four levels of access:

- *Level 1 Unrestricted access on legitimate business*
- *Level 2 Restricted access with specific authorisation from mortuary manager or APT*
- *Level 3 Access only when accompanied by an authorised individual (level 2)*
- *Level 4 Restricted to viewing area only."*⁸²

The policy states that Estates department staff, which would include the maintenance team from Interserve (Facilities Management) Ltd (Interserve), could have Level 2 access. Level 2 access was authorised by an APT or Mortuary Manager, and people in

⁷⁹ Witness transcript of N160, worked at Kent and Sussex Hospital from 1998, then Interserve employee.

⁸⁰ MTW NHS Trust, Annual Security Report 2009.

⁸¹ MTW NHS Trust, Standard Operating Procedures: Mortuary General Policy and Procedures Documents, version 1.0, 3 November 2011, p.10; MTW NHS Trust, Standard Operating Procedures: Mortuary General Policy and Procedures Documents, revision 1.1, September 2014, p.9.

⁸² MTW NHS Trust, Standard Operating Procedures: Mortuary General Policy and Procedures Documents, version 1.0, 3 November 2011, p.10.

this category “will be required to attend a formal mortuary induction and training session. These sessions will be documented and certificated.”⁸³ Under the terms of the policy, those with Level 2 access did not need to be accompanied while in the mortuary. David Fuller was given Level 2 access to the mortuary as an electrical maintenance supervisor, in accordance with Trust policy, and could access the mortuary with his electronic swipe card unaccompanied.

Access to the mortuary for maintenance staff

We heard that maintenance staff, who were employed by Interserve, had access to the mortuary through their individual swipe cards at Tunbridge Wells Hospital. This was in line with the Trust’s SOPs and the Mortuary General Policy and Procedures.⁸⁴

The Inquiry was told that there was a change in 2018, when access to the mortuary was removed from the swipe cards of Interserve maintenance engineers. There are conflicting accounts of the reason for this.⁸⁵ According to the Trust’s Security Policy and Procedure from 2018,⁸⁶ removal of access should have been approved by the Trust’s LSMS. We were told by the LSMS, N525, who was also the Trust Security Manager between 2016 and 2020, that they had not been informed of this change and therefore had not approved it.⁸⁷

A shared swipe card to access the mortuary for Interserve maintenance staff and contractors was introduced in 2018. This was stored in a key box, on the wall of the Maintenance department, which was often left unlocked. The Inquiry was told that “the security of the cards was not great”, and that before the discovery of Fuller’s crimes, the process for signing the shared card and other cards in and out was “pretty lax”.⁸⁸

Once individual swipe card access to the mortuary was removed from maintenance staff, they could only access the mortuary through the use of the shared card, which they should have signed out in a logbook. The Inquiry heard that this process was not closely monitored, with one witness commenting that “they were really left to their own devices to be quite honest with you”, and that “occasionally” the relevant Interserve manager would check and tell people off if the correct procedure was not followed.⁸⁹ The same witness told us that keys were kept in a key cabinet, which was often left unlocked or with the key left in the lock to the cabinet. If the key was not in the cabinet, it was in a key safe next to it, with a combination code. However, the Inquiry was told: “[W]e all knew the number.”⁹⁰ The Inquiry was also told that there was no process to follow when a card went missing and no regular auditing of cards.⁹¹

The Trust Security Manager and LSMS in post at the time, N525, informed the Inquiry that they were unaware that there was a shared card for maintenance staff to access

83 Ibid.

84 Ibid.

85 Witness transcripts of N408, Interserve manager, 2018–2020; N127, Interserve employee from 2016.

86 MTW NHS Trust, Security Policy and Procedure, version 6.0, 2018.

87 Witness transcript of N525, Security Manager, 2016–2020.

88 Witness transcript of N162, Interserve helpdesk employee, 2020–2022.

89 Witness transcript of N410, worked at Kent and Sussex Hospital switchboard, 2008–2010, Interserve helpdesk employee, 2010–2019.

90 Ibid.

91 Witness transcript of N162, Interserve helpdesk employee, 2020–2022.

the mortuary. They also explained to us how this practice contradicted the purpose of access cards:

*"[W]hy would you need it? Why wouldn't you just have your own access on your own ID badge, I don't. I've always tried to shy away from the shared card, for example it's always requested by A&E for locum doctors who show up and then can't get through doors, which operationally is really difficult but invariably they go home with them in their pocket. So, you know, you're constantly at loggerheads with departments about this but I could not see any rationale for somebody who's got a, an access card, why wouldn't you just put that on their access? I don't understand."*⁹²

The Inquiry was unable to identify who made the decision to introduce shared swipe cards for Interserve staff. However, it was clearly not in line with the Trust's security policy operating at the time. The Inquiry reviewed all Trust security policies in place for 2016 and 2018 in relation to the matter of shared swipe cards.^{93,94} Both of these policies emphasise the individual nature of access control cards. Indeed, the 2016 policy states the following:

*"5.5.4 Electronic access control A passport – AC cards serve as a passport for use by staff and other authorised personnel, e.g., contractors, etc., for use in and around our hospital buildings and should be afforded the same level of security that one would with any other such document, e.g., personal travel documents, etc."*⁹⁵

This illustrates that for the purposes of the policy, access cards were issued on an individual basis to those who had been deemed as requiring access to particular restricted areas. In addition to the emphasis on the individual nature of electronic access control, the policy makes provision for when variations in electronic access are identified to be necessary. Both policies state that, where variations are required to access, the Trust Security Manager must be informed.

The Trust Security Manager at the time, N525, told us that they had no memory of being contacted about this and that they were sure they would have remembered such an important request, as demonstrated by this extract from their interview: *"In terms of providing a centralised card, I wouldn't understand the logic for it, and I would be concerned if that was brought to my attention."*⁹⁶

The Inquiry found that David Fuller, by his own admission, continued to access the mortuary with his own electronic swipe card even when a shared card was introduced in 2018. This was still in accordance with the policy operating at the time. However, the removal of individual swipe cards from Interserve staff and the introduction of a shared card may have increased his confidence that he was less likely to be disturbed in his offending. It also further strengthened his special status in relation to the access he had to the mortuary.

92 Witness transcript of N525, Security Manager, 2016–2020.

93 MTW NHS Trust, Security Policy and Procedure, version 5.1, 2016.

94 MTW NHS Trust, Security Policy and Procedure, version 6.0, 2018.

95 MTW NHS Trust, Security Policy and Procedure, version 5.1, 2016, p.15.

96 Witness transcript of N525, Security Manager, 2016–2020.

- The introduction of shared cards not only undermined the purpose of access control, but it also breached the security policy with regards to requesting variations in access control. The Trust Security Manager was not consulted about the decision and was not invited to give the benefit of their expertise on the matter. Furthermore, the introduction of a shared card, against Trust policy and without the Security Manager's knowledge, demonstrates a disregard for security systems and a culture in which the security of the estate was not valued or prioritised. Similarly, the expertise of the Trust Security Manager was not valued, even though they were an acknowledged specialist in the field of hospital security systems and employed specifically for that purpose.
- The Inquiry considers that a culture that demonstrably did not prioritise the security of the hospital estate, by ignoring the Trust's own policy on access cards, contributed to the environment in which David Fuller was able to offend.

5.4 The adequacy of the security arrangements at Maidstone and Tunbridge Wells NHS Trust between 2005 and 2020

There have been four Trust Security Managers at the Trust since 2006.⁹⁷ As previously stated, one of these, Mr Sinclair (now deceased), was an interim and only held the position for a few months. Two of the three Trust Security Managers told us that security had a low priority compared with other hospitals in which they had worked.⁹⁸ Although Ms Gallagher disagreed with this assessment, stating that security was a priority for the Trust,⁹⁹ both former Trust Security Managers expressed a view that their advice was not heeded. One commented:

*"I found that the situation at Pembury [Tunbridge Wells Hospital] was poorly, in terms of systems, poorly thought out. Poorly consulted on. I felt that, you know, whoever had been asked to do it, if anyone had been asked to do it perhaps hadn't had a full grasp of security in the NHS."*¹⁰⁰

They also told the Inquiry:

*"And in terms of how it was run and how it was managed, on arrival it very much felt like lip service was being paid to security. The security team was understaffed, so for that big site, you know, you had I think it was four staff."*¹⁰¹

The Inquiry heard about the effect of the Trust's financial pressures upon security services and the perceived importance of security at the Trust:

97 Paper provided by Mr Kevin Rowan, Trust Secretary since 2013, in response to Inquiry question, 24 April 2023.

98 Witness transcripts of N526, Security Manager, 2006–2015; N525, Security Manager, 2016–2020.

99 Witness transcript of Ms Angela Gallagher, Chief Operating Officer, 2011–2018.

100 Witness transcript of N525, Security Manager, 2016–2020.

101 Ibid.

*"[I]n my first year of arrival there were, we were put under pressure to cut extensively, and we lost our site contract manager, our security contracts manager. So, he was taken out of the equation. So, they had nobody directly managing them except me, but I worked for the Trust. So, I just, I really felt that we were, you know, grossly understaffed and grossly, the system was underfunded."*¹⁰²

*"I always felt that we were perhaps, as I said before, a financial burden that was constantly having, looking to be cut, cut, cut and not invested."*¹⁰³

The current Trust Security Manager, N266, identified that there was inadequate security guard provision on joining the Trust:

*"Currently, we are running two extra at each site, erm, because one of the things I first identified when I first came into the Trust was, given the size of the hospitals, the way they've both expanded over the years, erm, the amount of ground to cover and the amount of patients they deal with, three is not enough."*¹⁰⁴

N526, the Trust Security Manager between 2006 and 2015, was concerned about the performance of Interserve as a security provider. Interserve held the security contract from 2014 to 2017:

*"Interserve to me were, as a security company, very good at laundry, and they were very good at facilities. But security, they were lacking, and the first time it came to my notice how bad it was going to be, was when they put in place a security policy for their staff. Not our staff, and not under our policies. Under their policy, and the policy read, 'make sure you wind your horse up properly and put your gun in the cupboard'. And you think, hang on a second, where has this come from. And it was an American security policy, that they had forgotten."*¹⁰⁵

N256 told the Inquiry that, during the time Interserve had responsibility for operational security, there was no Security Manager in post at Interserve and none of the staff had training beyond the basic level required to hold the contract:

*"There was no Security Manager as such. They just had a supervisor. None of them, apart from the SIA License, none of them had any other security training or experience. Which is very difficult in a hospital environment ... So, I was forever reminding them about that. Yeah, just unhappy basically."*¹⁰⁶

This concern about the standard of the security service provided by Interserve was echoed by another former Trust Security Manager, N525, who was in post from 2016 to 2020: *"They were not recognised on the regulatory system. I had never heard of them in my 20 plus years of security management."*¹⁰⁷

102 Ibid.

103 Ibid.

104 Witness transcript of N266, Security Manager since 2020.

105 Witness transcript of N526, Security Manager, 2006–2015.

106 Ibid.

107 Witness transcript of N525, Security Manager, 2016–2020.

The Inquiry heard from both Trust Security Managers that funding for security was piecemeal, often coming from departmental budgets rather than being strategically funded by the Trust:

“And anything that I needed in terms of systems, such as CCTV or access control, either had to be paid by the departments themselves that wanted it, or we had to put business cases together.”¹⁰⁸

They explained that, although they had a basic maintenance budget, they did not have a budget for new equipment.¹⁰⁹ Both N525 and N526 told us that they were not listened to when concerns about security were raised and that they felt they were not taken seriously by the Director of Estates and Facilities at the time, as indicated by this comment:

“[T]he way I saw security in the Trust, between 2005 and almost 2015 when I resigned, was that they were treating security as a convenience rather than a necessity. And that’s the big mistake.”¹¹⁰

N526 told the Inquiry that they resigned because they were not being taken seriously, and were managed by individuals without any expertise in security:

“There was an attitude. Which is one of the reasons that I resigned, rather than just moving. It was, I wasn’t being taken seriously ... [an individual] who has no security experience whatsoever was put in, over me. Don’t know why. And it just became a sort of bullying. ‘Do this, do this, do this’, and ‘yes, but that’s not the role of the LSMS. As laid down by the Secretary of State’s directions.’ ‘Yes, but, I’m telling you to do it.’ ‘Enough is enough.’”¹¹¹

N525 reported similar difficulties with their experience of Trust management:

“[T]he Director of Estates and Facilities at the time, I don’t think was particularly pro-security or pro-me. And so, I don’t believe that anything I would have raised would have been taken particularly seriously.”¹¹²

5.4.1 Impact of the Private Finance Initiative on CCTV

The Inquiry was told that the opening of Tunbridge Wells Hospital in 2011, under a Private Finance Initiative (PFI), complicated the delivery of security systems on the new site.¹¹³ This was because any developments to the security system were required to go through the PFI management arrangements:

“It was a bit more complicated at Pembury [Tunbridge Wells Hospital] because Pembury’s a Private Finance Initiative building so largely the control came under the Estates provider there.”¹¹⁴

108 Ibid.

109 Ibid.

110 Witness transcript of N526, Security Manager, 2006–2015.

111 Ibid.

112 Witness transcript of N525, Security Manager, 2016–2020.

113 Ibid.

114 Ibid.

*"[I]t made it very difficult to manoeuvre through the systems and made it incredibly expensive so, although we, I was very acutely aware that systems were not as they should have been and actually, I think I put at least access control onto the risk register, if not that and CCTV. Because there was points of failure that would have been fatal for the organisation, really. That, to take remedial action would have cost the Trust hundreds of thousands of pounds if not into the realms of, I would guess something in the region of half a million to a million to remedy. And the system was antiquated and very difficult to use, with both CCTV and access control."*¹¹⁵

*"At Maidstone we had free reign because, you know, we weren't contractually obliged to anybody, and it was a very different ball game over there."*¹¹⁶

5.4.2 Security provision focused on car parking

The Inquiry heard that, historically, the development and focus of the Trust security function was on car parking.

N392, an Interserve manager from 2010 to 2016, commented that the focus of security was on car parks:

*"We had – most of the focus with security that I was involved in was blinking money and car parks. Because that was the – I would say, every meeting was, you know, the meetings that were about car parks, trying to get the money collected, what was the best time?"*¹¹⁷

This focus of security on car parking continued until February 2022:

*"[W]hen I first took the job, I still had the car parks and they were in the process ... they'd literally just started to build the two new double-deck car parks, and there was an awful lot of priority and emphasis placed on those as well. So I would suggest that, possibly for a fair while, I was tied up with the car park and bringing them online."*¹¹⁸

5.4.3 Trust Board understanding of security issues

The Inquiry saw no evidence that between 2005 and 2020 the Trust Board had any understanding of the inadequacy of its security arrangements. This is despite the issue of security being on the risk register, under the heading of Estates and Facilities.

Mr Scott, the current Chief Executive of the Trust, told us:

*"So pre, pre-Fuller's arrest, erm, you know, our security was not something where I have a load of complaints or a lot of information came to me to suggest that there were, there was a particular problem erm, but in digging around things, er, you know, as a consequence of the Fuller investigation, erm, you know, it became clear that actually the, the security system er, had, had weaknesses in it."*¹¹⁹

115 Ibid.

116 Ibid.

117 Witness transcript of N392, Interserve manager, 2010–2016.

118 Witness transcript of N266, Security Manager since 2020.

119 Witness transcript of Mr Miles Scott, Trust Chief Executive since 2018.

Mr Scott acknowledged some of the difficulties experienced in establishing the security systems at the new Tunbridge Wells Hospital:

*"[B]ut it does seem to me there were two, two or three quite specific missed opportunities. And for me, one of those was that when the new hospital was opened in 2011, it was opened with all of this security infrastructure that was not properly set up. And, er, and, and that erm, that in sense gave us false, a sense of false assurance. A really false so you know, really false assurance . . . the missed opportunity there was that all of this technology was introduced but was introduced in such a haphazard way that erm, that, that people like Fuller had, you know, virtually unlimited access around the organisation and you know, that wasn't controlled."*¹²⁰

We saw that the Trust Security Manager at the time of the transition to the new Tunbridge Wells Hospital, N526, had been raising concerns about the CCTV and access at the new site prior to its opening. Their concerns about security continued throughout their tenure and were such that they raised them, externally, with the Area Security Manager:

*"My concerns were so much that I went to my Area Security Management Specialist. Actually reporting to the Security Management company itself. The actual company, the Board of the SMS. And told him what my fears were and what was happening. He saw it, and sadly is not there now. But his remark to me was, 'get out.'"*¹²¹

- The Inquiry heard of protracted problems with the security function at Tunbridge Wells Hospital between 2006 and 2020. The security service was focused on hospital car parking, rather than the hospital estate. We heard that the senior executives of the Trust did not listen to the advice of its Security Managers. These matters included: access control arrangements on the transfer from Kent and Sussex Hospital to the new Tunbridge Wells Hospital; the installation and operation of CCTV; the provision of security services; and the management of the security contract.
- We heard that the Trust Security Managers' expertise was dismissed and that the first two Security Managers left the Trust because they were unhappy with how the Trust addressed security. One was sufficiently concerned about what was happening at the Trust that they raised their concerns externally. The Inquiry considers that it is significant that the former Trust Security Managers judged that the way in which security worked at the Trust was worse than in other NHS Trusts in which they had worked.

120 Ibid.

121 Witness transcript of N526, Security Manager, 2006–2015.

- We have considered the evidence we heard about Trust security, alongside evidence relating to the security of the mortuary. We find that it is impossible to separate the two. The Trust told the Inquiry that the focus of the annual security reports to its Board was violence and abuse towards staff rather than the security of individual areas of the Trust, because this was the principal area of risk identified by security and operational managers.¹²² We consider that the Trust did not place an overall strategic value on the security of its estate and this had an impact on how security of the mortuary was approached.

David Fuller knew that there was no CCTV in the mortuary until 2020. In his evidence to the Inquiry, David Fuller stated: “[I]f it [CCTV] was in place, then it wouldn’t have been possible no matter what mental state I was in, to actually carry out anything illegal.”

David Fuller had been accessing the mortuary at Tunbridge Wells Hospital since 2011 without any check on his activities. He would have been aware of the low numbers of security guards and the likelihood of them patrolling the mortuary area. It is likely he used this knowledge, together with his unchecked and unmonitored access, to enter the mortuary and commit sexual offences against the deceased.

What we have found

- The security systems in place at the Trust between 2005 and 2020 have been historically inadequate. The senior executive team at the Trust did not place an overall strategic value on the security function, indicated by how they ignored the advice of security experts and devolved security improvements to individual budgets. This meant that the security systems in place were updated in a piecemeal manner and lacked cohesion.
- The Inquiry considers that in 2011 on the move to the new Tunbridge Wells Hospital site, the Trust did not recognise the importance of ensuring the security of its estate, nor the potential safety impact that security lapses might have for those for whom it was responsible.
- The CCTV that was installed in the mortuary was ineffective, in terms of protecting the deceased, as it was not installed in the post-mortem room but also because there was no regular monitoring of it.
- The Inquiry considers that the Trust senior executive team failed to listen to the advice of successive security experts in relation to maintaining a secure estate. In addition, we consider that Trust senior executives failed to listen to mortuary staff and successive Designated Individuals regarding the necessity of installing CCTV in the mortuary.

122 Response received during the Inquiry’s Fairness Process from MTW NHS Trust.

- The Inquiry has identified that discussions about the installation of CCTV in the Kent and Sussex Hospital mortuary took place as early as 2008. Further discussions about the subject continued in 2013/14 and again in 2017/18. We know that CCTV was not installed in the mortuary until 2020 for financial reasons. The Inquiry considers that the Trust failed to prioritise the safety of the mortuary in a way that could have protected the deceased people resting in it.
- David Fuller was given key access to the mortuary at Kent and Sussex Hospital from 2002, as a result of his appointment as an electrical maintenance supervisor. His access to the mortuary was not monitored as there was no system of monitoring in place for those who had keys.
- David Fuller accessed the mortuary at Tunbridge Wells Hospital through the use of an electronic swipe card, given to him in his position as an electrical maintenance supervisor. The issuing of this card was in accordance with mortuary policy. There was limited oversight of maintenance staff using electronic swipe cards to access the mortuary. In particular, when access to the mortuary was removed from Interserve maintenance engineers' individual swipe cards, it was done in contravention of Trust policy and without the knowledge of the Trust Security Manager. Although it is unclear why this decision was made, the Inquiry considers that David Fuller being the only engineer to have an individual swipe card that allowed access to the mortuary further strengthened his special status in relation to access to the mortuary.
- The Trust failed to put in place adequate security systems to monitor staff access to the mortuary, such as regular review of usage of electronic swipe access cards.

Chapter 6:

The wider system

In this chapter, the Inquiry considers the effectiveness of the external regulation and oversight of the Maidstone and Tunbridge Wells NHS Trust's mortuaries.

We examine the arrangements for post-mortem examinations (PMEs) at the Trust, including the involvement of pathologists, anatomical pathology technologists (APTs), coroners and local authority staff, to consider whether they were adequate and if they presented opportunities to detect David Fuller's offending.

Finally, we look at arrangements for transferring the deceased to and from the Trust to identify whether concerns were or should have been raised.

We will consider the above in relation to other NHS mortuaries and other settings in the next phase of the Inquiry's work.

6.1 Transfer of the deceased to and from the Trust's mortuaries

If a person dies in hospital, they are taken to the mortuary by trained porters. If the cause of death is known and certified by a registered clinician, the deceased will be collected by an undertaker on instruction from the relatives.

If a person dies outside of hospital (e.g. at home or elsewhere in the community) and appears to have died of a known and natural cause, they require a medical certificate of cause of death (MCCD) from a registered clinician, after which they will be collected by the nominated funeral director. If it is not possible to issue an MCCD because the cause of death is unknown, or if the death appears to be unnatural, the deceased will be referred to the coroner for an assessment of the cause of death. The funeral director that has a contract with the local coroner will collect the deceased and take them to the mortuary. This could be an NHS hospital mortuary or one run by the local authority.

Deceased people usually leave the mortuary by being brought into the care of a funeral service and are collected by an undertaker.

6.2 Post-mortem examinations

Pursuant to section 14 of the Coroners and Justice Act 2009, coroners can request a PME to help establish a cause of death.

PMEs can be requested by:

- a senior coroner – because the cause of death is unknown, because the death was sudden, violent or unexpected, or because the death occurred in custody or state detention (relatives' consent is not required);
- a hospital doctor – to find out more about an illness or the cause of death, or to further medical research and understanding (relatives' consent is required); and, in some cases,
- relatives of the deceased.

A PME is carried out by a pathologist (a doctor who specialises in understanding the nature and causes of disease) supported by APTs. A forensic PME may be requested by the police or the coroner if the cause of death is unknown, there were any suspicious circumstances or there was potential third-party involvement. This is a more detailed examination and is performed by a Home Office-registered forensic pathologist.

6.3 External regulation and oversight of the Trust's mortuary

The Human Tissue Authority (HTA) is the independent regulator of licensed establishments that remove, store and use human tissue for research, medical treatment, PMEs, education and training, and display in public.¹ The Inquiry has focused on the HTA's interactions with the Trust in relation to post-mortem activity.

Other organisations that have had a role in overseeing the Trust's mortuary to some extent include the Care Quality Commission (CQC), UK Accreditation Service (UKAS), NHS England (NHSE) and the Health and Safety Executive (HSE).

Organisations that have had a role and have been succeeded by other organisations include the Department of Health (DH) and clinical commissioning groups (CCGs).

6.4 The Human Tissue Authority

The HTA was created in April 2005 following events in the 1990s that revealed a practice in hospitals of removing and retaining human organs and tissue without consent, mainly at Alder Hey Children's Hospital in Liverpool and Bristol Royal Infirmary. It is an executive non-departmental public body (ENDPB) of the Department of Health and Social Care (DHSC). As with all other regulatory frameworks, the HTA is under a duty to act in a manner that is proportionate and fair to all parties.

Before the HTA was created, there was no national regulation of NHS mortuaries. Pathologists undertaking PMEs have always been bound by the rules of their own professional regulation, but APTs are not regulated. The staff in NHS mortuaries are employed by the NHS Trust that runs the hospital concerned, although some medical staff may be employed by a university medical school and have an honorary contract

1 HTA, 'Who are the HTA?', HTA website.

with the hospital in which they undertake clinical activity. There is no independent regulation of NHS body stores, which house the deceased but do not undertake any HTA-regulated activity. We will explore the issue of regulation of APTs and NHS body stores in the second phase of the Inquiry's work.

The HTA monitors and inspects licensed establishments against published standards, supported by guidance. The HTA has published Inspection Reports since November 2010. Where it identifies shortfalls against standards, it works with establishments to ensure that improvements are made in line with an agreed action plan. In relation to post-mortem activity, the HTA's website states: *"We help mortuaries improve the standard of care they provide, so the public can have confidence that deceased people are treated with dignity and respect."*²

Since May 2010, the HTA has required establishments licensed in the post-mortem sector to notify them of serious incidents. These were originally known as Serious Untoward Incidents (SUIs). However, this terminology was changed to HTA Reportable Incidents (HTARIs) in April 2013 to distinguish between incidents that should be reported to the HTA and those that fall within the reporting framework of the NHS National Reporting and Learning System (to be replaced by the Learn from Patient Safety Events service). Before May 2010, serious incidents in establishments licensed in the post-mortem sector may have been reported to the HTA, but there was no formal reporting process in place. Since July 2020, the HTA has published quarterly reports containing details of HTARIs on its website.³

Organisations licensed in the post-mortem sector must have a Licence Holder and a Designated Individual (DI), and may also appoint Persons Designated to be accountable to the DI for specific departments or activities. These roles are discussed in more detail later in this chapter.

The following sections give details of the HTA inspections and investigations at the Trust's mortuaries between 2007 and 2020. The mortuaries at Tunbridge Wells Hospital and its predecessor, Kent and Sussex Hospital, were inspected, as they had a PME licence. Although Maidstone Hospital has a body store and is not licensed to undertake PMEs, it does have a licence for 'Storage of a Body or Relevant Material' and 'Removal of Relevant Material', and so was inspected by the HTA.

6.4.1 2007 HTA inspection, Kent and Sussex Hospital mortuary

The HTA informed the Inquiry that, when the licensing process was established, if an organisation applied for a licence it was deemed to have been granted at Phase 1 of the application process.⁴ Such a licence would remain in force until the completion of Phase 1, which was a desk-based evaluation of an organisation's self-assessment compliance as reported in their application for the licence. Phase 2 of the application process involved the on-site inspecting of hospital mortuaries. The purpose of Phase 2 of the licensing process was to review the organisation's operational policies and procedures, as well as inspecting its premises and scrutinising its practices. Phase 2

2 HTA, 'Guidance for professionals: Post-mortem', HTA website.

3 HTA, 'Disclosing information of incidents', HTA website.

4 Response received from HTA during the Inquiry's Fairness Process.

allowed for “the HTA to follow up on any areas of non-compliance and evaluate progress against any licence conditions imposed at Phase 1 inspection”⁵

In addition, the Phase 2 inspection was:

“aimed at providing an on-site in-depth assessment of establishments for whom a formal decision had already been taken to grant a licence at the end of Phase 1, as part of an ongoing regulatory assessment process through Phases 1 and 2 of the initial inspection programme.”⁶

In August 2007, the HTA inspected the Kent and Sussex Hospital mortuary to review its policies and procedures, assess premises and scrutinise practices as related to HTA legislation, as per Phase 2. The Inspection Report stated the following:

“Out of hours access to the mortuary requires consideration. The current arrangement allows undertakers and portering staff to access the mortuary unaccompanied, using a keypad code to gain entry. The firm of funeral directors, Dignity Care, works under contract to the Coroner and staff have key access and instructions to disable and reset the alarm. This is not considered to present a risk. Portering staff have access to the mortuary out of hours, in order to bring the bodies of patients who have died in the hospital to the mortuary. There has been at least one incident where personal property belonging to a member of the mortuary staff was stolen, during a period when no bodies had been delivered.”⁷

As written, the Inquiry considers it is ambiguous if it was the Trust or the HTA that considered the matter of funeral directors having key access to the mortuary to not present a risk.

The licence application form included a question about adverse events in the mortuary in the past 12 months, but without a requirement to submit details. The completed form stated that there had been five adverse incidents and one complaint.⁸ The Inquiry reviewed the details supplied by the Trust of all recorded incidents at that mortuary but could not identify five in that time period. We cannot account for the discrepancy from the evidence available.

The HTA granted the licence with conditional requirements relating to consent and risk assessments being met. The HTA informed us that, following its comments regarding security, the Trust took actions:

“[T]he Trust acted on this matter, which the HTA had highlighted, providing the HTA with an action plan ... to address these concerns, which included reference to ‘business case for CCTV to be written.’”⁹

The HTA report made it clear that the establishment, that is, the Trust, should be a high priority for inspection.

5 Response received from HTA during the Inquiry’s Fairness Process.

6 Response received from HTA during the Inquiry’s Fairness Process.

7 HTA Inspection Report, 2007.

8 MTW NHS Trust, Table of incidents supplied to the Inquiry by HTA.

9 Response received from HTA during the Inquiry’s Fairness Process.

6.4.2 May 2009 HTA investigation, Kent and Sussex Hospital mortuary

This investigation was triggered by two SUIs, one of which involved the wrong child's body being released to an undertaker. The HTA noted that this error was logged on the mortuary incident register as "low' grade",¹⁰ which is concerning and indicates a lack of appreciation of the gravity of this mistake by the Trust. The other SUI related to storing human tissue on an unlicensed external site. The SUIs and the review are described in Chapter 4.

The HTA Investigation Report states that there was a failure in the governance framework and a failure of the DI to discharge their duty.¹¹ It also notes that the Mortuary Manager was overstretched, covering four sites in addition to their role as Cellular Pathology Service Manager.

Following the investigation, the HTA placed two conditions on the licence, one of which was: "[T]he Designated Individual will ensure that there is a trained and suitable individual nominated as a Person Designated on the licence."¹²

The Inquiry has seen the report of a significant external review by Mr James Lowell and Mr Terry Johnson that took place shortly after the HTA investigation, which concluded that the mortuary service had "serious internal problems".¹³ The HTA confirmed that the Trust shared the report of this review with it for information in October 2009.¹⁴ The HTA appears not to have taken any additional regulatory action or discussed the report with the Trust. However, the HTA informed the Inquiry that the report was taken into account in the HTA's continuing regulatory action.¹⁵

6.4.3 April 2010 HTA inspection, Kent and Sussex Hospital mortuary

In April 2010, a further inspection took place at Kent and Sussex Hospital.

The Inspection Report stated that the conditions placed on the licence in 2009 had been met.¹⁶ However, at this inspection the HTA found that two standards were not met and seven were partially met. The two standards that were not met were as follows:

- *"A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail."*
- *"Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately."*

10 HTA, Investigation Report for MTW NHS Trust, 5 May 2009.

11 Ibid.

12 Ibid.

13 Mr James Lowell and Mr Terry Johnson, Independent Review of Mortuary Services, MTW NHS Trust, September 2009.

14 HTA, Timeline of interactions between the Trust and the HTA.

15 Response received from the HTA during the Inquiry's Fairness Process.

16 HTA Inspection Report, 2010.

Of particular interest to the Inquiry was the following observation: *“The mortuary access doors are secure and only mortuary staff hold the keys to gain entry.”*¹⁷ It is not clear how the HTA made such a positive observation in this respect, given the now-known practices with keys at the time.

The HTA deemed the issues it found during its inspection to have been resolved later that year, based on information it received from the Trust.¹⁸

The Trust reported an SUI to the HTA in December 2010 concerning retained tissue (see Chapter 4) and informed the HTA that it was temporarily suspending PME activity. The HTA was satisfied with the Trust’s reporting of the investigation into the SUI and closed the case. During this time, people requiring PMEs were taken to Medway Maritime Hospital, part of another NHS Trust, and Maidstone and Tunbridge Wells (MTW) NHS Trust’s own mortuary staff went there to assist. An internal review concluded that, as the staff were travelling and using unfamiliar equipment, it would in fact be safer to resume the PME service at Kent and Sussex Hospital.¹⁹ The review also noted that there had previously been serious incidents at Medway Maritime Hospital. The PME service resumed at Kent and Sussex Hospital for a few months, and then was discontinued when the Trust decided to relinquish its HTA licence (see Chapter 4).

- We have been unable to confirm if the HTA was aware that the PME service was resumed at Kent and Sussex Hospital. The HTA’s only involvement appears to have been after the PME service was eventually discontinued, and this was only to request formal confirmation of the Trust’s intention to relinquish its licence. It is concerning that the HTA did not make enquiries into the reasons why the Trust had relinquished its licence. Had it done so, it may have established that the Trust had identified that there were serious quality and safety issues in the mortuary.

6.4.4 2014 licence application, Tunbridge Wells Hospital mortuary

When the new Tunbridge Wells Hospital mortuary opened in September 2011, although it had facilities to undertake PMEs, it was initially used only as a body store. PMEs of people from the area were undertaken at the local authority mortuary in Greenwich. Following local political pressure to undertake PMEs at Tunbridge Wells Hospital, the Trust successfully applied for an HTA licence at the site in 2014.

The HTA inspected the mortuary in 2015 and 2018. It is relevant to note the areas where the inspections identified shortfalls in meeting the standards, and the timescales for these to be remedied:

- Critical shortfalls require immediate action.
- Major shortfalls require actions to be completed within one to two months.
- Minor shortfalls require actions to be completed within three to four months.

17 Ibid.

18 HTA, Timeline of interactions between the Trust and the HTA.

19 MTW NHS Trust, Mortuary Services Review: Audit and Risk Assessment, 18 January 2011.

A summary of the shortfalls is in Table 2 below.

Table 2: Human Tissue Authority identified shortfalls, 2015 and 2018 inspections, Maidstone and Tunbridge Wells NHS Trust			
	Critical shortfalls	Major shortfalls	Minor shortfalls
2015	0	0	2
2018	0	3	11

Source: Human Tissue Authority.

6.4.5 January 2015 inspection, Tunbridge Wells Hospital mortuary

The Inspection Report states that there were two minor shortfalls:

“Standard operating procedures (SOPs) that were in place when the establishment was licensed previously have been updated to reflect current practices. However, further work is required to ensure there is an appropriate level of detail and embodiment of current practices.

...

[S]ome documented risk assessments, such as security of the hub and satellite premises, consider a wide range of potential risks to practice and premises and set out clearly the risk mitigating measures in place. However, several other documented risk assessments are limited in their scope to health and safety considerations. Also some key risks, such as traceability of deceased persons and of tissues and organs, do not appear to have been formally assessed.”²⁰

The report also states:

“[T]he DI is advised to place signage in the mortuary to raise awareness amongst all staff working there of the importance of reporting any incident, or near miss, through internal systems and, where applicable, to the HTA.”²¹

The HTA inspector’s notes from their visit state that swipe card entry to the mortuary from the hospital side was for mortuary staff, senior staff and porters.²² It is not clear how the HTA came to make this observation, given the evidence the Inquiry has seen that many other staff had swipe card access to the mortuary, including maintenance staff from Interserve (Facilities Management) Ltd (see Chapter 5).

The HTA confirmed to the Trust in July 2015 that, based on the evidence the Trust shared, it was content that the shortfalls had been addressed.

It appears to the Inquiry that the HTA must have been satisfied that the standard relating to the premises being secure (e.g. controlled access to bodies, tissue,

20 HTA Inspection Report, 2015.

21 Ibid.

22 N521, Human Tissue Authority Regulation Manager, 2009–2018, and lead inspector for 2015 inspection.

equipment and records) was met, as it is not identified as a shortfall. The report states: *“Premises are appropriately monitored and maintained.”*²³

This is at odds with evidence the Inquiry heard about the lax approach to security in the mortuary, as set out in Chapter 5.

The report also states: *“Mortuary staff have a good working relationship with the company overseeing maintenance of the mortuary premises and equipment [Interserve (Facilities Management) Ltd].”*²⁴

The support inspector (who later became HTA Head of Regulation), Ms Rachel Mogg, said: *“I don’t have any recollection of any particular concerns that we had around the running of that mortuary.”*²⁵

The lead inspector, N521, said that they:

*“... don’t remember any overarching concerns ... The designated individual there was a pathologist who undertook post-mortem examinations. So, I understand that he would be in the mortuary regularly and would engage closely with the staff that were in the mortuary.”*²⁶

The Inquiry does not know the basis upon which N521 came to this understanding of the level of engagement Dr Dominic Chambers – a consultant histopathologist as well as the DI, who was based at Maidstone Hospital – had with the mortuary and its staff. This contradicts evidence Dr Chambers himself gave to the Inquiry that he was, in fact, not closely engaged with the mortuary staff:

*“I think I was there once a week from a post-mortem point of view erm, and I would have been, depending on what needed to be done with, you know, we would have a governance meeting probably once a month.”*²⁷

6.4.6 November 2018 HTA inspection, Tunbridge Wells Hospital mortuary

Given the number of changes to the way the HTA regulates and interprets the governing legislation, there were revisions to the HTA standards and guidance in 2017. The Head of Regulation from 2019 to 2021, Ms Mogg, told the Inquiry that the new standards were more stringent than the previous ones.²⁸

The changes that are most relevant to the Inquiry’s Terms of Reference are:

- The change of a premises substandard, from *“The premises are secure (e.g. there is controlled access to bodies, tissue, equipment and records)”*, to *“The premises are*

23 HTA Inspection Report, 2015.

24 Ibid.

25 Witness transcript of Ms Rachel Mogg, Human Tissue Authority Regulation Manager, 2014–2019; Head of Regulation, 2019–2021; support inspector for 2015 inspection.

26 Witness transcript of N521, Human Tissue Authority Regulation Manager, 2009–2018, and lead inspector for 2015 inspection.

27 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

28 Witness transcript of Ms Rachel Mogg, Human Tissue Authority Regulation Manager, 2014–2019; Head of Regulation, 2019–2021; support inspector for 2015 inspection.

secure (for example there is controlled access to the body storage area(s) and PM room and the use of CCTV to monitor access)."

- A new premises substandard: *"Security arrangements protect against unauthorised access and ensure oversight of visitors and contractors who have a legitimate right of access."*
- A new governance substandard: *"There should be documented policies on access to the mortuary by non-mortuary staff, contractors and visitors."*

The 2018 Inspection Report of Tunbridge Wells Hospital states that there were 11 minor and three major shortfalls.²⁹ The major shortfalls related to:

- traceability of bodies and human tissue;
- storage capacity in winter months; and
- a lack of CCTV within, or at access points to, the mortuary at Maidstone Hospital as well as the absence of an audio-visual intercom system.

The major shortfall relating to CCTV at Maidstone Hospital was not resolved until May 2020. This is not compliant with the HTA requirement that major shortfalls are to be addressed within one to two months. Had the issue regarding CCTV at Tunbridge Wells Hospital been correctly identified as a major shortfall, this should have been resolved within one to two months. The CCTV installation is explored in more detail in Chapter 5.

The major shortfall in relation to storage capacity was also not resolved until November 2020, when the additional refrigerated storage in the mortuary at Tunbridge Wells Hospital was installed. The minutes of the Mortuary Management and Governance Meeting in December 2019 note that an *"HTA senior manager will meet with the Trust to discuss the Trust's commitment to the project"*, demonstrating the concern of the HTA regarding the pace of progress on this major shortfall.³⁰

Communication to the Board about the outcome of the HTA 2018 inspection is discussed in Chapter 7. Chapter 2 sets out how inadequate capacity in the mortuary led to undesirable contingency measures being taken that are not consistent with preserving the dignity and safety of the deceased.

In relation to security, the HTA appears to have been satisfied that the two new substandards were met, which include oversight of, and documented policies relating to, contractors accessing the mortuary. The report states:

*"The entrance to the mortuary from the hospital is secured by swipe card access, which is limited to mortuary and trained portering staff and there is a video intercom system in place."*³¹

The inspector's notes³² state that Security and Estates staff were also entering the mortuary. The HTA Regulation Manager indicated that they were aware that Estates

29 HTA Inspection Report, 2018.

30 Mortuary Management and Governance Meeting minutes, 2 December 2019.

31 HTA Inspection Report, 2018.

32 Witness transcript of N520, Support Regulation Manager for the 2018 HTA inspection.

staff were monitoring the temperatures in the mortuary. The Regulation Manager also confirmed with Trust staff that the Estates staff did not need to enter the mortuary to monitor fridge temperatures, as the system enabled remote checking. The HTA informed the Inquiry that it shared its findings with the Trust as part of a factual accuracy process prior to the Inspection Report's publication.

The Inquiry heard that Interserve (Facilities Management) Ltd (Interserve) maintenance staff and external contractors used shared swipe cards to access the mortuary and that David Fuller could access the mortuary unaccompanied using his own swipe card (see Chapter 5).

The Inquiry was unable to contact the 2018 lead inspector for interview but spoke to the HTA Support Regulation Manager, N520, who was present during the inspection. When questioned about the statement above, they said they were aware that maintenance staff had access, but noted, "[F]or our purposes ... they weren't accessing the mortuary for licensed activities."³³

N520 continued:

*"We're not prescriptive to a Trust on who they allow access to if they have a very good reason and the reason that the maintenance required access is because they needed access to certain – the mortuary to access for the hospital."*³⁴

- The Inquiry considers that, although the inspection team were aware that others besides mortuary and trained portering staff had access to the mortuary, they did not fully ascertain how this access was granted, the reason for access and how it was monitored.
- Both the 2015 and 2018 reports gave the Trust, and stakeholders taking assurance from HTA reports, a false impression of the security arrangements.

Dr Chambers and the Mortuary Manager, Mr Peter Deal,³⁵ said that, during this inspection, David Fuller was brought in to explain to the inspectors how the fridge temperatures were monitored, and *"he stood in front of the two regulators and talked to them about fridge temperatures and fridge management for about, probably about 10, 15 minutes"*³⁶

Although N520 told us they could not recall speaking to Estates staff during the inspection, they said they were aware that the Estates department monitored the fridge temperatures but noted *"they're not physically in the mortuary checking the temperature"*.³⁷

The HTA confirmed that the inspection staff asked for further details regarding Estates staff monitoring fridge temperatures, and it was confirmed by Trust staff that Estates staff did not need to enter the mortuary in order to read temperatures. From other evidence presented to the Inquiry, we know that this was not the case. The Inquiry has

33 Ibid.

34 Ibid.

35 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

36 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

37 Witness transcript of N520, Support Regulation Manager for the 2018 HTA inspection.

heard from several witnesses that David Fuller was known to be physically checking fridge temperatures in the mortuary, which was not in line with Standard Operating Procedures (see Chapter 3).

Given the revisions to the HTA standards in 2017, the Inquiry was concerned to note that in a compliance update submitted to the HTA by the Trust in October 2019, the following answer was supplied in response to Q61 (*“What systems are in place to control access to the mortuary?”*): *“Audio-visual main site [Tunbridge Wells]. Nil at satellite [Maidstone].”* Although this demonstrates non-compliance with the new premises substandard, the HTA did not appear to take any action.³⁸

- When undertaking regulatory activities at MTW NHS Trust, the HTA appears to have relied on what the team were told by staff at the Trust – in other words, providing ‘reassurance’ – rather than what the HTA inspectors witnessed or what evidence of compliance they were provided with, namely ‘assurance’.
- It is concerning that a representative of the HTA appeared to believe that the requirements for control of access only applied to those who were accessing the mortuary in relation to licensed activities (in this case, activity relating to PMEs) and not to the various other people, including David Fuller, who were accessing the mortuary.
- The Inquiry has only considered the HTA inspection framework as carried out at the MTW NHS Trust. We will consider the HTA inspection regime further in Phase 2 of the Inquiry’s work.

6.4.7 HTA Reportable Incidents

In addition to the SULs mentioned above, which took place between May 2010 and April 2013, there were a number of HTARIs at Tunbridge Wells Hospital between 2013 and 2020, including:

- failure in communication procedures that led to a PME commencing after withdrawal of the coroner’s authorisation;
- damage to a body caused by porters placing the deceased into an inappropriately sized fridge space;
- mortuary rear doors being left open after delivery of a deceased person (the HTA classed this as a ‘near-miss’ HTARI); and
- loss of traceability of a foetus following release to a funeral director.

These incidents could have indicated to the HTA that there may have been problems in this mortuary.

38 HTA, Timeline of interactions between the Trust and the HTA, June 2022.

6.4.8 The role of the Designated Individual and the Licence Holder

The HTA's website³⁹ states that DIs authorise and supervise the licensed activities. They may be a head of department, a clinician, a scientist or a manager and have primary legal responsibility to ensure that:

- suitable practices are used in undertaking the licensed activity;
- other persons working under the licence are suitable; and
- the conditions of the licence are complied with.

The HTA website also states that the Licence Holder does not impose the duties expected of the DI, but has the duty to ensure that:

- the conditions of third-party agreements are complied with;
- any Directions issued by the HTA that apply to the Licence Holder are complied with; and
- licence fees are paid.

Although the DI must be an individual, the HTA prefers the Licence Holder to be a corporate body where possible (e.g. an NHS Trust).

The Inquiry understands that, at the MTW NHS Trust, the Trust is the Licence Holder and the current DI is Dr Chambers.

Dr Chambers recalled a conversation he had had in 2014 with the Trust Chief Executive at the time, Mr Glenn Douglas, in which Dr Chambers demonstrated that he did not realise that the legal responsibilities rested entirely within his remit as DI, and thought they were shared with the Licence Holder:

"Well, he [the Chief Executive] also had the legal obligation as well, as the Trust license [sic] holder. So, there were the two of us at the time, it's what we were led to believe ... the role of DI is not managerial but one of clinical oversight, requiring assurance from PDs [Persons Designated] that scheduled activities are being conducted appropriately, are appropriately managed and risk assessed, according to HTA standards."⁴⁰

The DI from 2006 to 2010, Dr Graham Russell, told us he was "not desperate" to take on the role and said:

"[T]he HTA role I erm found pretty challenging and I ... it was vastly more time consuming than I thought it was going to be and as we sort of hinted up, I didn't feel I had actually control of all of the issues."⁴¹

When asked to confirm that he had been the DI, Mr Nigel Leftley, who held the role for a period in 2010, told us that the DI before him, Dr Russell, had said "it was fraught with

39 Guidance to professionals, licenses roles and fees, licencing, Designated Individuals and Licence Holders, HTA website.

40 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

41 Witness transcript of Dr Graham Russell, consultant pathologist at the Trust, 1991–2022, Designated Individual, 2006–2010.

danger ... don't touch it with a barge pole", and that he was pushed into the role because no one else would take it on.⁴² He spoke of how the DI role was only a small part of his other clinical responsibilities and described the pressures associated with managing competing priorities:

*"DI was only a very tiny part of my remit ... I had 450 odd staff, over 15 departments and there was always someone wanting me, someone who thought they had precedence ... I had this all of the time, the pressure was immense."*⁴³

However, in 2010, the HTA assessed Mr Leftley's suitability for the role and concluded that his position as General Manager for Pathology gave him the authority to effect change and oversee all staff carrying out activities under the licence.⁴⁴

Dr Chambers, who described the role as *"quite scary"*, told the Inquiry:

*"[I]t generally took the HTA to make a finding in their inspection for us to then use that finding as a, as a lever to get the funding. So when we needed more fridge space, we had to wait till the HTA said, 'you haven't had enough fridge space' for us to be able to get that strength of that evidence through to er, to get people to listen, to get the new fridge."*⁴⁵

However, the major shortfalls identified by the HTA in 2018 regarding fridge storage capacity and CCTV in the mortuary did not initially create a sufficient lever for the associated funding. Mr Deal told us that, when the DI eventually escalated the issue with the Chief Executive in 2019, this unblocked the delay: *"[W]hen Miles Scott says 'Do it' – people do it."*⁴⁶ But by that time, the business case had missed the funding rounds. This is explored in Chapters 4 and 5.

The Inquiry reviewed a report authored by Dr Sara Mumford, Clinical Director for Pathology, on 20 April 2011, concerning the review of mortuary services at Kent and Sussex Hospital. It states:

*"None of the post-mortem active consultant histopathologists is willing to take on the role of DI due to the onerous nature of the role and the potential for personal reputational damage."*⁴⁷

- The Inquiry concludes that the DI role at this Trust is a challenging one, with significant legal and operational responsibility attached to it. The evidence gathered by the Inquiry suggests that the current and previous DIs do not have the appropriate oversight and support, or the authority to effect change, that would be necessary to enable them to carry out the role of DI effectively. This is set out in greater detail in Chapter 4.

42 Witness transcript of Mr Nigel Leftley, General Manager for Pathology, early 2000s–2011, Designated Individual, May–December 2010.

43 Ibid.

44 HTA Inspection Report, 2010.

45 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

46 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021.

47 Dr Sara Mumford, Review of mortuary services, 20 April 2011.

On its website, the HTA has a publication titled *Sharing Learning: Lessons learned from HTA reportable incidents in the post mortem sector, 2012/13*. This publication includes the following hypothetical case study:

"A member of mortuary staff is escorting the contractors from the mortuary as work is completed for the day, when the telephone rings in the office. The member of staff leaves the contractors at the external door of the body store to answer the phone. When they return to the body storage area, one of the contractors has opened a fridge door and is looking at the bodies contained in the fridge."⁴⁸

The publication states the following as a 'key learning point':

"The mortuary can be a vulnerable area and needs to have adequate security arrangements in place to ensure the safety of those working there and the deceased. Particular attention should be paid to controlling access by non-establishment staff."⁴⁹

- The Inquiry concludes on the basis of evidence that the HTA did not scrutinise the underlying reasons for failings that consistently arose at the Trust's mortuaries. Instead, it adopted a passive, light-touch approach. In particular:
 - At every inspection, it did not identify that the mortuaries were not fully secure and access was not monitored.
 - As David Fuller was not accessing the mortuary to carry out a licensed activity, his access to the mortuary was not considered by the HTA .
 - It did not question why David Fuller was personally monitoring fridge temperatures during the 2018 inspection.
 - It allowed the Trust far longer than its one- to two-month timescale to address the major shortfalls relating to refrigerated storage capacity and lack of CCTV in 2018.
 - It did not have a system in place to recognise that there were systemic and prolonged problems in the mortuary. The HTA appears to have viewed every inspection and incident in isolation rather than having a long-term view of organisations and their issues.
 - Its assurance processes were focused on policies being in place rather than how these were adhered to in practice.
- The interviews the Inquiry conducted demonstrate that the current and previous DIs at the Trust found the role challenging. The role involved significant legal and operational responsibility but did not come with the adequate support or authority to be able to carry out the role effectively. This lack of authority is clearly shown by the lack of traction the DI had within the Trust to access funding for additional refrigerated storage capacity and CCTV in the mortuary, despite the HTA having identified these as major shortfalls. See Chapter 4.

48 HTA, *Sharing Learning: Lessons learned from HTA reportable incidents in the post mortem sector, 2012/13*, HTA website.

49 Ibid.

6.5 Other organisations involved in inspection and oversight of the Trust's mortuaries

6.5.1 UK Accreditation Service

UKAS is the UK's national accreditation body. It assesses and accredits organisations that provide services including certification, testing, inspection and calibration. It is independent of the government but has a Memorandum of Understanding (MoU) with the Department for Business, Energy and Industrial Strategy.⁵⁰ It acquired the Clinical Pathology Accreditation (CPA) service in 2009.

UKAS assesses mortuaries and body stores which choose to be accredited with the service against a standard called ISO 15189. This standard appears to be designed to assess cellular pathology laboratories. UKAS' specific role in considering a mortuary against this standard is to evaluate whether it is meeting the requirements of ISO 15189 from the perspective of quality and integrity of samples for scientific laboratory analysis and the prevention of cross-contamination.

The Inquiry understands that there are 138 mortuaries and body stores accredited with UKAS. UKAS does not publish the reports from assessments. It only shares assessment reports with third parties (e.g. regulators) if the organisation in question has waived the right to confidentiality.

The Inquiry understands that the Kent and Sussex Hospital mortuary was not accredited by the CPA.

The Trust's Clinical Governance and Risk Committee considered a list of the top 20 risks at its December 2006 meeting. The third-highest risk was: *"Mortuaries are not complaint [sic] with standards set by CPA. Risk to Trust reputation and staff health & safety."* The Trust was unable to locate copies of the Clinical Governance and Risk Committee papers. The Inquiry reviewed the CPA standards and could not find any relating to NHS mortuaries.⁵¹

UKAS carried out surveillance visits at the Trust in 2015 and 2019. The report of the 2015 visit noted the following at the Tunbridge Wells Hospital mortuary:

- There were no structured training records.
- Security was robust, with a voice entry system permitting entrance into an antechamber before entering through another locked door into the body reception area.
- Maintenance and day-to-day monitoring of fridges was controlled by an outside provider (Interserve).⁵²

50 Office for Product Safety and Standards and Department for Business, Energy and Industrial Strategy, Memorandum of understanding between BEIS and UKAS, 17 June 2013, gov.uk website.

51 CPA, Standards for the Medical Laboratory, November 2010.

52 UKAS, Assessment Report, 27–28 May 2015, 30 June 2015, 13 July 2015.

The report of the 2019 visit noted the following at the Tunbridge Wells Hospital mortuary:

- There were excellent processes in the mortuary, which was seen to be well run.
 - There was no record of objective and reflective evidence of competency in the procedures of mortuary staff.
 - Training of funeral directors and porters in mortuary procedures was last completed in March and October 2018.
 - HTA guidance requires a physical check of body state after the 30th day in the fridge. This was not included in mortuary policies and there was no evidence of this in practice.⁵³
- The 'well run' conclusion is at odds with evidence the Inquiry heard, which includes the finding that bodies of the deceased were regularly left out un-refrigerated overnight in the post-mortem room. It is also at odds with the lack of oversight and awareness of who was entering the mortuary, reflected by the fact that at that time David Fuller was allowed unaccompanied access (see Chapters 2 and 3). UKAS told the Inquiry that the assessment of whether maintenance engineers were accessing the mortuary unaccompanied was beyond its regulatory remit.
 - We will explore the differences in the structure and process of UKAS and HTA inspections in Phase 2 of the Inquiry's work.

The current DI, Dr Chambers, provided the following observation on the approach of the HTA compared with that of UKAS:

*"[T]he HTA are more significant in terms of what they can do. But I think they're also much more engaged and slightly less adversarial in terms of the way they interact with departments. I always found UKAS to be a little bit more pointy finger, and ... where's your calibration of this ruler and things like that."*⁵⁴

But Dr Chambers also said:

*"I don't think I would like to have the mortuary removed from UKAS, I know one of the quality managers has said you can do that, you know you don't have to have UKAS. I'm like yeah but actually it's a nice level of reassurance to have another, another bit of that extra reassurance that you're doing it right, as it were. I like, I think the HTA standards could be a bit more, I don't know, they seem to be getting woollier."*⁵⁵

6.5.2 Care Quality Commission

The CQC was created on 1 April 2009, replacing the Healthcare Commission. It is the independent regulator of health and adult social care in England and is an ENDPB of the DHSC.

53 UKAS, Assessment Report, 22–23 October 2019.

54 Witness transcript of Dr Dominic Chambers, consultant histopathologist, Designated Individual since 2014.

55 Ibid.

One of the eight core NHS services subject to CQC inspection in acute hospitals is End of Life Care, which includes, *“aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services”*.⁵⁶

The inspection framework for End of Life Care states that mortuary services should be inspected and mortuary staff should be interviewed.⁵⁷

The CQC inspected the mortuary at Tunbridge Wells Hospital in October 2014 as part of a routine inspection. The Inspection Report contains statements which indicate that the inspectors had considered a range of mortuary activity, from how faults with the fridges were identified to whether the forensic fridge was locked. Statements of particular interest to the Inquiry were as follows:

“Access to the mortuary was secured to prevent inadvertent or inappropriate admission to the area. Access out of hours was via security staff who would contact the porters.

...

*We observed that the [log] book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.”*⁵⁸

Both statements are inconsistent with evidence the Inquiry heard that various staff could access the mortuary out of hours, and anyone accessing the mortuary could view the logbook, including David Fuller, who used it to identify victims (see Chapter 2).

The CQC undertook a further inspection at Tunbridge Wells Hospital in October 2017 but did not visit the mortuary on this occasion. We heard oral evidence from Ms Carolyn Jenkinson, CQC Head of Hospital Inspection, that *“on the basis of risk and feedback [we were] choosing which core services to look at and re-inspect and end of life care wasn't re-inspected on that occasion”*.⁵⁹

Ms Jenkinson also told us: *“[T]he regulations are concerned with service users, and I think the interpretation of that it's very much for living, you know, for patients.”* Ms Jenkinson said that the guidance for inspectors looking at End of Life Care includes:

- talking to mortuary staff;
- talking to the porters who transfer deceased people to the mortuary; and
- visiting the bereavement suite and mortuary viewing area.⁶⁰

The CQC Chief Executive, Mr Ian Trenholm, told the Inquiry that the CQC's remit in relation to mortuaries is connected to End of Life Care and is mainly to assess the premises. Mr Trenholm told the Inquiry: *“[O]nce the body is then stored for the long term, then that is not something that we would, we would have a regulatory interest in.”*

56 CQC, 'Core services: NHS trusts', CQC website.

57 CQC, 'Inspection framework: NHS acute hospitals', CQC website; CQC, 'Core service: End of life care', CQC website.

58 CQC, Inspection Report, Tunbridge Wells Hospital at Pembury, October 2014. Published 3 February 2015.

59 Witness transcript of Ms Carolyn Jenkinson, Care Quality Commission, Head of Hospital Inspection.

60 Ibid.

Mr Trenholm explained that the CQC inspectors may well have checked mortuary equipment in 2014, but it is no longer the case.⁶¹

- The CQC's legislative framework does not include mortuary services, even though the End of Life pathway framework does. CQC told the Inquiry that, while mortuaries are not specifically referenced in CQC legislation, they are not excluded from the regulation and assessment of certain activities where this is in connection with CQC's broader regulatory remit. The Inquiry considers that this results in confusion about the extent of CQC's remit; we will consider this issue in greater detail in Phase 2 of the Inquiry's work.

6.5.3 NHS England

NHSE has led the NHS in England since 2013. Its predecessor organisations are described in the Background to this Report. Since April 2019, NHSE has worked together with NHS Improvement (NHSI) as a single organisation. NHSI was formed in April 2016 through a merger between the NHS Trust Development Authority and Monitor, and was responsible for overseeing NHS Trusts and NHS Foundation Trusts. Its functions were formally transferred to NHSE in July 2022. NHSE's regional teams are responsible for the quality, financial and operational performance of all NHS organisations in their region. NHSE is an ENDPB of the DHSC. It does not appear to have a specific remit in relation to NHS mortuaries, but it had the authority to direct NHS organisations to put certain measures in place in mortuaries and body stores when David Fuller's actions became known. This is described in the Background to this Report.

The Inquiry interviewed NHSE's Chief Delivery Officer, Mr Mark Cubbon, and NHSE's Regional Director for the South East of England, Ms Anne Eden.

When asked whether NHSE was aware of the number of HTARIs and shortfalls in reports following the HTA inspections at the Trust, Mr Cubbon told us:

"[NHSE] would not have had visibility of the reports ... we've been reliant on the organisation telling us about that ... wouldn't have triggered our oversight framework because it's not sensitive to these issues."⁶²

Ms Eden told us that she only took verbal reassurance from the Trust Chief Executive, Mr Miles Scott, about the HTA reports:

"[M]y understanding from the reports I've received, being verbal – and I haven't actually seen the reports per se – were that they were good reports. And, in fact, that the Trust ... there were some issues about CCTV and that the Trust went even further than the recommendations of the HTA in terms of the introduction of CCTV, is from memory. So I ... it's, to the best of my knowledge, I did not believe that there were issues then. I thought that they, as I say, that they were compliant reports. So therein

61 Witness transcript of Mr Ian Trenholm, Chief Executive, Care Quality Commission, since 2018.

62 Witness transcript of Mr Mark Cubbon, Chief Delivery Officer, NHS England, 2021–2023.

*lies ... there's an opportunity for us to have sight of, as opposed to take reassurance, as opposed to proper assurance."*⁶³

NHSE told us that responsibility for Estates and Facilities, including Health Building Notes (HBNs), was the responsibility of the DHSC until 2017, when responsibility was transferred to NHSI (now NHSE). Health Building Note 20 (HBN20) included guidance for hospital mortuaries on effective control and monitoring of access, storage arrangements that maintain the dignity of the deceased, and oversight of visitors and contractors, and was effective up to 2017. It was archived at the point of transfer in 2017 and only published as HBN16-01 on 10 May 2023, leaving the NHS with no guidance in this area for six years.⁶⁴

- NHSE did not have a mechanism for detecting problems with the mortuaries at the Trust. Mortuaries are not part of the central oversight framework of NHSE, and the NHSE Regional Director took verbal reassurance that the Trust was compliant with HTA standards.
- NHSE failed to publish vital and relevant guidance after taking over responsibility in 2017.

6.5.4 Health and Safety Executive

The HSE is Britain's national regulator for workplace health and safety.

The Inquiry was interested to discover that the HSE inspected the Kent and Sussex Hospital mortuary in September 2008 and was so concerned about the lack of assessment of risk of injury to staff involved in manual transfer of the deceased that it almost issued a prohibition notice, as it had previously identified this issue in the Maidstone Hospital mortuary in 2004. Following assurances from the Trust, the HSE issued an improvement notice instead.⁶⁵

Even though this issue indicated that there were problems with the way the mortuary was being run, Ms Jo Anderson, the HSE's Head of Operations for South East England, told the Inquiry that the HSE did not make the HTA aware of its concerns.⁶⁶ The Inquiry notes that the Trust voluntarily made the HTA aware of the HSE's concerns.⁶⁷

- Although the HSE was inspecting the mortuary with the safety of the mortuary staff in mind, not the safety and dignity of the deceased, this is yet another example of an organisation with significant statutory powers which found faults with practices and procedures in the mortuary that do not appear to have been acted on appropriately.

63 Witness transcript of Ms Anne Eden, Regional Director, NHS South East, since 2015.

64 NHSE, Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services, 10 May 2023.

65 Letter, HSE to MTW NHS Trust, 12 September 2008.

66 Witness transcript of Ms Jo Anderson, Head of Operations, South East England, Health and Safety Executive.

67 HTA, Timeline of interactions between the Trust and the HTA.

- The HSE did not have a process in place to alert the HTA of its concerns. We will explore whether these organisations should work more closely together in Phase 2 of the Inquiry's work.

6.5.5 Clinical commissioning groups

CCGs replaced primary care trusts on 1 April 2013. The CCGs were clinically led, statutory NHS bodies responsible for the planning, commissioning and quality of healthcare services for their local area. They were dissolved in July 2022, and their duties were taken on by integrated care boards.

The service specifications for pathology/laboratory medicine for the Kent and Medway CCG and various NHS trusts, including the MTW NHS Trust, state that the service provider should:

- provide mortuary services that comply with HTA requirements;
- comply with the DH's good practice guide for NHS mortuary staff (described below); and
- provide PME services that meet national and local requirements.

The only quality indicator for the mortuary relates to infection control.

The Inquiry spoke to Ms Paula Wilkins, the CCG's Chief Nurse, who confirmed the CCG's position was that the HTA licence provided sufficient assurance that the Trust was providing the required level of mortuary service.⁶⁸

6.5.6 Department of Health and Social Care

The DHSC, the government department that commissioned this Inquiry, supports ministers in leading the nation's health and social care to help people live healthier lives for longer. It does not currently have a specific remit in relation to NHS mortuaries; however, its Estates section had responsibility for HBNs until 2017 (see above).

The Inquiry notes that the DHSC's predecessor body, the DH, published a document in August 2006 called *Care and Respect in Death: Good practice guidance for NHS mortuary staff*.⁶⁹

This document contains guidance for staff working in NHS mortuaries to ensure they deal in a safe, secure and sensitive manner with the bodies of those who die in hospital or who are brought to the hospital mortuary after death. It describes the important and challenging role of mortuary staff, and also the importance of effective security systems and procedures and a pro-security culture among mortuary staff. This document does not offer practical advice and support.

While the Inquiry has no further details about how it was disseminated or the implementation of its guidance tracked, this document demonstrates that the DH was

68 Witness transcript of Ms Paula Wilkins, Chief Nurse, Kent and Medway Clinical Commissioning Group, since 2020; Chief Nurse, West Kent Clinical Commissioning Group, 2017–2020.

69 DH, *Care and respect in death: Good practice guidance for NHS mortuary staff*, 10 August 2006.

considering issues relating to the security of mortuaries back in 2006. When asked about this, the DHSC told the Inquiry that the document was superseded by guidance and standards produced by the HTA.⁷⁰

6.6 Interaction between regulators and organisations with oversight functions

Evidence reviewed by the Inquiry suggests that there appears to have been no process for formal information-sharing or joint working across the various organisations referred to above in relation to these interactions, observations and reports on the Trust's mortuaries.

NHSE's Chief Delivery Officer, Mr Cubbon, told the Inquiry there are "*certainly opportunities for better join-up around some of the more specialists' regulatory functions*".⁷¹

UKAS executive board director for accreditation, Ms Lorraine Turner, said there was a draft MoU with the CQC. The HTA Head of Regulation for the post-mortem and public display sector, Ms Kelly Sherlock, told the Inquiry that the HTA and UKAS have an MoU but it is not being followed.⁷²

Since 2013, the CQC has had an MoU with the HTA which sets out a framework to support the working relationship between the two organisations and an understanding of their respective regulatory roles and responsibilities. However, the Inquiry did not hear evidence that this was clearly understood.

The CQC Chief Inspector of Hospitals, Dr Sean O'Kelly, said: "*It would be quite rare to be having contact with the HTA. It's not one of the bodies that we would, you know, have much to do with.*"⁷³

Ms Jenkinson told us:

*"I know that the HTA have a regulatory role to play here as well and it's possible that there is an element of ambiguity about where one regulation set finishes and another takes over."*⁷⁴

6.7 Arrangements for coronial post-mortem examinations at the Trust

Coroners are independent judicial officers, appointed and paid for by local authorities. Coroners are responsible for investigating violent, unnatural or sudden deaths, deaths

70 Response received from DHSC during the Inquiry's Fairness Process.

71 Witness transcript of Mr Mark Cubbon, Chief Delivery Officer, NHS England, 2021–2023.

72 Witness transcripts of Ms Lorraine Turner, UKAS executive board director for accreditation since 2012; and Ms Kelly Sherlock, Head of Regulation for the post-mortem and public display sector, Human Tissue Authority, since 2021.

73 Witness transcript of Dr Sean O'Kelly, Care Quality Commission, Chief Inspector of Hospitals since 2022.

74 Witness transcript of Ms Carolyn Jenkinson, Care Quality Commission, Head of Hospital Inspection.

of an unknown cause, deaths in custody or otherwise in state detention, or deaths where the deceased was not seen by the doctor during the 14 days before the death.

The bodies of the deceased are under the legal control of the coroner once the duty to investigate is triggered and the coroner is made aware that the body is within the coroner’s area. However, the bodies are stored and cared for in NHS and local authority mortuaries through contractual arrangements.

Seventy-nine of the deceased people that David Fuller sexually abused were coronial cases – that is, they were legally under the control of a coroner.

The Inquiry received a letter from His Honour Judge Edward Thomas Teague KC, the Chief Coroner, on 26 January 2022, explaining that, as they do not have their own mortuaries, coroners use those of hospitals and local authorities, and it is therefore extremely important to the service that mortuaries properly safeguard the security and dignity of the deceased.

Arrangements for the coroners to use the mortuary facilities at the Trust are managed through Kent County Council (KCC) for the Kent North West and Mid Kent and Medway coroners and through East Sussex County Council (ESCC) for the East Sussex Coroner. In each case, the local authorities have contracts with the Trust to provide mortuary services. The majority of coroners’ cases at the Trust are for the Kent North West Coroner.

6.7.1 Kent County Council contract

The Inquiry has considered various versions of the contracts and service specifications in place from 2007 onwards between KCC and the Trust. They set out the processes for storing, viewing, undertaking PME on and releasing the deceased, and who should and should not have access to the mortuary. These are shown in Table 3.

Table 3: Kent County Council contracts for provision of post-mortem services at Maidstone and Tunbridge Wells NHS Trust

Contract/Service level agreement	Period	Site
Contract for the provision of mortuary services to KCC	1 December 2007 – 31 March 2011	Kent and Sussex
KCC SLA 2009–2011 – Amended service specification	June 2009 – 31 March 2011	Kent and Sussex
NHS Contract for the provision of mortuary services	1 April 2011 – 30 June 2011	Kent and Sussex
No PMEs undertaken at the Trust		
Contract for services for the provision of mortuary services	1 April 2014 – 31 March 2019	Tunbridge Wells
Contract for the provision of mortuary services	1 April 2019 – 31 March 2023	Tunbridge Wells

Source: Maidstone and Tunbridge Wells NHS Trust.

The Inquiry interviewed the Senior Coroner for North West Kent, Mr Roger Hatch, and the Senior Coroner for Mid-Kent and Medway, Ms Patricia Harding. Both coroners told the Inquiry that managing the contracts was the responsibility of KCC, but Ms Harding told the Inquiry that the coroners do have some influence over this (the contract) if they have concerns about the service. Mr Hatch told us: *“I, probably several years ago, would have seen the agreement, but I can’t recall in terms what was in it.”*⁷⁵

Ms Harding and Mr Hatch told the Inquiry that they take their assurance about safeguarding of the deceased from the contract arrangements and the HTA requirements. Mr Hatch told us: *“[O]nce the bodies are taken to either of those locations, the responsibility probably remains mine. But, effectively it’s carried out by the hospital concerned.”*⁷⁶

Mr Hatch said he does not have any control over who has access to bodies in a mortuary, whereas Ms Harding seemed reassured that only certain people have access:

*“So, it’s not that anybody can wander in there, they need specific authority to go in there. And a particular set of people will be able to deal with the individuals that are in there. Aside from that, the funeral directors are ... bring the bodies in and take them away again. And beyond that, it’s the technicians and the pathologists, and potentially some who are training and on occasion may visit the mortuary, but they would never be allowed access to the bodies.”*⁷⁷

The contracts contained clauses about access to the mortuary; for example, *“Access to the Mortuary should be restricted to those delivering or receiving bodies, viewing or attending for preliminary Inquests”* and:

*“After hours or in the event that the Hospital has no Pathology Technician, then no more than two designated posts should be recognised key holders. Keys should not be made available to other individuals and they and non-hospital staff should only gain access to a Mortuary Body Store in the company of an authorised key holder.”*⁷⁸

The 2019 to 2023 contract states the following:

*“Access should be restricted via the authorised representatives of the Trust, KCC or a Kent & Medway coroner’s officer ... Keys/swipe cards/security codes should not be made available to other individuals and they and Trust staff should only gain access to the Kent & Medway coroner’s body store in the company of an authorised key holder. Post Mortem rooms should be available to designated mortuary staff and pathologists and those specifically approved by them and accompanied by them. Other individuals should not have access to the Kent & Medway coroner’s post-mortem rooms or body storage unless authorised by senior mortuary staff or Pathologists.”*⁷⁹

75 Witness transcript of Mr Roger Hatch, Coroner for North West Kent from November 1997, and Senior Coroner for North West Kent since 2013.

76 Ibid.

77 Witness transcript of Ms Patricia Harding, Coroner for Mid-Kent and Medway since 2011, Senior Coroner since 2013.

78 KCC, Mortuary service level agreement, 2009–2011: Amended service specification, June 2009.

79 Contract for the provision of mortuary services, 1 April 2019–31 March 2023.

- The arrangements for restricted access to the mortuary as set out in the Trust's contract with KCC were not happening in practice. The Inquiry has heard evidence that access to the mortuary and the post-mortem rooms was not adequately controlled. This is illustrated by the fact that David Fuller was able to access the mortuary 444 times in the year from December 2019 until his arrest in December 2020 (see Chapters 3 and 4).
- The Inquiry notes that, while coroners have legal control of the body of the deceased until their coronial functions come to an end, they do not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of the deceased in their control. The Inquiry will consider this situation in Phase 2.

The Inquiry interviewed five people from KCC in relation to the contract. One of these was N535, the former Group Head of Service then Contract Manager, who managed the contract on their own from 2000 until 2015 and stayed on as part-time Contract Manager until 2020. The Inquiry also interviewed N529, the current Head of Coroner's Service, who was appointed in January 2015; N531, the Head of Operations, Coroner's Service, since 2021; and N442, the Coroner's Office Manager, who joined in 2019. The Inquiry also interviewed Mr Simon Jones, KCC's Corporate Director for Growth, Environment and Transport.

N535 said:

*"[T]here were a broad number of people that may require attendance at any time ... [the Trust] never produced a list and I have to say I never asked for one."*⁸⁰

They also said they thought maintenance staff were appropriately authorised to access the mortuary: *"[E]quipment breaks down and maintenance staff would be required to attend on occasions."*⁸¹

When asked who would make the decision as to who could have access, N529 said this would be *"the NHS Trust, the mortuary management team would decide on that ... in order to be compliant with the contract ... the coroner has no direct control over that"*.⁸²

N531 told us that the Coroner's Service has no direct control over access to the mortuary.⁸³

N529 told us that governance meetings were driven by the Trust.⁸⁴ N535 told the Inquiry that contract review meetings were not often held, because *"the mortuaries are all good at doing what they did"*, and that the approach to managing the contract was *"very light touch"*.⁸⁵

N529 said they would expect the Trust to tell KCC if it was unable to meet the contract requirements. N529 delegated responsibility for contract management to the Contract

80 Witness transcript of N535, Group Head of Service then Contract Manager, Kent County Council, 2000–2015.

81 Ibid.

82 Witness transcript of N529, Head of Coroner's Service, Kent County Council, since 2015.

83 Witness transcript of N531, Head of Operations, Coroner's Service, Kent County Council, since 2021.

84 Witness transcript of N529, Head of Coroner's Service, Kent County Council, since 2015.

85 Witness transcript of N535, Group Head of Service then Contract Manager, Kent County Council, 2000–2015.

Manager but told the Inquiry that they received no formal assurance on this, and they only looked at the contract once that staff member had left.

Mr Jones explained that the Coroner's Service was a relatively small aspect of the council's work compared with other services, such as waste disposal and libraries. He told the Inquiry that he would have sight of the contract when it was next renewed and that he had *"gone through a general overview of the performance of the service"*, and was reassured that staff knew how to escalate any issues. He told us there would usually be a governance board, but none of the KCC staff we interviewed mentioned this.⁸⁶

When asked if there were any reporting requirements in the contract, N535 said: *"I think in the last contract ... there were certainly some requirements in there in terms of reporting on the number of deceased in storage at any one particular time and then reporting back what those numbers were."*⁸⁷ However, N529 said: *"But at any one time we wouldn't, I wouldn't know, and the contract manager wouldn't know how many deceased were there."*⁸⁸

N535 said that the provision and suitability of mortuary staff was the responsibility of the Trust and that no assurance was sought of their competence and suitability. N535 also said:

*"[I]n terms of seeking assurance around the access to the mortuary, yeah absolutely, you know that is something that you know with that knowledge now we would be looking to seek assurances on a regular basis, and also in terms of the qualifications of the staff that are working on coronial post-mortems, yeah absolutely."*⁸⁹

N535 also confirmed that they had never seen any of the HTA Inspection Reports for the Trust.

6.7.2 East Sussex County Council contract

The Inquiry learned that ESCC began using Tunbridge Wells Hospital for some of its coroners' cases in 2015 due to a shortage of pathologists at the other hospitals it was using.

The Inquiry has reviewed the 2015 to 2020 contract, which was then extended to 2022. It specifies quarterly formal monitoring meetings and is very similar to the KCC contract. In relation to access to the mortuary, it states:

"Access to Post Mortem rooms is only available to designated Mortuary staff and Pathologists and those specifically approved by these groups of officers and accompanied by them.

Other individuals should not have access to Post Mortem rooms unless authorised by Senior Mortuary staff or Pathologists.

86 Witness transcript of Mr Simon Jones, Corporate Director for Growth, Environment and Transport, Kent County Council, since April 2021.

87 Witness transcript of N535, Group Head of Service then Contract Manager, Kent County Council, 2000–2015.

88 Witness transcript of N529, Head of Coroner's Service, Kent County Council, since 2015.

89 Witness transcript of N535, Group Head of Service then Contract Manager, Kent County Council, 2000–2015.

Access to the Mortuary is restricted to those delivering or receiving bodies, and identification. This access should be limited to identification and/or Body Store areas.

*Visitors attending for identification should be accompanied at all times by a Police representative, or a Coroner's Officer as appropriate.*⁹⁰

The Inquiry invited the Senior Coroner for East Sussex, Mr Alan Craze, for interview, but he declined. He instead provided a written response to a set of questions. He stated that he is not involved in the contractual arrangements for the post-mortem service at the Trust.⁹¹

The Inquiry spoke to three people from ESCC in relation to the contract for post-mortem services at the Trust: Mr Philip Baker, the Assistant Chief Executive; N583, the Legal and Coroner Services Manager; and N584, the Coroner Services Manager.

When asked about assurance of the qualifications and training of mortuary staff (as specified in the contract), Mr Baker said that the council takes its assurance from the HTA licence. He was not aware of any concerns about the mortuary service.⁹²

N583 said that no contract management meetings took place with the Trust, and that any issues would be fed back to ESCC by the coroner's officers. N583 also said they were reassured by the fact that the Trust's mortuary staff are NHS employees and that they did not need to check their qualifications.⁹³

N584 said they were aware of when the HTA was going to inspect the mortuary, but did not receive any feedback, and the reports of the 2015 and 2018 HTA reports had not given them any cause for concern.⁹⁴ N584 indicated to the Inquiry that, if the 2018 HTA report had explicitly stated that there was an issue with a lack of CCTV in the mortuary at the Tunbridge Wells Hospital and at the Maidstone Hospital, this would have given the ESCC cause for concern and investigation, but this was not the case.

- Both KCC and ESCC told the Inquiry that they did not seek assurance that the mortuary service was being provided to the standard required by their contracts. The council staff responsible for the contracts with the Trust to provide mortuary services did not seek assurance that the mortuary at the Trust was secure and that internal controls were in place to protect the deceased who were under the legal control of the coroners. The councils took assurance from the fact that the mortuaries had an HTA licence, and that the staff were NHS employees. They relied on the Trust to ensure that the deceased in their care were in a safe, secure setting which preserved their dignity.
- The Inquiry intends to consider the role and responsibilities of local authorities, in particular in respect of the oversight and enforcement of standards in mortuaries, in Phase 2.

90 ESCC and MTW NHS Trust, Contract for the provision of mortuary services, 1 November 2015–31 March 2020.

91 Written statement of Mr Alan Craze, Coroner East Sussex since 1998, Senior Coroner since 2013.

92 Witness transcript of Mr Philip Baker, Assistant Chief Executive, East Sussex County Council.

93 Witness transcript of N583, Legal and Coroner Services Manager, East Sussex County Council, since 2019.

94 Witness transcript of N584, Coroner Services Manager, East Sussex County Council, since 2021.

6.8 Pathologists' observations

Please note that the following sections contain material which may be distressing to read.

The Inquiry interviewed pathologists who had undertaken PME's in the Trust's mortuaries during the time in which David Fuller was offending, to explore whether they could have detected the offending. Some were employed by the Trust, and some were visiting pathologists. The Inquiry received evidence from Kent Police that some of the pathologists had undertaken a PME on David Fuller's victims after he had offended.

The Inquiry considered the possibility that sexual abuse could be identified during a coronial PME. Dr Anna Rycroft, consultant pathologist, said:

"[A]ll bodies are examined fully, externally. You're looking for external injuries but post-mortem injuries aren't going to be obvious, there aren't going to be any. You're not going to bruise or abrade ... you might get some skin slip in a slightly decomposing body, but the answer is, is that just body handling?"⁹⁵

Dr Rycroft said:

"Although it would be difficult to state the difference between pre- and post-mortem sexual assault, that actually wouldn't make any difference to what you did. You would refer it to the coroner nonetheless, if there was any evidence of any assault at any time."⁹⁶

Dr Rycroft confirmed that, in her opinion, if sexual abuse happened after death, she would not expect any bleeding or bruising or inflammation because you have to be alive in order for those changes to happen.

When asked whether they routinely take vaginal and anal swabs, Dr David Rouse, forensic pathologist, said:

"If I had to take those sort of swabs I wouldn't be doing a routine coronial case. I mean as soon as, as soon as you say to me you know – I want those swabs – my immediate response would be this is not a coroner's case, this is a homicide and should be treated as such."⁹⁷

Dr Rycroft said:

"The answer is no, I didn't. Erm, when you're not looking for nefarious activity. I've subsequently done a forensic qualification, so the answer is it's a very different mindset when you go into it thinking there is criminality and you're looking to prove or disprove it."⁹⁸

95 Witness transcript of Dr Anna Rycroft, consultant pathologist, conducted PME's at the Trust, 2016–2021.

96 Ibid.

97 Witness transcript of Dr David Rouse, independent forensic pathologist conducting Home Office and coroners' PME's in Kent, 1988–2009. Conducted Medway and Maidstone coronial area PME's, 2009–2018.

98 Witness transcript of Dr Anna Rycroft, consultant pathologist, conducted PME's at the Trust, 2016–2021.

The Inquiry sought advice from its Independent Advisers – Professor Michael Osborn, President of the Royal College of Pathologists, and Mr John Pitchers, Chair of the Association of Anatomical Pathology Technology – and from an experienced forensic pathologist, Dr Paul Johnson. After careful consideration of a sample of the offending material (as described in Chapter 2), they concluded that evidence of the offending could not reasonably have been detected during a PME in the cases they considered.

6.8.1 Transfer of the deceased to and from Tunbridge Wells Hospital

In this section, we consider arrangements for the transfer of the deceased between the Tunbridge Wells Hospital mortuary and other organisations, including funeral directors and the ambulance service, to ascertain if there were opportunities to identify something of concern.

The Inquiry spoke to staff from six funeral companies and one private mortuary that transfer the deceased to, or from, the mortuary at Tunbridge Wells Hospital.⁹⁹ They explained that it was not their role to examine the bodies of the deceased, and that they do not have details of how the person died, or their history before death. None could recall anything concerning about the condition of bodies collected from the mortuary at Tunbridge Wells Hospital. Some explained that the decomposition of the body or the PME process itself would make any interference difficult to identify.

A representative from Southborough Funeral Directors told the Inquiry that it would be difficult for funeral home staff and embalmers to notice physical damage to a body after death:

*"[I]t's very difficult with [the] deceased because if something happened post-mortem, so post death, it would be very difficult to identify ... because there's no bruising."*¹⁰⁰

A representative from Birds Funeral Directors told the Inquiry:

*"No, because obviously, the trouble is, we don't know any story beforehand so we wouldn't know if that person 2 days ago fell down the stairs, so any bruising or anything wouldn't necessarily be a red flag to us because we're obviously not aware of anything that happened ... sometimes a lot of bruising can come out after a person's passed away. If they've had a post mortem they can obviously be a bit bruised."*¹⁰¹

A representative from CW Lyons and Son Funeral Directors told the Inquiry in similar terms that the funeral directors would not be checking the condition of the body:

99 Representatives from Southborough Funeral Directors; Birds Family Funeral Directors; Henry Paul Funerals; CW Lyons and Son Funeral Directors; Coop Funeral Care; CPJ Field Funeral Directors; and Jacksons Hub private mortuary.

100 Witness transcript of a representative from Southborough Funeral Directors.

101 Witness transcript of a representative from Birds Family Funeral Directors.

“[W]e wouldn’t be questioning bruises or any cuts or that because we’re collecting deceased and it’s not our position to know how that person died or what happened. The only thing we know is the name and the date of birth and we would not want to know how that person died.”¹⁰²

A representative of Jacksons Hub Ltd had not seen anything unusual in relation to bodies of the deceased: *“I don’t know what they died of ... This deceased may have been abused prior to death. That could be the cause of death. I’m not to know.”¹⁰³*

A representative of Henry Paul Funerals spoke of it being hard to identify any marks of concern given the process of decomposition:

“[Y]ou know unfortunately when we do pass away changes start to happen. And some people change quickly, some people change slowly ... I could see things sometimes just not being noticed because when people do, you know, decompose et cetera, ... it’ll be sometimes hard to actually notice let’s say if a body had been tampered with you might not notice it because the bodies already starting to really change.”¹⁰⁴

The Inquiry team also interviewed Ms Emma Williams, the Executive Director of Operations for South East Coast Ambulance Service NHS Foundation Trust (SECAMB).¹⁰⁵ Ms Williams told us that SECAMB rarely takes deceased people to the Trust’s mortuary and that, where this has happened, the process for doing so was no different from other mortuaries. SECAMB managers wrote to its operational staff to ask if any had any concerns about the Trust’s mortuary. No replies were received, indicating that there had been no concerns.

What we have found

- There have been many external organisations involved in assessing the Trust’s mortuaries over the years, all with different and often unclear remits. The framework of external oversight did not detect and address serious issues at the Trust’s mortuaries, including lax security, non-compliance with policies and inadequate management arrangements.
- The Inquiry found a number of instances where its inspectors relied on ‘reassurance’ rather than ‘assurance’. There was a reliance on policies being in place rather than assessing adherence to them in practice.
- The processes of the Human Tissue Authority (HTA) meant that it did not identify and respond to systemic and prolonged problems in the Trust’s mortuary service. The HTA appears to have viewed the various inspections and incidents in isolation.

¹⁰² Witness transcript of a representative from CW Lyons and Son Funeral Directors.

¹⁰³ Witness transcript of a representative from Jacksons Hub Ltd, private mortuary.

¹⁰⁴ Witness transcript of a representative from Henry Paul Funerals.

¹⁰⁵ Ms Emma Williams, Deputy Director of Operations, South East Coast Ambulance Service NHS Trust, 2019–2021, Executive Director of Operations since 2021.

- Where the HTA identified major shortfalls, such as CCTV and fridge storage capacity in November 2018, it did not monitor the Trust's compliance in remedying such shortfalls, which should have taken place within one to two months but which in fact only occurred two years later.
- Those who held the position of Designated Individual at the Maidstone and Tunbridge Wells NHS Trust found the role challenging, having significant legal and operational responsibility but without the authority and support required to carry out the role effectively.
- There is confusion as to the duties of the Care Quality Commission compared with those of the HTA, which leads to some uncertainty as to who does and does not have the remit to inspect and review the adequacy of mortuary facilities. Within this, there appears to be a regulatory gap, with no statutory provision for the inspection of the security and dignity of facilities for the deceased if they are not subject to HTA-licensed activities.
- NHS England (NHSE) did not have a mechanism for detecting problems with the mortuaries at this Trust. Mortuaries are not part of its central oversight framework, and its Regional Director took verbal reassurance that the Trust was compliant with HTA standards. NHSE failed to publish vital and relevant guidance after taking over responsibility for Estates and Facilities, including Health Building Notes, in 2017.
- The Health and Safety Executive did not have a process in place to alert the HTA of its concerns about the lack of assessment of risk of injury to staff involved in manual transfer of the deceased, which indicated problems with the way the mortuary was being run.
- There appears to have been no process for information-sharing or joint working across the various external organisations in relation to their interaction with the Trust's mortuaries.
- While coroners have legal control of the body of the deceased until their coronial functions come to an end, they do not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of the deceased in their control.
- The Inquiry's Independent Advisers concluded evidence of David Fuller's offending could not have been reasonably detected during a PME in the cases they considered.

Chapter 7: Governance and accountability within Maidstone and Tunbridge Wells NHS Trust of matters relating to David Fuller

In this chapter, we consider whether the governance arrangements in place for the mortuary at Maidstone and Tunbridge Wells NHS Trust (the Trust) were adequate and how they operated. We consider whether the Trust Board received sufficient information to provide the necessary assurance on the key issues raised by the case of David Fuller, namely the management and oversight of the mortuary service, the Trust's compliance with the requirements of the Human Tissue Authority (HTA) and the adequacy of the Trust's arrangements for criminal record checks. We examine how the Board was apprised of the requirements and reports of the wider system, including regulation, and the level of importance it attached to each organisation.

In addition to interviewing the previous and current Chief Executives and Chairs who were in post during the period David Fuller offended at the Trust, we have reviewed Trust Board papers from 2000 to 2020; Quality Committee (and its predecessor) papers from 2008 to 2021; and executive team meeting papers from 2003 to 2010, and 2016 to 2021.

7.1 Maidstone and Tunbridge Wells NHS Trust governance arrangements

Hospitals are managed at the highest level by boards of directors. In most NHS organisations, including Maidstone and Tunbridge Wells NHS Trust, this is a unitary board, with at least half the board, excluding the chair, made up of non-executive directors. While all directors are collectively and corporately accountable for the organisation, non-executive directors provide independent oversight and constructive challenge to the executive directors on the board. The chair of the board is responsible for ensuring the board is accountable for governing the organisation. The chief executive leads the executive and the organisation and is the trust's accountable officer.

The role of the board is to develop the strategy for the organisation; hold the executive to account for the delivery of the strategy and receive assurance that systems of control are robust and reliable; and ensure a healthy culture within the organisation.¹

Robust structures and processes of corporate and clinical governance are integral to a well-run organisation.

This Inquiry has considered whether Maidstone and Tunbridge Wells NHS Trust's governance structure allowed its Board to consider the quality of mortuary services. The Trust provided the Inquiry with a diagram setting out the governance structure that was in place in 2009. The Inquiry has also seen a diagram setting out the Board committee structure that was an appendix to the Trust's Risk Management Policy and Procedure ratified by the Board in September 2017. These diagrams are at Appendix 6.

We were told that issues relating to the mortuary would have been discussed at meetings of the Trust's Quality Committee. This is covered later in this chapter.

7.1.1 Responsibility for the mortuary and Human Tissue Authority requirements at Board level

It was unclear to the Inquiry which specific Board member was responsible for the mortuary and compliance with the regulatory requirements over the period of interest.

Ms Avey Bhatia, the Chief Nurse at the Trust between 2013 and 2017, told the Inquiry that she thought the Trust's Medical Director had responsibility for the HTA licence. Ms Bhatia went on to say that, as she had overall responsibility for quality and safety, she did get involved in issues around tracking patients in and out of the mortuary, and the wishes of families of the deceased, but that *"in terms of overall responsibility for compliance with standards and regulations for the mortuary, that didn't sit with me"*²

Ms Claire O'Brien, the Trust's Chief Nurse between 2017 and 2021, told us that she believed the Trust's Chief Executive was responsible for compliance with HTA requirements, rather than this being the responsibility of herself or the Medical Director.³

Dr Paul Sigston, the Trust's Medical Director between 2010 and 2017, told the Inquiry that he did not believe he had specific executive responsibility for the mortuary in his role as Medical Director:

*"I can't recollect at any point thinking that this [the mortuary] was some, a specific area that I was responsible for, other than being responsible for everywhere. So, I cannot remember any time when I thought it was my responsibility to check out the mortuary versus others there."*⁴

The Trust's current Medical Director, Dr Peter Maskell, told the Inquiry that he believed the Chief Operating Officer had executive responsibility for the mortuary and that

1 NHS Leadership Academy, 2013.

2 Witness transcript of Ms Avey Bhatia, Chief Nurse, 2013–2017.

3 Witness transcript of Ms Claire O'Brien, Chief Nurse, 2017–2021.

4 Witness transcript of Dr Paul Sigston, Medical Director, 2010–2017.

executive responsibility for the HTA inspections of the Trust sat with the Chief Executive through their relationship with the Designated Individual (DI).⁵

Ms Rose Rees (formerly Gibb), Chief Executive of the Trust between 2003 and 2007, could not, given the passage of time, recall who had executive responsibility for the mortuary. She thought that the Chief Nurse would have had responsibility for HTA matters, following the establishment of the HTA in 2005.⁶

Mr Glenn Douglas, Chief Executive between 2007 and 2017, told us that it was originally the Medical Director who had executive responsibility for the mortuary, but that this changed to the Chief Operating Officer. He explained that this was done:

*"... to bring the two sides of the organisation together, 'cause you had parallel universes of the clinical directors reporting on one way and the ... and that was diffuse anyway between the medical director and the chief executive, to bring it within one solid line."*⁷

The Trust's current Chief Executive, Mr Miles Scott, told the Inquiry that the Chief Operating Officer has executive oversight of the mortuary, while the DI is responsible for compliance with HTA requirements and reports directly to the Chief Executive on this.⁸

Mr Sean Briggs, the Trust's current Chief Operating Officer, told the Inquiry of his responsibility for the mortuary and outlined the role of the DI:

*"So, very much I would be responsible for the day-to-day running of the mortuary, responding to quality initiatives in there with the team of, the team that I've described. Making sure it's planning properly for capacity and any issues that are coming up like that, responding to the HTA and making sure we've got a good relationship with the HTA. But I would, so very much directly, in the same way I'd see Cardiology, I'd see the mortuary in exactly the same way. The only difference there is of course the DI that does have that different relationship with our Chief Executive as well to provide more assurance."*⁹

The Inquiry heard differing accounts of who executives considered had accountability to the Trust Board for the mortuary. We were told that the Medical Director was responsible for the mortuary until 2017, when responsibility transferred to the Chief Operating Officer.¹⁰ Dr Sigston did not think he had specific responsibility for the mortuary. While there appears to be agreement between the Chief Executive and the Chief Operating Officer, both appointed in 2018, and with the current Medical Director, that executive responsibility for the mortuary sits with the Chief Operating Officer, this was not clear from the Inquiry's interview with the Chief Nurse who was in post between 2017 and 2021. The Trust told the Inquiry that executive responsibility for the mortuary had always sat with the Chief Operating Officer. See Chapter 4.

5 Witness transcript of Dr Peter Maskell, Medical Director since February 2017.

6 Witness transcript of Ms Rose Rees (formerly Gibb), Chief Executive, 2003–2007.

7 Witness transcript of Mr Glenn Douglas, Chief Executive, 2007–2017.

8 Witness transcript of Mr Miles Scott, Chief Executive since 2018.

9 Witness transcript of Mr Sean Briggs, Chief Operating Officer since 2018.

10 Witness transcript of Mr Glenn Douglas, Chief Executive, 2007–2017.

7.1.2 The Quality Committee and oversight of mortuary and Human Tissue Authority compliance

The Inquiry was told that issues regarding the mortuary and HTA requirements were discussed at the meetings of the Quality Committee and that this committee was responsible for escalating issues to the Trust Board as necessary. The Trust Secretary, Mr Kevin Rowan, told us:

“Q: [T]hinking about areas of regulated activity and external accreditation specifically to the mortuary, where do they get reported to?”

A: Yeah so, that would be so through the Quality Committee up through the divisions into the Quality Committee and then it will, as determined will ultimately run through the Board as required.”¹¹

There have been three HTA routine inspections, one HTA investigation and seven incidents that required reporting to the HTA since the Trust was first granted its HTA licence in 2007. In addition, the Trust voluntarily surrendered its HTA licence in 2011 and successfully reapplied for it in 2014. We examined how the Quality Committee had been kept informed of these issues and other matters relating to the mortuary.

We consider the reporting arrangements to have been complicated. In 2009, eight groups reported directly into the Quality and Safety Committee and a further 19 forums reported into these eight. By 2017, this had increased, with 11 groups reporting directly into the Quality Committee and a further 28 forums reporting into these 11.

The Trust told the Inquiry that the governance and reporting structure it has in place is based on, and has been informed by, NHS corporate governance directions and best practice guidance, including: the ‘NHS Code of Conduct and Code of Accountability’ (1994); ‘Clinical governance. Quality in the new NHS’ (Health Service Circular 1999/065); *Quality Governance in the NHS – A guide for provider boards* (National Quality Board, 2011); and *The Healthy NHS Board 2013: Principles for Good Governance* (NHS Leadership Academy). While this may be the case, it is difficult to understand how the Quality Committee can have sufficient time to oversee HTA and mortuary matters, given the breadth of its responsibilities.

We asked Mr Rowan whether it is clear which are executive and which are oversight groups. He replied: *“It’s absolutely clear to me. If you were to ask, you know, kind of someone in the middle management of the organisation, they may not know. But then I wouldn’t be surprised because they probably don’t need to know.”¹²*

The Trust Secretary expressing the view that middle managers do not need to understand the Trust’s governance structure did not inspire our confidence that the arrangements and chain of responsibility would be well understood within the Trust.

The Quality and Safety Committee was established in 2008. Before this, issues relating to the mortuaries at the Trust appear to have been dealt with by the Clinical Governance and Risk Committee. The Trust has only been able to locate one set of

11 Witness transcript of Mr Kevin Rowan, Trust Secretary since 2013.

12 Ibid.

minutes for this committee, for its meeting in January 2002. There is no mention of the mortuary in these minutes.

Mr James Lee, Chair of the Trust between 2003 and 2007, provided us with papers from the Clinical Governance and Risk Committee from December 2006. At that time, the committee was chaired by the Nursing or Medical Director. The papers include the Terms of Reference for the committee, which show the committee reporting directly to the Trust Board and include the following purpose:

“... to oversee the implementation and management within the Trust of governance and risk. The committee will ensure that the Trust has the structures, systems and processes in order to achieve agreed clinical outcomes, key clinical and operational functions and improve the patient experience. It will take an overview of the arrangements to identify where clinical and non-clinical service delivery, quality and performance fall below acceptable standards. When this occurs it will take steps to improve these services and to promote a culture of improvement and excellence. It will work with members of the Trust Management Committee to ensure all aspects of governance are addressed in an integrated manner.”¹³

One of the papers from the meeting in December 2006 lists the top 20 risks that were reported to the Board. Risk number three related specifically to the mortuaries and stated: *“Mortuaries are not complaint [sic] with standards set by CPA [Clinical Pathology Accreditation Service]. Risk to Trust reputation and staff health & safety.”¹⁴* See Chapter 6.

We were unable to locate any reference to this risk in Trust Board papers around this time. In September 2006, however, the Trust Board had been advised of *“weaknesses and deficiencies in current structures and policies for the mortuary service”*, which had been identified during preparations for the Trust’s licence application to the HTA. The Trust Board was further informed in this ‘Clinical Governance Report’ that *“it is anticipated that the HTA will want reassurance that these are being addressed, and these items have been entered onto the Trust risk register.”¹⁵*

This update to the Board is likely to relate to the ‘Gap Analysis’ that Dr Graham Russell, consultant pathologist at the Trust between 1991 and 2022, and DI between 2006 and 2010, was undertaking in relation to meeting the HTA requirements. This ‘Gap Analysis’ and associated action plan, dated September 2006, identified, among other actions, that mortuary policies, Standard Operating Procedures (SOPs) and risk assessments were either out of date or incomplete. In addition, as reported to the Clinical Governance and Risk Committee, the mortuary was not accredited with the CPA and therefore not required to be compliant with CPA standards.

Terms of Reference were submitted to the Quality and Safety Committee meeting on 15 October 2008. These explain that the committee was:

“... constituted at the request of the Trust Board to oversee the implementation and management within the Trust of structures, systems and processes to facilitate risk

13 Clinical Governance and Risk Committee, December 2006.

14 Appendix H, Board Level – High Rated Risks (25 October 2006).

15 MTW NHS Trust, Board meeting papers Part 1, 26 September 2006.

assessment (both clinical and non-clinical), mitigation and monitoring to support the delivery of the organisation objectives and promote a culture of improvement and excellence”.

It was agreed at the meeting on 15 October 2008 that the Terms of Reference would be submitted to the Trust Board for ratification, and this took place on 25 February 2009, when they were approved, subject to a change about required attendance. In introducing the item, Ms Sylvia Denton, Non-Executive Director at the Trust between 2008 and 2017, noted that *“the Divisional reports to the Committee need to improve to better reflect to clinical governance work being done at divisional level”*.¹⁶

At its meeting on 13 May 2015, the Quality and Safety Committee considered a proposal to change its title from ‘Quality and Safety Committee’ to ‘Quality Committee’, in recognition that ‘safety’ was one of the three tenets of the accepted definition of ‘quality’ (along with ‘clinical effectiveness’ and ‘patient experience’). This was agreed and the name of the committee was changed at the June meeting.

Ms Sarah Dunnett, a Non-Executive Director at the Trust, chaired the Quality Committee. She told the Inquiry that the papers for the monthly meetings of the Quality Committee could be 350 pages long or more. On becoming Chair of the Committee, Ms Dunnett introduced a ‘deep dive’ at its meetings every other month on a particular subject, *“because it’s very easy to look at everything, but actually, sometimes you need a laser focus on falls, or end of life”*.¹⁷ She told us that she could not recall there being a deep dive on the mortuary or HTA requirements at the Quality Committee.

The Deputy Chair of the Quality Committee from 2017 and Chair of the Committee from 2022, Ms Maureen Choong, told the Inquiry that she would expect regulatory findings about the mortuary to be brought to the Quality Committee and had confidence that the relevant Director would have done so, but could not recall if this had happened in practice.¹⁸

We were told that the Quality Committee was regularly attended by the Trust’s Chief Nurse, Medical Director and Chief Operating Officer.¹⁹

Neither of the two Chief Nurses the Inquiry interviewed who were in post prior to David Fuller’s arrest in December 2020 could recall discussion of the mortuary or HTA requirements at the Quality Committee, although one was sure there would have been:

*“I do remember estates issues being reported at quality committee and there’s obviously wider regulation requirements on other activities, but what I don’t remember is mortuary being reported.”*²⁰

16 MTW NHS Trust Board meeting minutes, 25 February 2009, 005/09, Matters Arising and Sub-Committee Reports, Quality and Safety Committee, p. 4.

17 Witness transcript of Ms Sarah Dunnett, Non-Executive Director and Chair of the Quality Committee from January 2014 to December 2021.

18 Witness transcript of Ms Maureen Choong, Non-Executive Director since 2017.

19 Witness transcripts of Ms Sarah Dunnett and Ms Maureen Choong.

20 Witness transcript of Ms Avey Bhatia, Chief Nurse, 2013–2017.

“So, I can’t recall, but I’m pretty sure it [reports on HTA compliance] would be the sort of report that would’ve come to the quality committee.”²¹

Dr Sigston told the Inquiry that he thought serious matters regarding the HTA requirements had been discussed directly at Board level rather than at the Quality Committee.²²

Dr Maskell told the Inquiry that he thought HTA inspections had been discussed at the Quality Committee, but that *“I don’t recall that it’s [the mortuary] ever been discussed at a Quality Committee deep dive”*²³

Mr Briggs told the Inquiry that any issues relating to the mortuary or the HTA would be reported to the Quality Committee.²⁴

Speaking about the HTA inspection of the mortuary at Tunbridge Wells Hospital in 2018, Mr Scott told us:

“I know the Quality Committee didn’t have a big examination of the HTA report in 2018. It didn’t. And I suppose the question is: were the issues raised of a nature that, other than, you know, other than through notification and incorporation of the quality account and so on, that there should have been a big debate about it at the Quality Committee? And I think that’s an important question. The judgement was that there was an inspection. The licence was maintained. There were some recommendations for action. There were some minor ones, some major ones. No critical ones. And there was an action plan put in place and all of those things were addressed ... The assurance from the HTA goes through that system that I described. Which is Pathology Board, up to Quality Committee. That’s how that operates.”²⁵

The extent to which the Quality Committee considered HTA inspections is set out in three case studies later in this chapter.

The Inquiry found only limited reference to incidents in the mortuary in the minutes of the Quality and Safety Committee and the Quality Committee meetings. There are two references to a Health and Safety Executive (HSE) improvement notice regarding the mortuary at Kent and Sussex Hospital in 2008. In 2009, there are two references to health and safety guidelines in the mortuary and mention of the incident regarding the retained tissue of a child. In 2010, there is reference to the Mortuary Manager reviewing procedures and the lack of a bariatric trolley in the mortuary at Kent and Sussex Hospital. In 2011, the fact that there had been two incidents related to the mortuary is noted in minutes, together with a brief reference to the fact that post-mortem examinations (PMEs) had stopped at the Trust. Minutes of meetings held in 2012 include references to capacity issues in the mortuary, to the mortuary action plan being presented to the Divisional Operations Committee, and to the fact that there had been *“good progress against non confirmed mortuary assurance framework”*.

21 Witness transcript of Ms Claire O’Brien, Chief Nurse, 2017–2021.

22 Witness transcript of Dr Paul Sigston, Medical Director, 2010–2017.

23 Witness transcript of Mr Peter Maskell, Medical Director since February 2017.

24 Witness transcript of Mr Sean Briggs, Chief Operating Officer since 2018.

25 Witness transcript of Mr Miles Scott, Chief Executive since 2018.

There is no mention of the mortuary in the minutes of meetings held in 2013, 2014, 2015 and 2016. The mortuary is mentioned in the context of End of Life Care (EoLC) in 2017. In 2018, capacity issues in the mortuary and the approval of a business case for additional storage are included in the minutes. In 2019 and 2020, there is no mention of the mortuary in minutes of the Quality Committee. In the 12 years from 2008 to 2020, there are six years where there is no mention of the mortuary or the HTA in the minutes of the Quality and Safety Committee or the Quality Committee that replaced it.

- The Inquiry found no reference in the minutes of the Quality and Safety Committee or the Quality Committee to significant discussion of the reports of HTA inspections of the mortuary that occurred in 2010, 2015 and 2018.

The Inquiry found no reference to a discussion about the HTA licence in the Quality and Safety Committee minutes throughout 2011. This was despite a paper that went to the Divisional Operations Committee in April 2011, which concluded that *“continuation of the Post Mortem service represents a considerable risk to the organisation, both reputational and financial, which outweigh any advantage in continuing the service”*. In her evidence to the Inquiry, Dr Sara Mumford, Clinical Director for Pathology from 2010 to 2018 and Deputy Medical Director since 2018, explained that the conclusion drawn was that the post-mortem service *“just wasn’t safe”*.²⁶

In the minutes of the January 2011 meeting, there is a brief reference to two incidents related to the mortuary. There is one brief mention of PMEs ceasing in the Quality and Safety Committee minutes of 13 July 2011, on page 5 of 7. The record is as follows:

*“The two mortuaries are now body stores only as post mortems take place outside of the Trust.”*²⁷

- The lack of discussion in 2011 by the Quality Committee, let alone the Board, of the fact that the Trust decided voluntarily to relinquish its HTA licence is concerning, given that this was a regulated activity and the decision was taken in part because the service was considered by the Pathology Directorate to be unsafe. The decision, in effect, removed a part of the Trust’s service from external statutory oversight.
- Equally concerning, we found no reference to the Trust reapplying for an HTA licence in 2014, in either the Quality Committee or Board meeting minutes. The lack of discussion about this decision by the Quality Committee is surprising given that the licence had been relinquished for quality reasons and that, once the licence was granted again, the mortuary and its services would again be subject to statutory regulation and inspection.

26 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

27 Quality and Safety Committee meeting minutes, 3 July 2011, p. 5.

- The Quality Committee had very many other committees, groups and forums reporting into it. We heard from the Chair of the Committee between 2014 and 2021 that it had a busy agenda, with every second meeting being a ‘deep dive’.²⁸ Within this context, it is clear from the recall of those who attended the Quality Committee meetings and from examination of the minutes of meetings that there was a very limited focus on the regulated activity of the mortuary. Some who attended the meetings told the Inquiry that they were sure HTA activity would have been discussed. However, this is not evidenced from the minutes of the meetings. If these matters were not on the radar of the Quality Committee, and this was the gateway to the Board, it seems there would be little likelihood of them reaching the Board. This is considered in the next section of this chapter.

7.2 Trust Board awareness of and engagement with Human Tissue Authority requirements

Within the Trust’s governance arrangements, the expectation was that the Quality Committee would report to the Board on matters relating to the mortuaries and HTA requirements. Given that we found the Quality Committee had little focus on these issues, we examined what the Board knew of the HTA inspections and incidents that had happened at the Trust, and the extent to which it had been engaged in decisions to voluntarily revoke the Trust’s HTA licence in 2011 and to reapply for this in 2014.

Ms Choong, who has chaired the Quality Committee since 2022 and was its Deputy Chair between 2017 and 2022, told us how the committee reports to the Board:

“So, well there are two ways, one is so verbal presentation, so it’s every board meeting there is a board update from the Quality Committee either from a deep dive because we also have deep dives into specific matters we select topics that we want additional assurance and spend the whole meeting on a much smaller number of topics to get the data. Or we have a summary of the minutes of the meeting itself and each of the NEDs [Non-Executive Directors] who chair and that’s the same for all the subcommittees, each of the NEDs, non-executives who chair present that report. We have changed that in the last year so we now present those reports at the beginning of the meeting rather than at the end of the meeting because the Chairman felt, sometimes they can feel like a little bit of an afterthought. And actually, if you’re thinking about board assurance and looking at the context of the whole meeting it was good to have the thoughts and views of the feedback from the subcommittees. And probably from the key lines in the verbal report it’s where we’ve felt there was robust assurance or where we needed to do more work or particularly wanted to commence [sic] on some progress that had been made.”²⁹

28 Witness transcript of Ms Sarah Dunnett, Non-Executive Director and Chair of the Quality Committee from January 2014 to December 2021.

29 Witness transcript of Ms Maureen Choong, Non-Executive Director since 2017.

As set out in Chapter 6, the first inspection of the Trust by the HTA took place in August 2007. Neither this inspection, nor the subsequent granting of the Trust's HTA licence in May 2008 and the work to achieve compliance for the licence, were noted in Trust Board papers.

As set out above, in September 2006 the Trust Board was made aware that the application process for the HTA licence had highlighted "*certain weaknesses and deficiencies in current structures and policies for the mortuary service*", but there appears to have been no progress update to the Board on resolution of those deficiencies.³⁰

In May 2007, the Board was informed that the Maidstone mortuary had been declared unfit for use by the HSE, as this risk was included on the Board Level Risk Register, which was an appendix to the papers for the public meeting of the Trust Board.³¹ Highlighted in the description of the risk was the risk to HTA compliance and CPA accreditation if the Trust failed to meet HSE requirements, as well as the potential for prosecution. Identified mitigating actions included the cessation of PMEs at Maidstone Hospital. The mortuary at Maidstone Hospital subsequently became a body store only. In November 2008, the mortuary featured again on the Board Level Risk Register, once more in relation to an improvement notice issued by the HSE. This time the concern was that facilities were inadequate for the handling of bariatric bodies at the Kent and Sussex Hospital mortuary.³²

In December 2008, the mortuary at Kent and Sussex Hospital released the body of a child to an undertaker in error. This was reported to the HTA by the Trust in January 2009. The incident was the subject of a formal complaint to the Trust by the coroner and an HTA investigation. This was reported to the private session of the Trust Board meeting, known as 'part 2' of the Board meeting, each month from January 2009 to July 2009. The reporting of the incident was contained in the Serious Untoward Incident report that was prepared for the monthly Board meeting. This report was eight pages long, and the mortuary incident was one of many other incidents reported, alongside issues such as the death of a staff member and assaults on patients. It is unlikely that the mortuary incident was identified as requiring any special attention by those reading the Trust Board papers, as there was nothing to make it stand out against other very serious incidents. When the investigation into the incident was closed, this was also reported to the Board. There is no evidence of a review of the action plan by the Trust Board in relation to this incident, even though it had been the subject of a formal complaint by the coroner. This was a missed opportunity to learn lessons to improve practice in the mortuary.

A further serious incident regarding the retention of human tissue, which occurred in April 2009, was reported to the Trust Board in June 2009, again as part of the wider Serious Untoward Incident report presented to the private session of the Board meeting.

30 Meeting of MTW NHS Trust Board, September 2006, Clinical Governance Report, Agenda Item 050/06 – iii, Appendix J.

31 Meeting of MTW NHS Trust Board, 29 May 2007, Appendix I.

32 Meeting of MTW NHS Trust Board, 26 November 2008, Appendix I.

In July 2009, the mortuaries at the Trust were included in the organisation-wide risk register that was an appendix to the papers for the public meeting of the Trust Board.

The risk as set out in the risk register contains a summary of the HTA findings in terms of the adequacy of the governance arrangements for the mortuary, an HSE improvement notice regarding the risk of injury to staff in the mortuary while moving bodies of the deceased, and reference to Serious Untoward Incidents. The risk register states that the mortuary staff were “not confident or competent to manage day to day mortuary activities effectively”, and that “there is no day to day supervision of staff”. See Figure 6.

This risk was comprehensively set out and judged to be a high risk. The commentary was about events that had actually happened rather than those that were at risk of happening. Given the length and content of the risk report and the paper it was appended to, it is unlikely that a reader of these papers would appreciate the significance of the risk identified. The report included many other high risks, and there was nothing to identify the risk in the mortuary services as being higher or more serious than these other risks. This is concerning given that the risk was related to statutory, regulated activity. The Inquiry has not seen any evidence that details of the HTA inspection referred to in the risk register were reported to the Trust Board.

Figure 6: Appendix I, Assurance Framework and Risk Register

131	1577	5/5/09	mortuary/body store management	Directorate	Pathology	Lack of effective management for mortuary/body store Lack of compliance with policies & procedures by mortuary technicians (APTs) and one pathologist 2 SUIs related to autopsy work in 4 month period HSE improvement notice imposed on department. Triggered visit by Human Tissue Authority to the Trust. 3 complaints about APT attitude and procedures in past 6 months. The grade of mortuary staff currently employed is not confident or competent to manage day-to day mortuary activities effectively. There is little understanding of the need or purpose of written protocols and little evidence that these are being followed. HTA and CPA require a quality managed system. There is little understanding of this concept among the current APT staff. There is no day-to-day supervision of these staff. They are isolated on a different site from the rest of the cell path department. The mortuary manager is also manager for the whole cell path service (histology/cytology) cross site and has to divide his time between all services, total 4 sites. Cytology manager (Preston Hall) has recently retired. Histology manager Pembu	1	High risk	Jim Withell	30/6/09
-----	------	--------	--------------------------------	-------------	-----------	---	---	-----------	-------------	---------

Source: MTW NHS Trust Board papers, July 2009, Part 1, Appendix I, p. 33.

The HTA inspected the mortuary at Kent and Sussex Hospital in April 2010. It identified failings relating to lack of processes and procedures and the competency of staff regarding knowledge of statutory procedures such as consent. The HTA Inspection Report also noted that the DI, Dr Russell, reported that the Mortuary Manager was overstretched, with the HTA commenting that Dr Russell required more support in his role as DI. The HTA put two conditions on the Trust licence that required the DI to report to the regulator on progress in implementing the action plan in response to the inspection each month.

There was no mention of the HTA 2010 inspection, or the mortuary, in the Trust Board papers for 2010. This is surprising given the findings of the 2010 inspection resulting in a further seven conditions being placed on the HTA licence.

Furthermore, there was no mention in the Board papers of the HTA communication confirming that the Trust had subsequently met the conditions the HTA had stipulated following its inspection. The HTA inspection of 2010 was not included in any minutes of the Quality and Safety Committee meetings for that year.

In the Quality and Safety Committee report that went to the public Trust Board meeting in January 2011, two incidents were reported under 'Cancer Services Division Reports':

*"There are a cluster of incidents regarding CT Scanning which are being investigated and 2 related to the Mortuary."*³³

These incidents were a breach of HTA licensing requirements and related to the tissue of the body of a child that had been the subject of serious incident reports in 2009. There was no reference in the Quality and Safety Committee report to the Trust Board to this being in breach of HTA requirements, nor to the fact that it had triggered an HTA investigation. There was also no reference in the meeting papers to previous serious incidents, and the incidents were not reported in the private session of the Board meeting.

In November 2011, the Trust voluntarily relinquished its HTA licence; see Chapter 4. It appears that this decision was taken by the Executive Directors of the Trust without reference to the Trust Board. Dr Sigston, then Medical Director, wrote to the HTA in October 2011 to ask to relinquish the licence.³⁴ The Inquiry found no reference to the HTA licence or the mortuary in any of the Trust Board papers for 2011. There was no Board scrutiny of the decision to remove the mortuary from external, statutory regulation. This is concerning in itself, but more so given that the incident regarding the tissue of the body of a child was reported in national media in September 2011, with a headline in the *Daily Mail* that read: "*Catastrophic impact' on family as baby is buried without brain because hospital staff left it on a shelf for FIVE months*".³⁵

Dr Sigston told the Inquiry that he recalled there may have been discussion about the HTA licence at the Trust Board meeting:

*"I think there was a board discussion regarding HTA license and I think me taking over as the designated individual. I'd assume that would be minuted in a board paper round about that time, but I can't, I haven't re-read it, but I think that would have been right up at a board level rather than being seen as a quality committee issue. Not that it wasn't a quality issue, but you know, it was a much higher level of importance and therefore the execs were all being involved, so I think that's where it would have been."*³⁶

In 2014, the Trust applied for an HTA licence. Mr Douglas, then Chief Executive of the Trust, included the following in his update to the Board:

*"The Trust is going to provide full mortuary services from Tunbridge Wells Hospital in the coming months. This is an important step forward for bereaved families, providing post-mortem facilities locally instead of at Greenwich. The Trust expects the service to begin in April."*³⁷

33 Quality and Safety Committee minutes, 12 January 2011, p. 2.

34 Timeline of interactions between the Trust and the HTA, supplied by the HTA.

35 *Daily Mail*, 3 September 2011.

36 Witness transcript of Dr Paul Sigston, Medical Director, 2010–2017.

37 MTW NHS Trust Board papers, Chief Executive's update, 29 January 2014.

At its meeting on 28 May 2014, the Trust Board had an update on the Trust's Internal Audit Plan for 2013/14, which had been agreed by the Trust's Audit and Governance Committee. This included a review of the mortuary that had been conducted by NHS South Coast Audit.³⁸ The review had been prompted by the incidents in the mortuary at Kent and Sussex Hospital that had led to the Trust relinquishing its HTA licence in 2011.³⁹ The Audit and Governance Committee Annual Report 2013/14 update to the Board referenced the NHS South Coast Audit and its conclusion that "*significant assurance could be provided that the mortuary was operating in accordance with approved policies and procedures*".⁴⁰

This is inconsistent with what the Inquiry found regarding non-compliance with mortuary policies (see Chapters 2, 3 and 4).

The HTA inspected the mortuary at Tunbridge Wells Hospital in 2015. The Trust received a brief report on this at its January 2015 Board meeting. Dr Mumford, the then Deputy Medical Director, gave a presentation which mentioned that "*the Mortuary had recently been inspected by the Human Tissue Authority, and the feedback had been very positive*".⁴¹ The HTA inspection had, in fact, found that, while the Trust had met the majority of its standards, there were two minor shortfalls, one relating to the need to review SOPs and the other relating to some key risks having not been assessed. As far as the Inquiry has seen, these shortfalls were not referenced at any point in the January 2015 Board meeting. Dr Mumford explained to the Inquiry that her presentation to the Board took place just seven days after the HTA inspection. Her presentation was based on verbal feedback from the HTA inspectors, which was positive. Dr Mumford believed that what she had said to the Board was accurate at the time.⁴²

The HTA inspected the mortuary at Tunbridge Wells Hospital in 2018. The HTA found three major and 11 minor shortfalls against its standards, and the Trust was required to complete an action plan to remedy these (see Chapter 6). This indicates that there were still problems with the mortuary service. The Trust informed us that this inspection was referred to once at a meeting of the Quality Committee, on 8 May 2019, where it was listed alongside other external reviews, and that the only reference to the inspection at the Trust Board was in the Quality Accounts.

The Inquiry has spoken with two Non-Executive Directors who have chaired the Quality and Safety Committee or Quality Committee. Their period of tenure at the Trust spans 2014 to the present day, which means that they were present for at least one, or in one case two, HTA inspections. We also interviewed Mr David Highton, who has been Chair of the Trust since May 2017. All three struggled to remember HTA inspections being

38 NHS South Coast Audit delivered a range of internal audit and counter-fraud services to the NHS and public sector bodies in the south of England. It merged with TIAA in January 2014.

39 NHS South Coast Audit Internal Report on the mortuary, 12 July 2013.

40 MTW NHS Trust Board papers, 28 May 2014.

41 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

42 Response received during the Inquiry's Fairness Process from Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

discussed at Trust Board level, or in the meetings of the Quality Committee or the Quality and Safety Committee.⁴³

Mr Douglas told us:

"It sounds really strange to say that, given what happened subsequently, but it [the mortuary] was not an area I had any reason to have any concern about, and no concerns were directly raised in terms of the management of it. The only interaction, as I say, that ... of any consequence I had was around the reopening of the post-mortem service."

In answer to a question about how engaged the Board was in performance and quality during his time as the Chief Executive, Mr Douglas responded:

"[I]f you're asking me were they concerned about the mortuary or that as a particular part of the service, I think not ... And I think they were ... they genuinely thought ... probably considered it to be, dare I say, the living rather than the dead."

Mr Douglas clarified later that *"the dead need to be treated as the living"*.⁴⁴

The Board's attention appears to have been focused on areas other than the mortuary. For example, Mr Douglas told us that the key areas for attention by the Board were the Care Quality Commission (CQC) report into a *Clostridium difficile* (*C. difficile*) outbreak, and financial pressures.⁴⁵

Mr Lee, Chair of the Trust between 2003 and 2007, confirmed that the *C. difficile* outbreak and financial matters had taken up a lot of attention, and told the Inquiry that building the new Private Finance Initiative (PFI) hospital had done likewise: *"[I]n the latter stages of course erm I wouldn't say we got our eye off the ball but the whole top management became absolutely tied up with the PFI and the fact that we you know were trying to build that."*⁴⁶

Mr George Jenkins OBE, Interim Chair of the Trust between 2007 and 2008, told the Inquiry that, on his appointment, his priority had been to focus the Trust Board on issues that most affected patients and to move away from the distractions of finances and *C. difficile*:

"Establishing corporate governance, so that the board was actually focused on exactly what it should've been focused on, because it had become completely distracted by meeting financial numbers required by the Strategic Health Authority, much of which was challengeable. It was ... had been focused on reporting on issues such as C Difficile and the ramifications of that disease in that organisation, much of which was challenged by the Healthcare Commission. And they were much focused on a new-build hospital over at Pembury, which is on the edges of Tunbridge Wells, as

43 Witness transcripts of Mr David Highton, Trust Chair since May 2017; Ms Sarah Dunnett, Non-Executive Director and Chair of the Quality Committee from January 2014 to December 2021; and Ms Maureen Choong, Non-Executive Director since 2017.

44 Witness transcript of Mr Glenn Douglas, Chief Executive, 2007–2017.

45 Ibid.

46 Witness transcript of Mr James Lee, Chair of the Trust, 2003–2007.

opposed to managing that that they were tasked to manage and operate for the benefit of patients.”⁴⁷

Despite the efforts of Mr Jenkins OBE, the view that infection control and finances were the focus of the Board’s attention was shared by his successor, Mr Anthony Jones, Chair of the Trust between 2008 and 2017.⁴⁸

Mr Scott, current Chief Executive of the Trust, told the Inquiry that, up until David Fuller’s arrest, the priority of the Trust was to manage financial pressures and performance issues:

“So without a doubt, the first priority was to deal with the fact we had a very big deficit. We were in financial special measures. And we had a whole range of kind of clinical and operational performance issues that needed to be addressed. And so, you know, that was a strong area of focus. Those things were a strong area of focus.”⁴⁹

He went on to say that the Trust had successfully resolved some of its clinical challenges – for example, the improvement of cancer services – despite the financial problems it faced.

When asked how the Board was kept informed of HTA inspections, Mr Scott talked about the role of the DI and how he took assurance that matters were being appropriately dealt with because of this:

“I’ve got a Designated Individual who is telling me whether or not the action plan is being investigated and it is being completed on time. And all of that is in the knowledge that there’s a regulator who is engaging directly with the Designated Individual and the Pathology team on the implementation of the action plan. So across those three things, I, at that time, took assurance that we were dealing appropriately with the HTA inspection. And so what I would say to the Board, I suppose my point ... is, so I would say to the Board, I would say that the Board can take assurance that this is being sorted out.”⁵⁰

Given that David Fuller committed 40 per cent of his known offences in the mortuary in 2018 and 2019, the period immediately after Mr Scott’s appointment in 2018, it would seem that the Board was being reassured by Mr Scott that all was well in the mortuary, rather than receiving evidence-based assurance on this point.

Mr Scott told the Inquiry:

“[I]t [the Trust Board] takes its assurance from the fact that there’s an organised system, there’s an organised scheme of delegation. And that it takes its assurance from that. And from within that scheme of delegation, people escalate things as appropriate. And then you’ve got the safety valve in the case of the HTA, you’ve got the safety valve of a system where the Designated Individual has direct access to the Chief Executive as the Licence Holder. To raise things.”⁵¹

47 Witness transcript of Mr George Jenkins OBE, Interim Chair of the Trust, 2007–2008.

48 Witness transcript of Mr Anthony Jones, Chair of the Trust, 2008–2017.

49 Witness transcript of Mr Miles Scott, Chief Executive since 2018.

50 Ibid.

51 Ibid.

Having an organised scheme of delegation and lines of accountability is important, but so is being provided with evidence that the system is working. It is apparent to the Inquiry that something within this system of delegation inhibited important matters regarding the mortuary from reaching the Trust Board.

Each NHS trust is required to produce Quality Accounts annually. Quality Accounts are an important way for NHS providers to report on the quality of their services as part of the NHS's commitment to transparency. These reports are required to describe significant quality issues and demonstrate improvements in services delivered to local communities and stakeholders.

The production of Quality Accounts is a Department of Health and Social Care (DHSC) requirement, as set out in the Health Act 2009. There is no reference to mortuaries or HTA inspections in the guidance about what should be included.

The Inquiry checked each of the Quality Accounts for the Trust to see if issues relating to the mortuary had been included. We found that, for 2012/13, 2013/14 and 2018/19, there is a section on external reviews of the Trust's services, which lists the organisations that reviewed the services, including the HTA. The reports also include the following text after the list:

"The outcomes of these are included within our triangulation process to review clinical areas and identify any, where additional support and actions are required to maintain standards. Reports are scrutinised within identified committees within our governance structure and where necessary action plans are developed and monitored."

There is no reference in the Trust's Quality Accounts to the HTA licence being voluntarily relinquished in 2011. This is significant, given that the effect of this was to remove the Trust's mortuary from external, statutory regulation. Failure to mention the ongoing problems in the mortuary from 2009 and the subsequent decision to relinquish the HTA licence suggests that either the senior management of the Trust were not aware of the issues or that they were being less than transparent in their reporting.

In 2015/16, there is a reference in the Quality Accounts to the Trust declaring 99 serious incidents. The report states:

"[A]ctions and learning from serious incidents are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2015/2016 learning and actions included ... an awareness to staff that mortuary viewing should only occur out of hours if it is an emergency."

The 2019/20 Quality Accounts include the following in relation to EoLC: "A wide range of initiatives have been progressed during 2019/20 to improve EoLC in the Trust." The ensuing list includes:

"The mortuary process for viewing the deceased patient has been reviewed and changes were implemented to improve the process for relatives. A workshop with all relevant departments was held in March 2020 and the pathway refined to reflect the changes. This will be kept under review."

- As set out above, the Inquiry has seen limited evidence of concerns about the mortuary being raised with the Trust Board. The Inquiry has not been able to identify evidence that the Trust Board had oversight of the serious failures in 2009. The Inquiry has not seen evidence that the Trust Board saw the HTA Inspection Report in 2010 or that the report was discussed at a meeting of the Trust Board.
- The Inquiry found no evidence that the decision to voluntarily relinquish the HTA licence was discussed at a meeting of the Trust Board in 2011, which is concerning given that this would have prevented the Trust from undertaking PME in its mortuary. The regulatory impact of the Trust reapplying for its HTA licence and resuming PME in 2014 was not made clear to the Board. The HTA Inspection Reports in 2015 and 2018 were not substantively discussed at the Trust Board level.
- The Inquiry considers that the Trust's governance arrangements ought to have enabled the Trust Board Chair and Chief Executive to be informed of weakness in the Trust's compliance with statutory and regulatory requirements. The governance arrangements at the Trust did not fulfil these requirements.
- The Trust Board did not have the opportunity to consider and discuss important matters regarding the mortuary and the HTA requirements. We have seen no evidence that the Board understood the requirements of the regulated activity that was taking place in the mortuary.

7.3 How the Trust Board received and considered three key external reports – case studies

We have commented on how key information relating to the mortuary and the HTA was apparently not reaching the Trust Board. To understand this better, we asked the Trust to set out how three key reports had progressed through its governance processes. We set out its response below.

Case study 1

Case study 1 is the report produced by Lowell and Johnson in September 2009, described in detail in Chapter 4.⁵² Given the findings set out in the Lowell and Johnson report, *Independent Review of Mortuary Services*, together with the context within which it was commissioned, the Inquiry would have expected the report to have been discussed at a meeting of the Trust Board.

⁵² Mr James Lowell and Mr Terry Johnson, *Independent Review of Mortuary Services*, MTW NHS Trust, September 2009.

The Trust has confirmed that the report was not discussed at the Trust Board level, nor was there any further mention of either the Human Tissue Authority (HTA) or the mortuary service in Trust Board meeting minutes for the remainder of the year.

The report was referred to in papers for five of the Quality and Safety Committee meetings in 2009 and 2010 but only received cursory attention. For example:

“Pathology – there has recently been an independent review of the mortuary service at K&S [Kent and Sussex]. Actions resulting from the report findings are being considered.”⁵³

“Mortuary Review – The only outstanding action was for the recently appointed Mortuary Manager to review procedures. The K&S did not have a trolley capable of lifting up to 50 stone. [X] would look into this.”⁵⁴

“The recently appointed Mortuary Manager was to review procedures. The K&S did not have a trolley capable of lifting up to 50 stone. The committee noted the report.”⁵⁵

It appears that the serious findings of the report were underplayed at the Quality and Safety Committee. Given the serious nature of the report’s findings, it is extraordinary that the focus of the committee was on the lack of a trolley.

We requested evidence of how the Lowell and Johnson report was tracked through the other committees and meetings in the Trust. We were told that the report was considered at the Mortuary Service Governance meeting on 26 October 2009. The minutes record that the report “*was discussed in a closed meeting at the end*”.

The report was also discussed on two occasions at the Standards Committee (a subcommittee of the Quality and Safety Committee, chaired by the Medical Director). The minutes of the Standards Committee meeting on 14 April 2010 refer to the “*Mortuary Review*”, stating that “*the recently appointed Mortuary Manager was to review procedures*”. The minutes of the meeting on 9 June 2010 simply refer to the delivery of a trolley to the mortuary.

It is difficult to understand why the Trust Board did not have the opportunity to consider and discuss the findings and recommendations of this report. It is clear that senior officers of the Trust, who must have commissioned the report, were aware of its findings about significant and serious failings in the mortuary. There was minimal evidence of consideration of the report throughout the various governance meetings of the Trust.

53 ‘Cancer and Clinical Support Services Report to the Quality & Safety Committee’, 11 November 2009, p. 4.

54 Standards Committee, ‘Report for Quality and Safety Committee’, 14 April 2010, p. 7.

55 Quality and Safety Committee minutes, 12 May 2010, p. 5.

Case study 2

The second case study is the 2015 Human Tissue Authority (HTA) Inspection Report. The inspection took place on 20 and 21 January 2015, and the report was published on 6 March 2015.⁵⁶ This was the first routine site visit conducted by the HTA since the Trust received its HTA licence in April 2014 to undertake post-mortem examinations at the new Private Finance Initiative hospital in Tunbridge Wells. The inspection identified two minor shortfalls relating to Standard Operating Procedures and documented risk assessments (see Chapter 6).

At departmental and directorate levels, short summaries of the outcome of the HTA report were noted at meetings of: the Cellular Pathology Laboratory Management; the Pathology Quality Committee; and the Pathology Directorate Board. The March meeting of the Pathology Quality Committee received the most detailed summary, as follows:

“Two minor findings were found:

- *documentation not reflective of current practice*
- *no risk assessment of potential HTARI [HTA Reportable Incident] incidents (e.g. traceability)*

There was one scare – a tissue block had not been filed at the time of the visit but was found later that evening. More robust filing systems have subsequently been put in place. Draft action plan has been submitted to HTA – awaiting feedback.”⁵⁷

The outcome of the HTA inspection was noted above directorate level at the meeting of the Quality and Safety Committee, which, in March 2015, noted the “unconfirmed” outcome of the HTA inspection as “maintain licence: 2 minor findings”.⁵⁸

The Trust Board received a verbal update from the then Clinical Director for Pathology, Dr Mumford, who told the Board that the “[m]ortuary had recently been inspected by the Human Tissue Authority, and the feedback had been very positive”.⁵⁹ The meeting of the Board was in January 2015, and at that point this assessment can only have been based on initial feedback from the HTA.

56 HTA Inspection Report, 2015.

57 Pathology Quality Committee minutes, 18 March 2015, p. 3.

58 Quality and Safety Committee minutes, March 2015, item 3–21; attachment 19, Schedule of planned visits.

59 MTW NHS Trust Board meeting minutes (Part 1), 28 January 2015, item 1–9, Presentation from Clinical Director, Diagnostics, Therapies and Pharmacy.

Case study 3

The third case study is the 2018 Human Tissue Authority (HTA) Inspection Report. The inspection took place from 27 to 29 November 2018 and was the first inspection under the 2017 revised HTA standards.⁶⁰ The inspection identified 11 minor and three major shortfalls. The three major shortfalls related to traceability; storage capacity; and CCTV (see Chapter 6).

The outcome of the HTA inspection was tracked at departmental and directorate level as follows:

- December 2018: The Cellular Pathology Laboratory Management Group and the Pathology Board both received the following initial feedback: *“There was no indication at the concluding meeting that from the evidence supplied there were any major non-compliance.”*^{61,62}
- January 2019: The Pathology Board minutes note that the *“Preliminary report of HTA inspection has been presented to the department for factual checking”*.⁶³
- 11 February 2019: The Pathology Board was told that there were three major HTA findings and 12 minor findings (the HTA report identified 11), that an action plan was 75 per cent complete, and that work would be undertaken with the Quality Manager to formulate a response to the HTA. The Board also noted that *“capacity is a major HTA finding”* in relation to the fridge expansion business case that awaited approval, and that *“proof of progress”* would be required by the HTA to close the major shortfall. On CCTV, the Board noted that the cost would have to come from the directorate budget.⁶⁴
- 18 February 2019: The mortuary management and governance meeting minutes note discussion about re-drafting Standard Operating Procedures and risk assessments; that a gap analysis is being conducted against audits; and discussion about ID check procedure. There is an indication that this was to be discussed at the next Mortality Surveillance Group.⁶⁵
- 26 February 2019: The Pathology Quality Committee noted the three major and 12 (11) minor findings and that an action plan was being developed.⁶⁶
- 11 March 2019: The Pathology Board received the draft Corrective and Preventative Action (CAPA) Plan on actions following the HTA inspection and noted that business cases had been raised for fridge expansion (both sites) and CCTV (Maidstone).⁶⁷

60 HTA Inspection Report, 2015; HTA Inspection Report, 2018.

61 Cellular Pathology Departmental Management Group meeting minutes, 5 December 2018.

62 Pathology Board meeting, Cellular Pathology Report, minutes, 10 December 2018.

63 Pathology Board meeting, Cellular Pathology report, minutes, 7 January 2019.

64 Pathology Board meeting, Cellular Pathology report, minutes, 11 February 2019.

65 Mortuary management and governance meeting, minutes, 18 February 2019.

66 Pathology Quality Committee, minutes, 26 February 2019.

67 Pathology Board meeting, Cellular Pathology report, minutes, 11 March 2019.

- 15 April 2019: The Pathology Board was advised that the *“mortuary had been working hard on clearing the findings from the HTA visit”*.⁶⁸
- 9 September 2019: The Pathology Board noted that *“mortuary evidence had been submitted to the HTA”*. The accompanying Cellular Pathology report notes: *“[A]ll evidence submitted to HTA August 2019 – awaiting response.”* Also noted is a request for temporary storage facilities for the winter months. In relation to the fridge expansion business case, *“discussion with [X] indicated that the project will progress after winter”*.
- 2 December 2019: The mortuary management and governance meeting minutes note that actions in relation to the HTA’s findings have been submitted, with all but three cleared. The minutes note that, on fridge storage, if the HTA has not been informed of an installation date by 20 January 2020, a *“senior manager will meet with the Trust to discuss the Trust’s commitment to the project”*. The same is noted for installation of CCTV.⁶⁹

The mortuary management and governance meeting took place only in February and December in 2019, which is concerning given the number of actions from the HTA inspection and implementation of the resulting CAPA Plan. The mortuary management and governance meeting did not take place again until April 2021.

The Trust’s Quality Accounts for 2018/19, which were reviewed by the Quality Committee and signed off by the Trust Board, simply note that the HTA visited the Tunbridge Wells Hospital mortuary in December 2018. Despite the number of shortfalls, three major and 11 minor, there is no evidence that the Quality Committee or the Trust Board was notified of, or considered, the 2018 HTA findings.

This is particularly striking when considering the delay in implementation of two of the three major shortfalls identified by the HTA – the need for additional fridge storage and CCTV – and that the HTA was so concerned about progress, or lack thereof, that, according to the minutes of the Mortuary Management and Governance Group, it was questioning the Trust’s commitment to achieving compliance with the HTA standards. The additional fridge capacity was not installed at the Tunbridge Wells Hospital mortuary until November 2020.

68 Pathology Board meeting, Cellular Pathology report, minutes, 15 April 2019.

69 Mortuary management and governance meeting, minutes, 2 December 2019.

7.4 Trust Board awareness of and engagement with the Care Quality Commission

CQC inspections focus on the whole of the activity of a trust, rather than the narrower remit of an inspection by the HTA, which focuses on the requirements of the Human Tissue Act. The CQC ratings influence the external reputation of the trust. The CQC can take regulatory action against a trust, including the imposition of fines and the initiation of legal action. Consequently, it is not surprising that the Inquiry was told that the CQC findings received more attention from the Board than the HTA findings. The current Medical Director at the Trust, Dr Maskell, told the Inquiry:

*"[Y]ou know the CQC ... so we're aiming for outstanding and that's well known probably this is what we're aiming for, we're frustrated we haven't been inspected for some time. So, erm, and it is one of our missing [mission] critical kind of things to do is to make sure that we're, you know hitting all of our CQC standards. I can't say the HTA receives the same amount of focus."*⁷⁰

This view that CQC findings were treated differently from those of the HTA was shared by the Trust's Deputy Medical Director and the two Chief Nurses who were in post between 2013 and 2021.

Dr Mumford, the current Deputy Medical Director, told the Inquiry:

*"CQC I think is everything isn't it, it's the whole Trust, it is everything that we do, it encompasses the whole working of the Trust and I think therefore it does naturally command a bigger profile within the organisation."*⁷¹

Ms Bhatia, Chief Nurse at the Trust between 2013 and 2017, told us that the focus was:

*"... very comprehensive in terms of CQC, so there's nothing that you wouldn't report to the board. They would see, you know, the full CQC reports, they would want to see the action plan. So, you know, anything CQC activity related was comprehensive."*⁷²

In answer to a question about whether, at Board level, compliance with HTA standards would be handled in the same way as compliance with CQC standards, Ms Bhatia replied, *"I don't think they were."*⁷³

Ms O'Brien, Chief Nurse at the Trust between 2017 and 2021, told us that the action plans arising from CQC reports would be considered by the Quality Committee, and then the Board would receive a very condensed report of them. She could not recall a similar process happening for HTA incidents.⁷⁴

Mr Jones, Chair at the Trust between 2008 and 2017, also spoke to the Inquiry about how CQC inspections were treated differently from HTA inspections:

70 Witness transcript of Dr Peter Maskell, Trust Medical Director since February 2017.

71 Witness transcript of Dr Sara Mumford, Clinical Director for Pathology, 2010–2018, Deputy Medical Director since 2018.

72 Witness transcript of Ms Avey Bhatia, Chief Nurse, 2013–2017.

73 Ibid.

74 Witness transcript of Ms Claire O'Brien, Chief Nurse, 2017–2021.

“Well, the CQC programme was a massive deal. Let’s be honest. It occupied probably too much of the Trust time for too long. I don’t mean in response to what they found, I meant in just preparing, making sure that records were just so and getting things mended and all that stuff. I’ll be honest, I don’t think it [the HTA inspection regime] featured very largely at all.”⁷⁵

Dr Sigston, Medical Director between 2010 and 2017, told the Inquiry that he did not believe there was any differentiation in how CQC and HTA findings were considered within the Trust.⁷⁶

The CQC visited Tunbridge Wells Hospital in October 2014. As reported in Chapter 6, it made the following comments in relation to the mortuary:

- Access to the mortuary was secured to prevent inadvertent or inappropriate admission to the area. Access out of hours was via security staff who would contact the porters.
- The forensic fridge was locked at all times but the other fridges were not locked out of hours as porters would require access to the fridges.

The findings from the Inspection Report were reported to the Trust Board on 28 January 2015, and again at its meeting on 25 February 2015, but there is no reference to the aspects relating to the mortuary in the minutes of the discussion.

Instead, discussion concentrated on the aspects of the report that focused more widely on Trust governance. For example, the CQC drew attention to the governance and risk management systems used throughout the Trust as being unclear, not robust and not demonstrating consistent and effective management of the risks throughout the organisation. The CQC also noted that the responsibilities and remit of each subcommittee of the Board was not always clear, commenting that the Trust recognised this and was taking steps to review the committee structure throughout the Trust.

The overall rating for being a well-led organisation improved in 2017 to ‘Good’. The CQC commented:

“The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the service and they responded when services needed more support.”⁷⁷

Mr Scott told the Inquiry that the CQC’s inspections were wide-ranging and so involved large parts of the organisation, which is different from other regulators, including the HTA, that are more specific in their focus.⁷⁸

75 Witness transcript of Mr Anthony Jones, Chair of the Trust, 2008–2017.

76 Witness transcript of Dr Paul Sigston, Medical Director, 2010–2017.

77 CQC, Inspection Report, 2017.

78 Witness transcript of Mr Miles Scott, Chief Executive since 2018.

- The Inquiry has heard from current and former Trust Board members that the Board engaged with the CQC as a regulator differently from how it engaged with the HTA. This was attributed to the CQC having a Trust-wide focus and, in the case of the current Chief Executive, to the different legal accountabilities that are in place through the DI having personal responsibility for meeting HTA requirements. The Trust Board did not consider the requirements of the HTA in sufficient detail.
- There is a difference between the CQC and the HTA in respect of legal responsibility. Under the Human Tissue Act 2004, the DI has primary legal responsibility for ensuring compliance with the requirements of the HTA licence. The licence holder (e.g., the Trust) has responsibility for ensuring that any licence fees are paid, conditions of third-party agreements are complied with, and any directions issued by the HTA under the Human Tissue Act 2004 which apply to the licence holder are complied with. However, the CQC states that the registered manager shares legal responsibility for meeting the requirements of the relevant regulations and enactments with the provider; that is, the Trust. It appears that the Board at the Trust was leaving the responsibility for the mortuary's compliance with the HTA's requirements solely with the DI. The Human Tissue Act 2004 will be reviewed further in Phase 2 of the Inquiry.

7.5 Trust Board awareness of and engagement with Disclosure and Barring Service requirements

The CQC deems that Disclosure and Barring Service (DBS) checks are important in helping to keep those who pose a risk to people who use CQC-registered services, such as those provided by the Trust, out of the workforce.⁷⁹

The issue of David Fuller's criminal record checks is dealt with in Chapter 3. This section of the Report examines how the Board received assurance that the Trust was compliant with DBS requirements.

The earliest version of a disclosure policy we have traced for the Trust is undated but has a review date of 2006, so it is assumed it was issued prior to then. It focuses on disclosure of convictions on recruitment and contains a list of roles aligned to the level of Criminal Records Bureau (CRB) check required for each. The policy should be reviewed every two years, but it appears that there was not a further version until 2013.⁸⁰ The policy from 2013 focuses on disclosure on recruitment, but states that the Trust maintains the right to re-check staff every three years. It sets out that the Director of Strategy and Workforce has executive responsibility for ensuring implementation and effective monitoring on behalf of the Trust Board and that the Human Resources (HR) Committee will review quarterly compliance reports in order to satisfy CQC and

79 Disclosure and Barring Services Checks Guidance, CQC, October 2019.

80 MTW NHS Trust, Disclosure Policy, undated.

NHS Litigation Authority monitoring and reporting requirements.⁸¹ The latest guidance from NHS Employers sets out that, while it is not a legal requirement to do DBS re-checks, NHS trusts may require periodic DBS checks as part of their local policies.⁸²

In addition to the Trust's own policy on DBS checks, there was an additional focus on this area in 2015 following Kate Lampard's report on lessons learned from the NHS investigations into Jimmy Savile.⁸³ The investigation report included the following recommendation, which was 'accepted in principle' by the then Department of Health:

"All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers."

While three-yearly DBS checks were not mandatory and NHS Employers guidance was that a risk-based approach should be adopted, in response to this recommendation the Trust agreed an action plan as follows:

"Ascertain resources required to undertake blanket three yearly checking requirement for ALL staff and implement an eDBS system by June 2015;

*Process for interims/contractors reviewed and agreed with finance, HR and procurement by September 2015."*⁸⁴

The Inquiry has been unable to determine what action was then taken by the Trust in relation to instigating a three-yearly DBS check for staff as set out in its action plan, but it is clear from the evidence below that the three-yearly re-check was not implemented until 2020.

The issue of DBS checks was raised by Mr Steve Beaumont, the Chief Nurse of West Kent Clinical Commissioning Group (CCG) in 2016, at the Trust's Quality Committee meeting on 6 July 2016. The meeting heard that the CCG had raised concerns at the level of DBS checks at the Trust, "*which had often been discussed at the public meetings held within the CCG over the past year*".⁸⁵ Ms Jenny Davidson, the Associate Director of Quality Governance in 2016, stated at the meeting that following such concerns, she had liaised with HR and had provided feedback that compliance had improved. It was agreed that the latest situation would be reported to the next meeting of the Trust Board, for the Trust Board to determine what action was required.

This issue was briefly reported at the public session of the Trust Board meeting on 20 July 2016, where it was pointed out that a report had been submitted to the private session of the Board meeting scheduled for later that day. Mr Richard Hayden, then Executive Director of Workforce, highlighted that the Trust was currently at 93 per cent compliance with DBS checks, adding that "*data cleansing had been at the root of the*

81 MTW NHS Trust, Disclosure and barring checks policy and procedure, September 2013.

82 Criminal Record Checks, NHS Employers, May 2022.

83 Kate Lampard, *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile*, February 2015.

84 MTW NHS Trust response to NHS Trust Development Authority, 15 June 2015.

85 Quality Committee meeting minutes, 6 July 2016, p. 10.

*reported problems, and he had informed the Chief Nurse for West Kent CCG of the improvement during the previous weekend”.*⁸⁶

At the private session of the Trust Board meeting on 28 September 2016, the Chair, Mr Jones, asked if there was a reason why a three-year automatic re-check was not done. Mr Hayden is reported in the minutes as saying that there was a cost associated with this, that it was within employees’ contracts to declare convictions, and that *“he preferred reliance on cultural imperatives to declare convictions”*.⁸⁷

Mr Jones asked at the meeting whether it was possible, for example, for a cleaner to be working at the Trust with a conviction that could have been discovered by applying the DBS process differently from at present, and asked Mr Hayden to consider whether the current process needed to be strengthened.

Mr Hayden was not invited to interview by the Inquiry. He provided the Inquiry with a written response to the comments reported in the private Board meeting on 28 September 2016.⁸⁸ Mr Hayden said that at no time did he say that DBS checks should not be done because of costs; he pointed out that the more frequent the checks, the greater the cost would be. He further commented that he was making no judgement about whether this should be done or not. Mr Hayden, in his comments, informed the Inquiry that he did not believe the minutes to be accurate and that he did not say he preferred to rely on cultural imperatives to encourage declarations of convictions.

The Inquiry has seen no evidence from subsequent Board papers that the concern discussed at the meeting of 28 September 2016 was followed up. It is not clear what assurance the Trust Board received on DBS checking or re-checking at this time. When concerns were raised with the Board about DBS checks in 2016, it is not clear what action was taken. Mr Hayden informed the Inquiry that a significant amount of work was undertaken on DBS compliance during his tenure.

In its 2017 Inspection Report of the Trust, the CQC stated:

*“We looked at 10 staff files and saw they were complete, contained job descriptions, qualifications, professional registration checks, disclosure and barring service checks, references, occupational health clearance, fitness to practice declarations and evidence of right to work.”*⁸⁹

However, the CQC took a different view three years later. In September 2020, an independent healthcare provider raised concerns with the CQC when recruiting Maidstone and Tunbridge Wells NHS Trust staff to honorary contracts. Some staff had not had DBS checks for more than ten years.⁹⁰

86 MTW NHS Trust Board meeting minutes, Part 1, 20 July 2016, Item 7–17, Quality Committee, 6 July 2016.

87 MTW NHS Trust Board meeting minutes, Part 2, 28 September 2016.

88 Response of Richard Hayden, Deputy Director of Workforce, September 2011 to February 2016, Executive Director of Workforce, March 2016 to July 2017.

89 CQC, Inspection Report, 2018.

90 CQC, Information disclosure to the Inquiry, 7 September 2022.

Mr Scott told the Inquiry that, following the CQC concerns in 2020, three-yearly DBS re-checks have been introduced at the Trust, with the Workforce Directorate monitoring compliance.⁹¹

- The Trust had an intention to introduce three-yearly DBS re-checks for staff in 2015 in response to Kate Lampard's report on lessons learned from the Jimmy Savile investigations. This did not happen until the matter was raised by the CQC in 2020, despite concerns about DBS re-checks being discussed at both the public and private meetings of the Trust Board in 2016.
- The lax approach to DBS re-checking at the Trust until 2020, despite re-checks being the intention in the Trust's action plan in 2015, may be indicative of a wider culture of not complying with internal controls, for example as we have set out in Chapter 4 in relation to the mortuary. It is not clear in the evidence reviewed by the Inquiry that the Board was fully apprised of the extent to which DBS checks for Trust staff were more than three years old.

What we have found

- The governance structures in place at the Trust were overly complex. This complexity and ineffective delegation arrangements meant that serious issues regarding the mortuary and the Human Tissue Authority (HTA) requirements received little focus at the Quality Committee and did not reach the Trust Board. Executive Director responsibility for the mortuary was not clear.
- Concerns about the mortuary management and security outlined in Chapters 4 and 5 did not reach the Trust Board. The Board did not have the opportunity to discuss these and receive assurance on action to address the concerns. The Board did not receive assurance regarding statutory, regulated activity in the mortuary. Successive Chairs and Chief Executives failed to provide the level of Board leadership required for effective governance of the mortuary.
- Trust Board assurance had a focus on the requirements of the Care Quality Commission. It did not consider the requirements of the HTA in sufficient detail. The fact that the Designated Individual (DI) has primary legal responsibility for compliance with the HTA licence meant that the Board did not engage with the issue and relied on the DI.
- Despite the Trust's intention to introduce three-yearly criminal record checks in 2015, this did not happen for a period of more than five years. The Board was not kept apprised of this.

91 Witness transcript of Mr Miles Scott, Chief Executive since 2018.

Chapter 8:

Allegations of inappropriate conduct in the mortuaries at Kent and Sussex Weald NHS Trust in the late 1990s

Please note that this chapter contains details of material concerning the alleged abuse of deceased people. Only relevant and necessary information is included, but, nonetheless, the material may be distressing to read.

In January 2023, the Inquiry received an email from N573, who in 1998 was an Executive Director at Mid Kent Healthcare NHS Trust.¹ In 1998, Maidstone and Tunbridge Wells NHS Trust had not yet been formed, and the predecessor organisations were Mid Kent Healthcare NHS Trust and Kent and Sussex Weald NHS Trust.

The January 2023 email contained information relating to a conversation that N573 reported they had had in 1998 with a new Executive Director, N586, at Kent and Sussex Weald NHS Trust.² In the email, N573 stated that, during the conversation with N586, N586 had told N573 that it had been reported to N586 that an electrician had been entering the mortuary at Kent and Sussex Hospital at night for the purposes of necrophilia.

The Inquiry has recently investigated the various allegations that are raised in this chapter. The evidence for these allegations dates back to 1998 and, despite our enquiries, we have not been able to make factual findings in relation to these. As a result, the Chair has made the decision not to name the individuals involved in the allegations in order to ensure fairness to those involved. However, the Chair has included the detail of our enquiries, given the seriousness of these allegations and their relevance to the Inquiry's Terms of Reference.

8.1 New allegation

In the email to the Inquiry, N573 stated that a conversation took place in 1998 between N573 and N586. N573 also stated that, in anticipation of a merger between their respective organisations, the two organisations had frequent meetings to discuss matters of corporate importance, such as finance and human resources issues.

1 Email from N573, former Executive Director, Mid Kent Healthcare NHS Trust, 19 January 2023.

2 Ibid.

N573 stated that, following one of these regular meetings, N573 met with N586, alone, in N586's office at the old Pembury Hospital. In the email to the Inquiry, N573 stated that the following conversation took place:

*"[N586] said that a matter had been brought to [their] attention for advice and that ... [they] had never come across anything similar. The issue involved an electrician who was reportedly accessing the mortuary after hours and interfering with the bodies in storage there. [N586] asked my advice. I recall feeling shocked, and unsure from [their] description what it was [they were] talking about. I cannot remember exactly the words used in that conversation, but I do recall asking [N586] to clarify what [they were] talking about, and once [N586] had given more information I was left in no doubt ... I remember that the term necrophilia was used."*³

The Inquiry took the information in the email very seriously, as it contained allegations that the sexual assault of deceased people in the mortuary at Kent and Sussex Hospital happened several years earlier than 2005, the year of David Fuller's first known offence.

8.1.1 The action the Inquiry took

On receipt of N573's email, Sir Jonathan Michael, the Chair of the Inquiry, made the decision to pass the email to Kent Police in line with the Inquiry's Terms of Reference, as he considered it contained allegations of potential criminal acts. The Inquiry was unable to investigate the allegations made in N573's email while the police were undertaking their own enquiries.

Kent Police informed the Chair that they had undertaken enquiries into the contents of the email. This included interviewing key individuals, and the reports of these interviews were made available to us. On 19 April 2023, the Inquiry was informed by Kent Police that they had completed their enquiries and that they were taking no further action.⁴ At this point, the Inquiry was able to begin its investigation into the allegations.

This new allegation extended the timeframe on which the Inquiry was focusing by ten years, to 1995.

8.1.2 Investigation of the new allegation

- We identified porters, maintenance workers, domestics and mortuary staff who worked at the Trust in the mid- to late 1990s and called them for interview by the Inquiry.
- We identified former senior NHS Trust staff who were relevant to the allegation and invited them to interview.
- We requested documentary evidence from the Trust, such as Trust Board papers, work logs, and evidence of disciplinary allegations and actions involving current and former staff.

3 Ibid.

4 Email from Kent Police, 19 April 2023.

- The Inquiry Chair issued a call for evidence through national and local media on 21 June 2023. There was a very positive response to this call for evidence, with 13 former and current Trust employees coming forward to provide us with information. We had initial triage calls with all those who came forward to assess the relevance of the information they had. From this initial triage, we identified seven individuals who we invited to interview. Six of these attended for interview. The person who did not accept our invitation to interview had contextual information. However, from the triage call with this individual, it was clear that they did not have evidence that was central to N573's allegation.

8.2 Second allegation

During the investigation, we became aware of a separate allegation relating to misconduct in the mortuary in the late 1990s. Witness N589 told the police and the Inquiry that, during their time as an Assistant Director at Kent and Sussex Weald NHS Trust, they were aware of an alleged incident of the scalding of a deceased person in one of the mortuaries at the Trust in 1998 or 1999. The alleged perpetrator of this misconduct was a mortuary technician who the Inquiry will be calling N611.⁵ The Inquiry investigated this allegation alongside the allegation of necrophilia, noting that they were alleged to have happened around the same time.

8.3 The evidence of N573

The Inquiry interviewed N573 in May 2023 to find out more detail in relation to the information they had outlined in their email. N573 gave a compelling account of the conversation they report they had had with N586. This included when it took place, where it took place and the reason for it having taken place. When N573 recalled an event, they gave comprehensive details, and where they could not recall further details, they were clear about the limits of their memory. There were variations in N573's recall, but these were of very specific details rather than large sections of events. The Inquiry considers that this was to be expected given the passage of time.

N573 told the Inquiry that there were regional meetings between colleagues, across Kent, to discuss the new computerised systems. These meetings were called PReMIS. They also told the Inquiry that, on N586's appointment at Kent and Sussex Weald NHS Trust, there was an expectation that they would work collaboratively and find ways to reduce expenses. It was after one of these regional PReMIS meetings that N586 and N573 had agreed to meet:

"[N586] and I were at one of those regional meetings that I mentioned earlier ... It was something called the, I think it was the PreMIS Board or the PreMIS Team which was our ... computerised system that operated across Kent. And it was the only place in the NHS that used this particular ... system ... And in effect we had a meeting that, a PreMIS meeting for Kent that happened every two months. And it was that meeting that I had gone to, and [N586] was there, and it was the first time I'd ever seen [N586], in that, since

5 Witness transcript of N589, former Assistant Director at Kent and Sussex Weald NHS Trust, then Assistant Director at Maidstone and Tunbridge Wells NHS Trust.

*[N586] started at Tunbridge Wells. And we, we realised we were both going to be at the same meeting, and we'd arranged to meet up and go to [N586's] office afterwards and start to flesh out some of the things that we could, you know, get some bare bones for some early wins on collaboration, so that was the arrangement."*⁶

N573 told the Inquiry that the meeting between them took place in N586's office at the old Pembury Hospital. N573 described the location of N586's office at Pembury Hospital and the route N573 took to reach this office from where they had parked their car:

*"And I'd driven in, I parked, the meeting was, the old Pembury site, nothing like it is now, it's an old workhouse by the looks of it and there were many buildings all around the place. So, I'd had to park in this strange place that I thought looked like an old, walled garden with a wiggly path I can remember that we walked up through this walled garden up to the Trust headquarters."*⁷

N573 continued:

*"I came out of that room having had the conversation that I had, which I'm sure you've all read, with [N586]. And to me it appeared dark, in fact my memory is I walked into the dark, it was still drizzling slightly and I had to walk down these steps out of the building, through a staff car park down this windy little garden path into this walled garden and it was dark, and I was scared."*⁸

N573 told us that initially they discussed general matters:

*"For the most part I can't remember it. We talked about staff we had, staff you know who'd got talent as we thought, you know, where there may be problems. [N586] said I haven't got a this policy, I said well, I've got one you can start – use it as a starting block."*⁹

N573 told the Inquiry that at some point during the meeting they asked N586 why they had applied for the position in Kent and Sussex Weald NHS Trust:

*"Because [N586 had] ... worked with Roy Lilley and ... led the field on, you know, sort of changing NHS pay. So, [N586 had] done lots of really exciting things and I said do you mind me asking, what on earth has brought you here, this is Sleepy Hollows. You know, you know I would have thought you'd be in one of the big London teaching hospitals, not in Tunbridge Wells."*¹⁰

N573 reported that it was at this point in the conversation that N586 provided an explanation of their decision and introduced the matter of misconduct of an employee:

"[N586] said something along the lines of you know everywhere I've worked there has been something different to learn. And [they] said, for example, have you ever had experience, and I can't remember exactly what [they] said, but I, I thought that sounds

6 Witness transcript of N573.

7 Ibid.

8 Ibid.

9 Ibid.

10 Ibid.

*to me like a really weird conversation and that, and I can't really answer that question without knowing what [they're] talking about."*¹¹

N573 told the Inquiry that they were confused and sought clarification:

*"And I, so I said [N586] what, what are you talking about? Because what I was thinking was terrible. And [N586] looked really flummoxed. [They] looked flummoxed and puzzled as if [they were] saying – thought to – I don't know. I could see [N586] was very uncomfortable. So, I thought I need to – I need to rephrase the question, so I just said, let me make it easy are you talking about necrophilia? And [N586] said yes. So, it was exactly what I thought [they were] talking about but just, kind of – didn't want to reach that conclusion without knowing. So, I said no, I've never had anything like that. I've never had anybody accessing the mortuary, that I'm aware of."*¹²

N573 also told us that N586 had said that an electrician was entering the mortuary to interfere with the deceased:

*"[N586] said, I can't remember [their] words because I can't remember exactly, but broadly [N586] said we have an on-call electrician on our staff who is going into the mortuary, and he is interfering with the bodies."*¹³

Although N573 could not always remember the precise detail of the conversation, they were clear about the nature of what they say N586 reported to them:

*"When I talked to [N586] about it originally, I'd – I said well, you know, have you got CCTV in the corridors outside, and [N586] said no. Well, I said, well is there some way you could see if this is happening at night? How he accessed his keys, and [N586] said well, what's that going to tell me? And the electrician who's on call needs the keys, which includes the mortuary keys, what can that tell me? ... And I said if I was you, I would contact the police, I would ask for help and see what they can do. And I thought that's what [N586] was going to do."*¹⁴

The Inquiry asked N573 if N586 had spoken about how the allegation had been reported to them, and N573 told the Inquiry that N586 had not, but that N573 wished they had asked N586. N573 continued:

*"[W]e did talk about, if you got into a disciplinary situation, you would have the word of the person who'd reported it and the word of the electrician and you wouldn't be able, you wouldn't, how would you judge between those accounts? He could say it was malicious, and it could have been, and not true. And he/she could, so I got the impression it was a person and not an anonymous letter or something like that."*¹⁵

N573 stated that N586's demeanour during the conversation was that of a worried person. However, N573 also told us that they did not get the impression N586 had discussed the matter with the Chief Executive at the time, N587:

11 Ibid.
12 Ibid.
13 Ibid.
14 Ibid.
15 Ibid.

*"[N586] didn't tell me that [they] had spoken to anybody about it. My impression was they hadn't spoken to [N587] yet, that [N586] was in that oh my goodness, what on earth am I going to do about this stage. I think [N586] was, thinking about [them] and [their] demeanour. [N586] was ... very confident ... and when I think about [N586] on that day, [they were] worried ... I thought."*¹⁶

N573 stated that they thought N586 would go to the police, as they had discussed all other options: *"I thought [N586] was – I thought that [N586] would go to the police. And I don't know that [they] didn't."*¹⁷ N573 told the Inquiry that they never discussed the matter again with N586.¹⁸

N573 recalled hearing of David Fuller's conviction in November 2021, as they were making a routine journey. N573 told the Inquiry that when they heard about it:

*"I thought, good, good they've got him. They've had a long, they've had a problem for a long time at that hospital, excellent. And then in the same sort of minute I thought, what am I thinking? That is a long time ago. In fact, you know, what we're talking about is, we're talking around about 25 years ago. How can this have been uncovered for so long when I understood an investigation was starting off, I thought it was about '99 or '98 time."*¹⁹

N573 continued: *"But that's what happened, so it was a shock. I just thought good, hallelujah, they've got him, fantastic."*²⁰ N573 told the Inquiry that once they returned home, they read more about David Fuller's arrest:

*"I read the whole story, I knew before I read it that the man involved was an electrician. I knew he was in the Works Department. I didn't know whether it was Pembury Hospital or Kent and Sussex Hospitals, but I knew, I knew, yeah, I knew most of the other detail and I was absolutely convinced that I knew about it ... and then I started typing."*²¹

The Inquiry noted that in the email of 19 January 2023, N573 included a statement they had written in November 2021.²² This statement contained information reporting their meeting with N586 and what N573 alleged N586 had said to them. It was this statement that N573 referred to during their interview with the Inquiry. The Inquiry asked N573 why they had not sent the statement earlier. N573 explained that they had assumed the Inquiry would be looking at events over the entire time span as they understood it to be. N573 also explained:

*"But I thought that there – there would be at least two other people who could come forward. I thought [N586] will come forward, [N586] knows about this, it's not really my story to tell. And I thought [N586] must also have told the Chief Executive and possibly the board."*²³

16 Ibid.

17 Ibid.

18 Ibid.

19 Ibid.

20 Ibid.

21 Ibid.

22 Written statement of N573.

23 Witness transcript of N573.

N573 was clear with the Inquiry that they understood the matter N586 had allegedly discussed with them to be a serious matter for the Trust, and anticipated that N586 would have escalated it at or around the time they had discussed it with N573:

"I thought it was likely [N586 would] have to tell the board if you, well, you had, this is not porters having a punch-up, or you know, so-and-sos late. It's not even a massive theft. This is going to be, this would have been an enormous sort of, I don't know, disaster, I suppose for the local community. And the communications needed to be handled carefully. So, I thought that [N586] would have been at the centre or advising on all that and ensuring the right people knew and had colleagues lined up so, to deal with all of the fallout as well as leading the investigation."²⁴

N573 told the Inquiry that, in January 2023, following an article about the Inquiry appearing in the media, they realised the Inquiry timescale was not as they would have expected if N586 had escalated the issue at the time:

"There was something in the newspaper that made me look on your website and read something and I could see from that you, you were starting to collect evidence, or you collected evidence that went back to 2008, I believe. And I thought, they need to look further back, that's why I wondered why people, the person that I'd had a conversation with hadn't been in touch with you."²⁵

N573 told the Inquiry that, once they realised that the Inquiry timescale was limited to between 2005 and 2020, they decided they needed to come forward and inform the Inquiry about the information they believed was shared with them in 1998:

"But if I don't send it in and the inquiry team don't know where to start looking then something could be missed. And I knew it had started before then, I knew that absolutely for a fact."²⁶

The Inquiry found N573 to be a credible witness who was recalling the facts as they remembered them.

8.4 Evidence of N589, former Assistant Director at Kent and Sussex Weald NHS Trust

N589 was interviewed by the Inquiry in May 2023. N589 was also interviewed by Kent Police, and the report of this interview was made available to the Inquiry.

N589 told the Inquiry that they had never heard of any allegations of necrophilia occurring in the mortuary. Neither could N589 ever recall having a conversation with N586 about necrophilia. The Inquiry notes that this is consistent with the information N589 gave to Kent Police.

N589 told the Inquiry that they were aware of allegations against a mortuary technician, N611. N589 explained:

24 Ibid.

25 Ibid.

26 Ibid.

*"I believe we investigated that some scorching of a deceased member of the public had happened to their body through the use of hot water."*²⁷

N589 could not remember the details of the investigation that was undertaken or whether the allegations were found to be proved. N589 told us that they thought it was likely that the allegations were not proved as they thought that N611 went on to be dismissed for abuse of the Trust's sickness absence policy. When interviewed, N611 reported that they had left the Trust because they were made redundant.²⁸ The evidence of Dr Rachael Liebmann, a consultant pathologist, also supported the claim that N611 had left the Trust through redundancy.²⁹ The Inquiry considers that N589 had incorrectly remembered the reason N611 left the Trust.

N589 was very clear, however, that they thought the allegation was "horrific" and considered it to be extremely serious. Given this, N589 would have reported it to their superior:

*"All I can say is I – just as if it would have been escalated to me, if I would have deemed it to be significantly serious enough, it would have been escalated up to the director."*³⁰

N589 could not be certain who held the position of Director at the time the allegation was made. N589 thought it could have been either N588 or N586:

*"I can't quite place when they happened. [N586] was my manager from sort of 1998 to 2002 ... so I guess it was probably during that time, but without looking at the records, I couldn't say."*³¹

*"So, yeah, it could have been under [N588], when [N588] was my manager."*³²

N589 told the Inquiry that they had a good relationship with both N588 and N586. N589 was certain that they would have escalated the allegation to whichever person was in post at the time.

The Inquiry asked N589 how long Human Resources (HR) records were kept and whether there would have been a record of the allegation at the time. N589 told the Inquiry that HR records are kept for a maximum of six years, but could not say whether a record of the allegation would have been made at the time. N589 told the Inquiry that, if the allegation had not been proved, no record of it would have been retained beyond six years.³³ The Inquiry did request specific disciplinary records from the Trust, but the Trust confirmed that these were not available.³⁴ The Inquiry recognises that the Trust was not under an obligation to retain these records, even if an allegation was recorded.

27 Witness transcript of N589, former Assistant Director at Kent and Sussex Weald NHS Trust, then Assistant Director at Maidstone and Tunbridge Wells NHS Trust.

28 Witness transcript of N611, former mortuary technician, Kent and Sussex Weald NHS Trust.

29 Witness transcript of Dr Rachael Liebmann, consultant pathologist at Kent and Sussex Weald NHS Trust, 1999, then Maidstone and Tunbridge Wells NHS Trust to 2014.

30 Witness transcript of N589, former Assistant Director at Kent and Sussex Weald NHS Trust, then Assistant Director at Maidstone and Tunbridge Wells NHS Trust.

31 Ibid.

32 Ibid.

33 Ibid.

34 MTW NHS Trust response to the Inquiry, 'All disciplinary investigations that relate to the mortuary, including mortuary staff and any other staff from 1995 to present', 14 July 2023.

8.5 Evidence of N586, Executive Director at Kent and Sussex Weald NHS Trust

In June 2023, N586 was interviewed by the Inquiry in relation to the information contained in N573's email and information that had emerged regarding N611. N586 told the Inquiry that they could not recall meeting with N573 but accepted that they must have done: "[N]o I don't. I mean, obviously, I must have met [N573]. I don't recall it."³⁵

When asked about the work N586 would have undertaken with a neighbouring trust leading up to a merger, such as regular meetings that would have taken place between N586's department and colleagues at Mid Kent Healthcare NHS Trust, N586 said they could not remember these meetings taking place or participating in them:

*"I can't remember. I mean, clearly, I merged as the director for the new organisation ... But to be honest with you, I honestly can't remember. I know very little about the process at all."*³⁶

The Inquiry considers that these meetings, such as PReMIS meetings, did take place with the regularity reported by N573. We note that there are references to PReMIS's roll-out in Kent and Sussex Weald NHS Trust Board minutes in 1996 and 1997.^{37, 38} As Mid Kent Healthcare NHS Trust was adopting the same system of reporting, and this was an across-Kent initiative, the Inquiry considers it likely that there would have been collaborative working on this issue, particularly if there were considerations of a merger taking place. In addition to the Trust Board minutes of 1996 and 1997, N573 was able to show diary entries of the meetings taking place from October 1999 to the end of June 2000, although N573 had not retained their diaries for 1998. N586's predecessor, N588, told us that they did know N573 and that N573 was present at nearly all the meetings N588 attended:

*"I don't think I ever met [N573] on an individual basis, but [N573] was certainly present at I think nearly all of the meetings I was at, yes."*³⁹

N588's evidence supported N573's account of regular meetings with colleagues across the area. Given the evidence the Inquiry has reviewed, we consider it more likely than not that the same or similar meetings were happening in 1998 and that both N573 and N586 attended at least one of these regular meetings at the same time.

N586 could not recall the specific meeting and conversation that N573 alleged took place in N586's office:

"Q: [N573] tells us that [they have] a clear recollection of a conversation with you after a meeting where you told [N573] that you had an issue with an electrician accessing the mortuary and interfering with bodies. Can you tell us about that allegation?"

35 Witness transcript of N586, Executive Director at Kent and Sussex Weald NHS Trust, then Maidstone and Tunbridge Wells NHS Trust.

36 Ibid.

37 Kent and Sussex Weald NHS Trust Board minutes, 19 December 1996.

38 Kent and Sussex Weald NHS Trust Board minutes, 4 February 1997.

39 Witness transcript of N588, Executive Director, Kent and Sussex Weald NHS Trust.

A: *I have no recollection of that.*

Q: *You have no recollect-*

A: *And I would say that if I had said that I would have been doing something about it.*

...

I don't know where that came from.

Q: *But you can't recall the conversation with [N573]?*

A: *Absolutely not, no.*

Q: *Aside of the specific allegation, can you recall any discussions about necrophilia taking place at the Trust?*

A: *No, absolutely not.*

Q: *Or at Maidstone and Tunbridge Wells? Did anyone ever report any allegations of inappropriate conduct in the mortuary to you, leaving necrophilia aside? Any other inappropriate conduct?*

A: *No.*⁴⁰

N586 told the Inquiry that, had they been aware of such an allegation, they would have reported it to the Chief Executive:

*"[T]he first thing would be to establish whether there was ... well the first thing to do with the mortuary would be speak to the Chief Executive, because that's a serious, serious issue that could be damaging for many, many different parties. So, that would be the first thing to do, and then to decide what the way forward would be with the Chief Executive."*⁴¹

N587, the Chief Executive of Kent and Sussex Weald NHS Trust in 1998, told the Inquiry that N586 had not reported any allegations of necrophilia or any other form of inappropriate conduct taking place in the mortuary to them. They also told the Inquiry that they had a good relationship with N586 and that they were confident that N586 would have reported any such incidents to them.⁴²

In answer to many Inquiry questions related to this matter, N586 responded that they could not remember. The Inquiry accepts that the passage of time will have had an impact on N586's recall of events from that time.

The Inquiry heard two different accounts, from N586 and N573, regarding a conversation taking place about necrophilia in the mortuary at Kent and Sussex Weald NHS Trust in 1998. Given the passage of time, the Inquiry accepts that it is inevitable that memories fade and recall of events diminishes.

40 Witness transcript of N586, Executive Director at Kent and Sussex Weald NHS Trust, then Maidstone and Tunbridge Wells NHS Trust.

41 Ibid.

42 Witness transcript of N587, Chief Executive, Kent and Sussex Weald NHS Trust.

8.6 Evidence from other employees

The Inquiry interviewed 22 individuals who were either former or current employees of the Trust and who worked there in the mid- to late 1990s. None of the individuals we interviewed was able to give any evidence that supported the allegation contained in N573's account. However, the Inquiry is conscious that none of these staff would have been in a position to know about such allegations.

We were unable to interview two former employees of the Trust who might have been able to assist the Inquiry. These employees were Dr Basu, who was the Clinical Director of Pathology in the mid-1990s until his retirement in 2003, and Mr David Hawkes, who was David Fuller's line manager between 1998 and 2002. The Inquiry considers that if a report had been made of an electrician entering the mortuary for the purposes of necrophilia, or of any other kind of misconduct in the mortuary, it is likely that these individuals would have been made aware of such an allegation because of their positions in the Trust. Unfortunately, both Dr Basu and Mr Hawkes are deceased.

8.7 Allegation against N611

The Inquiry could find no evidence to support N589's statement that there was an allegation against N611 regarding the scalding of a deceased body with hot water. The Inquiry interviewed N611 and asked them about the allegation. They told the Inquiry that they had no knowledge of any such allegation being made against them.⁴³ The Inquiry considers that N611 might not have been informed of the allegation and accepts their assertion that they were not aware of such an allegation.

The Inquiry asked N586 about their recollection of an allegation made against N611 regarding the scalding of deceased bodies in the mortuary:

"Q: Were you aware of allegations against a mortuary technician regarding the scalding of bodies in the mortuary?"

A: No."⁴⁴

The Inquiry also asked N586 if they had ever heard of N611. N586 confirmed that they had heard of the name of N611:

"I have. Whether I heard it from the police or not, I can't recall. The police may well have mentioned it when they interviewed me."⁴⁵

The Inquiry has reviewed a copy of the Kent Police report of N586's interview, and there is no mention of N611 and no mention of the misconduct that they were alleged to have carried out. The Inquiry also notes that N586's police interview took place over six weeks prior to N589's interview. It was N589 who informed both the police and the Inquiry about the allegation against N611. The Inquiry is confident that Kent Police did

43 Witness transcript of N611, former mortuary technician, Kent and Sussex Weald NHS Trust.

44 Witness transcript of N586, Executive Director at Kent and Sussex Weald NHS Trust, then Maidstone and Tunbridge Wells NHS Trust.

45 Ibid.

not discuss N611, or the misconduct in which they were alleged to have engaged, with N586.

N589 was very clear that, because of the serious nature of the allegation, they would have discussed it with their Director at the time, who would have been either N588 or N586. Given that N586 could not recall any such report from N589, the Inquiry investigated the possibility that N589 had reported the incident to N588.

The Inquiry interviewed N588, who reported that they had retired from the Trust in either 1997 or 1998. We asked N588 if they were aware of allegations of the scalding of deceased bodies with hot water in the mortuary. N588 was clear in their evidence to the Inquiry that they had never heard of any allegations about such conduct occurring in the mortuary. N588 also told the Inquiry that, if such an allegation had been reported to them, they would have escalated it to the Chief Executive. The Inquiry asked N588 if they were aware of N611, and N588 told us that they were but that they had never met N611 and could not now recall why they remembered their name.⁴⁶ The Inquiry found N588 to be a credible witness who exhibited surprise when we informed them of the allegation. N588 reported no problems with recall and was certain they would have recalled such an allegation. We accept N588's account that they had never been told of such an incident.

N589 commented that N611 was known to the HR department:

"[I]n my career ... you spend the majority of your time on a very minority group of employees. There are certain individuals in a body of staff that take a disproportionate amount of your time, and [N611] was one of them. So [N611] was on our radar."⁴⁷

The Inquiry considers it likely that both N586 and N588 were aware of N611, through the amount of HR time they consumed.

In evaluating N589's evidence, the Inquiry found them to be a credible witness, in that they had good powers of recall and gave a consistent account of the matter. Both N588 and N586 spoke highly of N589 in the capacity of Assistant Director. N589 also reported good professional relationships with both of them. The Inquiry could find no motivation for N589 to fabricate their account. In giving their evidence to the Inquiry, N589 stated what they could remember, but also stated clearly what they could not remember in terms of details. For example, although N589 could recall the allegation, they could not recall to whom they reported the allegation, or what had happened about the allegation. We consider that N589 gave a truthful and accurate account of an allegation made against N611.

The Inquiry also asked other former and current members of staff about the allegation. One witness, Dr Rachael Liebmann, recalled the name of N611. She also recalled that they had already left the Trust when she commenced her employment at the Trust in

46 Witness transcript of N588, Executive Director, Kent and Sussex Weald NHS Trust.

47 Witness transcript of N589, former Assistant Director at Kent and Sussex Weald NHS Trust, then Assistant Director at Maidstone and Tunbridge Wells NHS Trust.

May 1999.⁴⁸ This leads the Inquiry to consider that the allegation was made sometime between N588 leaving in 1997 or 1998 and Dr Liebmann commencing her employment in May 1999. Dr Liebmann told the Inquiry she was informed that N611 left the Trust because of redundancy.⁴⁹

The second witness, N153, worked at Kent and Sussex Hospital. In their evidence to the Inquiry, they recalled N611 and stated that “[t]here was rumours that [N611] was ... interfering”. When the Inquiry sought clarification from N153, they did not know exactly what was meant by the term interfering. However, they did tell us that it was a widespread rumour across the Trust and that N611 went “off-site”.⁵⁰ When N611 gave evidence to the Inquiry, they denied that they had ever been involved in any misconduct towards deceased people in the mortuary.⁵¹

Other than the staff referred to above, 11 employees or former employees of the Trust could recall N611’s name but knew nothing about an allegation of misconduct in the mortuary.

Given the evidence we heard from N589 and N153, the Inquiry believes that an allegation relating to misconduct towards a deceased body was made against N611. Neither of the witnesses knew of each other’s evidence and they had no connection to each other, but taken together their accounts supported each other. The Inquiry also considers that it is likely the allegation was not proved, as N611 left the Trust for reasons other than misconduct towards a deceased person.

We have considered N586’s denial of receiving a report of this allegation from N589. We note that N586 had significant difficulty recalling any events at all in relation to N573 and N611. We have taken account of this alongside the timing of N611’s exit from the Trust, Dr Liebmann’s commencement of employment and N589’s evidence. Given the lack of contemporaneous evidence and with the passage of time, the Inquiry cannot reliably decide who said what, to whom and when.

The Inquiry also considered whether the two allegations had in some way become conflated. We considered whether N573 was mistaken in their recall of N586 discussing a hospital electrician, and N586 had actually discussed a mortuary technician with N573. Although we have no evidence that could assist us with investigating this possibility further, it is something that we have borne in mind.

Despite detailed investigations, the Inquiry was unable to find evidence to support either allegation. However, we recognised that a significant amount of time had passed since both incidents were alleged to have happened. This affected the evidence the Inquiry was able to gather in two ways. First, although we requested a number of documents from the Trust that would have assisted the Inquiry in understanding events that might have taken place, including employment records and work logbooks, these documents were not available. The Trust was not under an obligation

48 Witness transcript of Dr Rachael Liebmann, consultant pathologist Kent and Sussex Weald NHS Trust 1999, then Maidstone and Tunbridge Wells NHS Trust to 2014.

49 Ibid.

50 Witness transcript of N153, worked at Kent and Sussex Hospital, Interserve employee from 2011.

51 Witness transcript of N611, former mortuary technician, Kent and Sussex Weald NHS Trust.

to retain documents such as work logbooks from 1995, and the Inquiry recognises that to maintain such an archive would require financial and employment resources that could more valuably be spent elsewhere.

With regards to employment records, the Inquiry heard that the Trust was under an obligation to retain these records for six years.⁵² If any disciplinary investigation took place where allegations were proved against an individual, these were required to be retained for six years.⁵³ Given that we were looking at an event that was alleged to have happened in 1998, 25 years ago, the Inquiry is not critical of the Trust for these records not being available.

The second way in which the passage of time affected the Inquiry's investigation of the new allegation was that most people's memory of events had deteriorated to varying extents. We interviewed former employees of the Trust who were very anxious to assist the Inquiry, but for whom the details of events they were recalling proved difficult to remember.

The Inquiry considered the new allegation raised with it in January 2023, alongside the further allegation against N611. With regards to the allegation against N611, given the conflicting evidence we have heard, in particular N611's stringent denials that they were ever subject to any allegations of misconduct against deceased people, the Inquiry has no way of establishing what happened about the allegation. We accept N611's evidence to the Inquiry that they have no knowledge of such an allegation being made against them. However, the Inquiry found N589 to be a credible witness, with no obvious motivation for raising this issue with both Kent Police and the Inquiry if the allegation had never been made. The Inquiry considers it likely that an allegation was made against N611, but that N611 was not aware of this allegation. The Inquiry considers that the allegation was just that, an allegation that was not proved.

The Inquiry's interest in this allegation was that N589 was very clear to us that they would have reported the allegation to their superior because of the nature of it. The Inquiry received conflicting accounts regarding whether the allegation was reported to N586. It is impossible to reconcile them without contemporaneous evidence. Therefore, the Inquiry has been unable to make a finding about this matter. It is of concern that there were potentially two allegations of untoward behaviour in the mortuary that pre-date the known actions of David Fuller.

The Inquiry had to consider whether N573's account of the conversation they alleged took place in 1998 with N586 was credible. N573 described in detail where the meeting took place, the context in which it took place and the content of the meeting. N573 was able to describe their emotions on leaving the meeting and provide a topographical account of their exit from the Trust headquarters to their car. N573 had documentary evidence to support the regular meetings they attended with colleagues at the Trust, which was supported by N588.

52 Witness transcript of N589, Assistant Director at Kent and Sussex Weald NHS Trust, then Assistant Director at Maidstone and Tunbridge Wells NHS Trust.

53 Ibid.

The Inquiry could find no motivation for N573 to fabricate their account. N586 said in their police interview that both they and N573 were competitors for a position as Director in the merged Trust, but N573 pointed out that the meeting in 1998 happened prior to the merger in 2000.^{54, 55} The Inquiry found N573's account credible and them to be a credible witness, but we cannot discount the possibility that N573's recall of the details of the conversation with N586 was incorrect, and the conversation described related to a mortuary technician rather than a hospital electrician.

The Inquiry cannot rule out that someone at a senior level at the Trust may have been aware of these allegations, but we are unable to reach a positive conclusion that this was the case. The Inquiry considers that, if this were the case, knowledge of such allegations as these presented a missed opportunity to strengthen internal controls for the mortuary and its management in the late 1990s, which pre-dates David Fuller's first known offence by six or seven years.

What we have found

- We have no way of establishing if the conversation that N573 reported they had with N586 was regarding an allegation of necrophilia or the scalding of deceased bodies, but accept the possibility of the conflation of the two allegations.
- The Inquiry heard two accounts of allegations of serious misconduct in the mortuary in 1998. We have been unable to find evidence that would support either of these allegations. We have heard conflicting accounts regarding the reporting of the allegations. The Inquiry is unable to rule out that someone at a senior level at the Trust may have been aware of these allegations, but we are unable to reach a positive conclusion that this was the case.
- The Inquiry considers this to be a missed opportunity to strengthen controls in security of the mortuary in the late 1990s, which pre-dates David Fuller's first known offence by six or seven years.

54 Kent Police interview with N586.

55 Witness transcript of N573.

Chapter 9:

Culture

So far in this Report, we have largely focused on policies, internal controls, management and governance: the mechanics of how organisations assure themselves that the services they provide are appropriate and safe.

The impact of culture on organisational performance is well documented in management theory and study. Its origins are often attributed to Austrian-American management consultant, educator and author Peter Drucker, who claimed: *“Culture eats strategy for breakfast.”*¹

The Care Quality Commission (CQC) acknowledges the importance of culture in its assessment of how well led NHS healthcare providers are. It summarises a well-led organisation as:

*“By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.”*²

It is important to examine the impact that the culture at Maidstone and Tunbridge Wells NHS Trust (the Trust) had on David Fuller’s ability to offend, and on the response to the discovery of his crimes. In doing so, we consider attitudes to the deceased and the mortuary before moving on to consider the sense of denial that we observed and the ease with which the narrative that ‘nobody could have done anything’ became accepted within the Trust.

9.1 Attitudes to the deceased and the mortuary

The deceased women and girls whom David Fuller sexually abused in the mortuaries at Kent and Sussex Hospital and Tunbridge Wells Hospital were all someone’s loved relative. The impact of the abuse on the victims’ families is described in detail in Chapter 1.

The deceased are not included in safeguarding legislation. A deceased person does not usually hold any legal rights after their death.³ However, most people would expect the deceased to be treated with dignity and respect regardless of their legal status.

We heard from Trust employees that safeguarding training and policies did not include the deceased, which is in accordance with the legal position of the deceased and

1 Drucker, 2006. Quoted in Guley and Reznik, ‘Culture Eats Strategy for Breakfast and Transformation for Lunch’, *The Jabian Journal*, Fall 2019, p.1.

2 CQC website, last updated May 2022.

3 Advice from the Inquiry’s legal team, July 2022.

current safeguarding legislation. The wider issue of safeguarding in relation to the deceased will be considered by the Inquiry in Phase 2 of its work.

Dr Peter Maskell, Medical Director of the Trust since February 2017, commented on how the deceased were treated differently in safeguarding and that this may be part of a wider societal attitude to the dead:

*"I think dead bodies probably aren't given the same amount, hang on I want to say this correctly, you know just the safeguarding rule as well that's, you know that safeguarding doesn't apply to dead bodies and that on top of the DBS [Disclosure and Barring Service] checks just makes me think that you know, as a society maybe we don't put as much store in the dead as we do in the alive."*⁴

Given that the deceased are excluded from the Trust's arrangements for safeguarding, we explored the extent to which the Trust's executives considered the preservation of their dignity. Maintaining the dignity and safety of the deceased is a regulatory requirement and a guiding principle of the Human Tissue Authority (HTA) Code of Practice.⁵

The dignity of patients is part of the portfolio of the Chief Nurse of the Trust. We interviewed two former Chief Nurses, Ms Claire O'Brien, who was in post from February 2017 to June 2021, and Ms Avey Bhatia, who was in post from February 2013 to January 2017. We asked how they had assured themselves that the deceased were treated with dignity and respect in the mortuary:

*"So, whilst they were in the mortuary, I'm afraid we didn't have any process in place to make sure that they were treated with dignity and respect."*⁶

*"I have to say to you, in all honesty, I did not go into the mortuary to regularly check that privacy and dignity was being maintained of those patients."*⁷

Once in the mortuary, the deceased were not treated as if they were patients in the care of the hospital.

A previous Chair of the Trust, Mr Anthony Jones, told the Inquiry that the requirement to treat the deceased with respect was so obvious that it was not necessary to put policies or practices in place to ensure it happened:

*"I mean ... it's so obvious that ... dead bodies should be treated with the same respect as living bodies. That, I mean, you don't really need to state it, do you? You're a very funny person if you need to state that or put a policy on it. It would be a weird thing to do."*⁸

In Chapter 3, we discuss how David Fuller was permitted to undertake maintenance in the post-mortem rooms at both Kent and Sussex Hospital and Tunbridge Wells Hospital while deceased people were left out of fridges, often overnight. This again suggests

4 Witness transcript of Dr Peter Maskell, Medical Director since February 2017.

5 HTA, *Code A: Guiding Principles and the Fundamental Principle of Consent*, 20 May 2020.

6 Witness transcript of Ms Claire O'Brien, Chief Nurse, 2017–2021.

7 Witness transcript of Ms Avey Bhatia, Chief Nurse, 2013–2017.

8 Witness transcript of Mr Anthony Jones, Trust Chair, 2008–2017.

that consideration of the dignity of the deceased differed from that towards the living at the Trust, and demonstrates precisely why the dignity and safety of the deceased should be protected.

This different treatment of the deceased and the living is perhaps related to the fact that many of the deceased in the mortuary were not patients who died at the hospitals. Many had been transferred there from the community while their death was under investigation by the coroner. The Trust provides a post-mortem examination (PME) service as well as facilities for the 'lodging' and 'release' of deceased people on behalf of the coroner. Despite not being patients of the hospitals, deceased people transferred from the community still deserve to be treated with dignity and respect while being cared for in Trust facilities.

We heard the Trust's attitude towards the post-mortem work on behalf of the coroner described at times as *"openly hostile"* and an *"unpleasant scenario"*⁹ where some Trust managers viewed the coronial work as being conducted to the detriment of NHS priorities:

"Q: What support did pathologists receive within the Trust and externally relating to the mortuary activities and so forth?"

*A: Erm, no support at all. In fact, open hostility from the trust ... [the] medical director's main concern was me doing post-mortems you know, instead of reporting surgical. In fact, at the time I was reporting nine to ten thousand surgicals a year, which is more than most consultant pathologists do, and I was, as I say I was starting these post-mortems early making, making sure I got back to Maidstone or Preston Hall at nine o'clock to do my full day's work."*¹⁰

In Chapter 4, we learned that mortuary staff felt ignored by senior managers and separated from the rest of the Trust. The Inquiry was also told by a consultant pathologist and former Designated Individual (DI) that the mortuary staff were *"functionally isolated"*¹¹ because the focal point of their work was for the coroner and not directly for the Trust. Another consultant pathologist who conducted PMEs at the Trust for more than ten years shared her observations on this matter with the Inquiry:

*"I think there is always a problem with the APTs [anatomical pathology technologists] feeling that they're not employees of the Trust that they actually work for a visiting pathologist, or they work for the coroner because they get instructions about autopsies from it and because hospital autopsies are so very few and far between. That sense that you don't work for the NHS, but you work for somebody else outside it I think is quite widespread."*¹²

In Chapter 4, we discuss how the mortuary and its staff were largely left to their own devices.

9 Witness transcript of Dr Ann Fleming, consultant pathologist at the Trust, 2013–2019.

10 Witness transcript of Dr David Fish, consultant pathologist at the Trust, 2005–2020.

11 Witness transcript of Dr Graham Russell, consultant pathologist at the Trust, 1991–2022, DI, 2006–2010.

12 Witness transcript of Dr Rachael Liebmann, consultant pathologist at Kent and Sussex Weald NHS Trust, 1999, then Maidstone and Tunbridge Wells NHS Trust to 2014.

In our interviews with consultant pathologists at the Trust, we learned that the mortuary would be visited by several pathologists to conduct PME's on behalf of the coroner, but that they would not spend time at the mortuary otherwise: "[Y]ou want to get in and out as quickly as possible when you do post-mortems because you have to get back to work to do."¹³

Aside from two 'Board to Ward' visits made to the mortuary by non-executive directors in 2014,¹⁴ the mortuary appears to have been ignored by senior managers and leaders in the Trust. Ms O'Brien told the Inquiry that she did not visit the mortuary regularly – perhaps three to four times during her tenure – and that when she did, it was usually to see staff or for a specific purpose.¹⁵ It is usual for executives and non-executives within an NHS Trust to 'walk the floor', to be visible to staff and to observe day-to-day life within the hospital. This is part of monitoring and gaining assurance on the Trust's activities and culture. We heard from the three anatomical pathology technologists (APTs) who were working in the mortuary at Tunbridge Wells Hospital at the time of David Fuller's arrest that senior leaders did not visit the mortuary in this way until his crimes became public knowledge:

Q: And do you ever see any of the senior leadership team or any of the execs in the mortuary?

A: Erm, not really, nope.

Q: What about the Chief Exec and the directors? Have they ever been down to the mortuary?

*A: I think he, Miles Scott came down once when he started. When he first started, introduced himself and then that was it.*¹⁶

Q: You said that since the David Fuller incident you've seen Miles [Scott] more often. Prior to that did any of the execs or senior leadership team ever come to the mortuary at all?

*A: No.*¹⁷

Q: And how, how often have you seen, seen senior leadership and the execs down in the mortuary?

A: Historically or?

Q: Both historically and now.

*A: Historically never ... Recently, quite often.*¹⁸

13 Witness transcript of Dr Ann Fleming, consultant pathologist at the Trust, 2013–2019.

14 MTW NHS Trust, Board papers: March 2014, Recent quality assurance activity undertaken by Board members, January to March 2014, Item 3–14, p.76; September 2014, Board members' ward visits (01/08 to 10/09), Item 9–13, p.103.

15 Witness transcript of Ms Claire O'Brien, Chief Nurse, 2017–2021.

16 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

17 Witness transcript of N131, APT, worked in mortuaries at the Trust since 2012.

18 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

Mr Miles Scott, Trust Chief Executive since 2018, recalled that he had visited the mortuary infrequently and that when he had, in the majority of cases this was to have a meeting with Dr Dominic Chambers, the DI:

“I think actually I went there – I think I actually went into the mortuary and had a look round the whole mortuary when I first arrived. I had subsequent meetings with Dominic. But any of those that were in the mortuary would have been in the office. So they wouldn’t have been going right out into the mortuary. And it’s not a, you know, it’s not a spectator sport, is it?”¹⁹

Mr David Highton, Chair of the Trust since May 2017, told the Inquiry: *“I think the phrase sometimes used is out of sight, out of mind for mortuaries. Erm, so yeah, I would be honest I didn’t spend a lot of my time thinking about the mortuary.”²⁰*

The Inquiry heard similar reflections from Mr Jones, who said: *“[T]he number of times the mortuary crossed my mind in the ten or eleven years I was there are very limited indeed”²¹*

Mr Glenn Douglas, despite being Chief Executive of the Trust in 2011 when it voluntarily relinquished its HTA licence after significant failings in the mortuary, told us that he visited the mortuary at Kent and Sussex Hospital just once, shortly after joining the Trust. He visited the mortuary at Tunbridge Wells Hospital on three occasions: including when it first opened in 2011 and when it began to provide a PME service in 2014.²²

In Chapter 4, we heard that at departmental and directorate level managers were not frequently visible in the mortuary. Between 2011 and 2021, the mortuary was managed by people who were based off-site at Maidstone Hospital. The Mortuary Manager in the period 2016 to 2021, Mr Peter Deal, acknowledged that his visits to the mortuary were very infrequent, telling police that he visited the mortuary at Tunbridge Wells Hospital on just a handful of occasions.²³ Ms Theresa Welfare, line manager to Mr Deal and also based at Maidstone Hospital, acknowledged that this was the case, telling the Inquiry that she *“had no day to day contact with the mortuary team”* and that she *“acted on the reports that were received and the escalations from the mortuary manager”*. Ms Welfare also told us that, when she took over as temporary Mortuary Manager in 2021, she introduced a *“more physical presence”²⁴*.

The inadequate oversight of the mortuaries at Kent and Sussex Hospital and Tunbridge Wells Hospital is covered in Chapter 4. Chapter 7 sets out how issues regarding the mortuary rarely, if ever, reached the Trust Board.

To some, the presence of mortuaries can represent loss and grief. The mortuaries at Kent and Sussex Hospital and Tunbridge Wells Hospital, and the deceased people within them, were out of sight and out of mind, tucked away in the basement and largely unseen by senior leaders at the Trust.

19 Witness transcript of Mr Miles Scott, Trust Chief Executive since 2018.

20 Witness transcript of Mr David Highton, Chair of the Trust since May 2017.

21 Witness transcript of Mr Anthony Jones, Trust Chair, 2008–2017.

22 Witness transcript of Mr Glenn Douglas, Chief Executive, 2007–2017.

23 Witness transcript of Mr Peter Deal, biomedical scientist, Mortuary Manager, 2016–2021; and police officer’s report following interview with Mr Deal, 5 February 2021.

24 Witness transcript of Ms Theresa Welfare, Head of Biomedical Services and line manager to the Mortuary Manager since 2016.

9.2 Denial

There is evidence that the Trust acted quickly when it learned of David Fuller's offending in the mortuary. It fully cooperated with the police investigations into what had happened. The Trust has commissioned reviews of the mortuary and of its security services with the aim of identifying improvements.²⁵ It commissioned an independently chaired internal investigation into how David Fuller was able to offend undetected for so long, which was replaced by this Inquiry in November 2021. It is fair to say that the Trust has demonstrated its intention to learn what went wrong by fully cooperating with and supporting the work of the Inquiry.

However, given the highly distressing nature of the crimes that David Fuller committed, it is understandable that people working at the Trust might seek to distance themselves emotionally from the impact and from accepting any responsibility for what happened.

The Inquiry was told by two APTs who worked at the Trust at the time of David Fuller's arrest that they considered, in hindsight, that they or others had been 'groomed' by him – or that they had been told that they had been groomed by him:

"I mean groomed as in, erm, we was meant to see a certain facet of David Fuller, and we were groomed to that effect. And I think he groomed the entire trust for years because otherwise, it would have come to light a lot earlier, wouldn't it?"²⁶

"[E]verybody never suspected it they were pretty much groomed by him weren't they so ... So, we've spoken about this before as a team it's the way he would come in and be friendly with everybody, it's the way that he would build up a bit of a rapport with them all. I mean I'm talking based on what I've heard from the others because I've never met him to my knowledge ... And I reckon that we've thrown this word around that perhaps he was grooming them to get them on his side so that nobody would ever suspect.

Q: *[A]nd have other people used the term groomed at all?*

A: *I'm pretty sure Miles [Scott] did when he came and spoke to us about David in the first place."²⁷*

The Inquiry informed David Fuller that some APTs considered that they were groomed by him, which he denied.

Ms Maureen Choong, a Non-Executive Director at the Trust, also alluded to David Fuller having been manipulative, stating that this may have had an impact on others' judgement:

"[I]ndividuals who wish to perpetrate horrific activities are extremely manipulative and extremely skilled at doing so, and most people would never, ever, ever consider anything sinister or unpleasant about it. The NHS functions on trust and respect and people doing the right thing, most people, most of the time."²⁸

25 Response by MTW NHS Trust received during the Inquiry's Fairness Process.

26 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

27 Witness transcript of N140, APT, worked in mortuaries at the Trust since 2017, based at Maidstone Hospital.

28 Witness transcript of Ms Maureen Choong, Non-Executive Director of the Trust since 2017.

We asked Mr John Underwood, an independent media and communications adviser engaged by the Trust, if he had any thoughts about why staff were referring to themselves as having been groomed. He responded:

“Well, the word, ‘grooming’, specifically the word ‘grooming’ ... I have certainly heard the police use. So, I think it is a word which perhaps they may have either heard from people that they spoke to, or maybe it was a word they used with people that they spoke to. I don’t know, but it’s certainly a word that I’ve heard in the context of all of the conversations that have taken place around the Fuller affair. In a sense, it doesn’t surprise me actually that you reference that particular word. It’s a word that I’ve heard on a number of occasions.”²⁹

We also heard accounts of mortuary staff being reassured by Trust managers that they could not have known about David Fuller’s offending:

“Q: Knowing what you know now, erm, have you thought back over the time that you’ve known David Fuller and thought about whether there’s been any, anything at all that might have been unusual?”

A: Yeah. I have thought about it, but erm, nothing springs to mind cos I think he covered his tracks very, very well. [When asked how they knew this] I don’t, but from what I’ve heard from Miles [Scott] erm, and John Underwood that he made a mess in the post-mortem room. What that mess was, I don’t know, but if you did make a mess, he tidied it up very, very well, so when we come in the next day there was nothing to be seen. So, that’s what I mean by covering his tracks.”³⁰

“[T]hey [Mr Scott and the Trust Secretary] come down to talk to us to reassure us of er, processes, and, and what have you.

Q: And can you describe to me what you mean by reassure you of processes?”

A: Oh, that no one’s in trouble. Erm, the police findings have found that there’s no er, evidence of collaboration or anything like that by any, anyone else within the hospital. I don’t mean just mortuary stuff. So, that side of it is not an issue at all.”³¹

Mr Sean Briggs, who has been the Trust’s Chief Operating Officer since 2018, told the Inquiry that it was his opinion that staff in the mortuary were not responsible for creating an environment that enabled David Fuller’s offending:

“A point I didn’t make strongly, but believe in retrospect, is that even though there were challenges in the mortuary before 2020, I don’t believe the morale of staff or leadership contributed to Fuller being allowed to offend. He had spent many years building relationships with all staff in the mortuary, and throughout the hospital, and it was his job to be involved in maintenance issues in the mortuary. He was viewed as a popular and helpful member of the extended team, always having cover for his reasons for entering the mortuary.”³²

29 Witness transcript of Mr John Underwood, media and communications adviser to the Trust since 2021.

30 Witness transcript of N130, APT, worked in mortuaries at the Trust, 2014–2023.

31 Witness transcript of Mr Kenneth Crossley, employed by the Trust and its predecessors since 1986, worked in mortuaries at the Trust since 1994, Lead APT since 2011.

32 Witness transcript of N400; additional comments by Mr Sean Briggs, Chief Operating Officer since 2018.

Mr Scott told us that the basis for him reassuring mortuary staff was information he had received from the police:

“Erm, sure. So, er, what I have, what I have said to the er, to the, the APT team is that the police have been clear that from their investigation they had no reason to suspect erm, er, the, that either that they were involved or that they should have suspected and that is something the police have, have said.”³³

While the police may have had no reason to suspect that any APTs had been involved in the offending, the reassurance the APTs were given, while well intentioned, seems to have been premature – particularly when this was done at a time when the Trust’s own internal investigation had not concluded and the Inquiry had just been announced.

While mortuary staff may have been unaware of David Fuller’s crimes, failings within the mortuary that may have presented opportunities for him to offend more easily – such as permitting the carrying out of maintenance, unsupervised, while the deceased were laid out in the post-mortem room – are set out in Chapters 2 and 4 of this Report.

9.3 Staff reflections

In addition to identifying Trust employees whom the Inquiry wished to interview because of their particular roles, in early 2022 we invited anyone who worked at the Trust who believed they might have information that would be helpful to the Inquiry to get in touch. A total of 11 people came forward in response.³⁴ Of these, six were clinical staff and five worked in estates or maintenance.

When asked how they reacted when they learned of David Fuller’s offending, most employees of the Trust and Interserve (Facilities Management) Ltd (Interserve) spoke about feeling horror or revulsion at what he had done. We were struck that three of the six clinicians who contacted the Inquiry of their own volition also spoke of their concern that David Fuller had damaged the reputation of the Trust. Two spoke of a sense of personal loss, of David Fuller’s crimes *“ruining everything [they had] worked hard for”³⁵* and their dedication to the Trust *“meaning nothing”³⁶*.

All three clinicians had worked for the Trust for significant periods of time (between 13 and 32 years) and demonstrated a high degree of loyalty to the organisation.

While a small number of Trust staff told the Inquiry that they felt concern about reputational damage, this was not apparent among staff who had been employed by Interserve. This could perhaps be because Interserve staff now work for a different employer (Mitie Group PLC (Mitie), since December 2020), or because the focus of the media interest was on the NHS Trust at which they worked rather than on their direct employer.

33 Witness transcript of Mr Miles Scott, Trust Chief Executive since 2018.

34 N135, N138, N139, N141, N142, N174, N182, N240, N257, N448, N449.

35 Witness transcript of N139, clinician who has worked at the Trust since 1999.

36 Witness transcript of N141, clinician who has worked at the Trust since 2009.

One Interserve manager spoke of the impact on their professional pride (although this was not expressed by others):

"[I]t's life-changing because you think, I've always merited myself on being a relatively good judge of character and I was so proud of what we did at that hospital. So, it is life-changing because it's a whole part of my life that is tainted and it will forever be tainted."³⁷

The Inquiry noted a range of responses from Interserve staff. As with the Trust mortuary staff, the notion that they had been 'fooled' was most prominent, with six Interserve employees speaking of the trust they had placed in David Fuller and their shock at the crimes he had committed:

"I can't believe that I could work so closely with someone for so many years and have no suspicions, that's terrifying ... that man was a monster and he played every single one of us."³⁸

"He had me fooled. He had everyone fooled."³⁹

"[T]he Dave we knew, the nice Dave sitting in the corner of the office we knew was a thin veneer of the monster he was underneath you know, and he was very clever because he never ... he never once let that slip you know."⁴⁰

However, as described in Chapter 3, the Inquiry observed a culture of acceptance and tolerance of David Fuller's behaviour at work among Interserve staff, despite concerning behaviour being noticed by a minority of staff, some in managerial or senior positions.

In conducting its work, the Inquiry interviewed employees and ex-employees of Interserve. What they told us about David Fuller's performance, practices, ill health and behaviour is referred to in this chapter. Mitie, which acquired Interserve in December 2020, conducted its own internal investigation into how David Fuller was able to offend. Mitie told the Inquiry that its findings in relation to what David Fuller's colleagues and ex-colleagues knew about him differed from the findings of the Inquiry. In interviewing David Fuller's colleagues, Mitie was not told of any concerns about his performance or behaviour. It appears that individuals, as could maybe be expected, were more forthcoming with providing information to the Inquiry than they were to Mitie.

The culture among the Interserve staff at Tunbridge Wells Hospital, as observed by the Inquiry, was not one of questioning and curiosity. There was a lack of curiosity about David Fuller's work behaviour in relation to the mortuary, influenced by the staff's own feelings of discomfort at undertaking work there. As with the mortuary staff, David Fuller's colleagues at Interserve have found it easier to conclude that there was nothing they could have done to prevent his crimes. The Inquiry notes in Chapter 3 that this lack of curiosity may have led to missed opportunities to question David Fuller's behaviour at work.

37 Witness transcript of N392, Interserve manager, 2010–2016.

38 Ibid.

39 Witness transcript of N164, Interserve employee from 2017.

40 Witness transcript of N169, Interserve employee from 2015.

9.4 Discussion about necrophilia

The Inquiry heard an account of porters discussing the possibility of necrophilia happening in the mortuary at Maidstone Hospital in the 1980s.

N391 worked as a domestic at Maidstone Hospital in the 1980s. They told the Inquiry that the porters they worked with at the hospital talked about someone locking the mortuary door so that they could have sex with the body of a deceased female:

“They always used to chat away and they always used to say, ‘I hope we can get into the mortuary, because, erm, you know, we very often can’t get in there, ‘cause this chap, this bloke that works down there, erm, has always got the door locked.’ And they said, ‘We’re sure he does something down there to the bodies ... And there was ... it was that ... there was one particular young lady, that, er, apparently, she was ... they said, ‘She’s absolutely stunning. She’s beautiful and she hasn’t got a mark on her, and it always seems to be locked when we’ve gotta go in there, and we’re sure that he’s giving her one’ they were saying.”⁴¹

N391 told us that, at the time, they thought the porters were just making the story up. Given the passage of time and the paucity of information, it is not possible for the Inquiry to investigate this allegation further and it is not in the Inquiry’s Terms of Reference to do so. N391 contacted Kent Police to pass the information on to them.

There is no evidence that the person the porters were talking about was David Fuller. The incident pre-dates him working for the NHS, and there is no evidence that he ever worked at Maidstone Hospital.

However, the incident illustrates that some hospital staff in the 1980s were able to ‘think the unthinkable’ – that necrophilia could take place in a hospital mortuary – in the period before David Fuller is known to have offended. The allegations the Inquiry received about inappropriate conduct in the mortuary at Kent and Sussex Hospital in the late 1990s also suggest that discussion of necrophiliac activity pre-dated David Fuller’s first known offence, and that ineffectiveness of internal controls in the mortuary may have been an issue in one of the Trust’s predecessor organisations (see Chapter 8).

9.5 Thinking the unthinkable post-Savile

The crimes committed by David Fuller in the Trust’s mortuaries are not the first instance of sexual abuse of deceased people in NHS mortuaries coming to national attention.

The report of the investigation into Jimmy Savile’s activities at Leeds Teaching Hospitals NHS Trust was published in June 2014. The investigation considered an allegation that Jimmy Savile sexually abused bodies of the deceased in the mortuary at Leeds General Infirmary. It concluded that, while there was no way of proving this allegation, Savile’s *“interest in the mortuary was not within accepted boundaries”*.⁴²

41 Witness transcript of N391, domestic at Maidstone Hospital in the 1980s.

42 Leeds Teaching Hospitals NHS Trust, *The Report of the Investigation into Matters Relating to Savile at Leeds Teaching Hospitals NHS Trust*, June 2014.

This aspect of the investigation was the subject of much media attention when the report was published.⁴³

In February 2015, the investigation into Savile's activities at Stoke Mandeville Hospital reported that it had heard hearsay about Savile sexually abusing deceased people in the hospital mortuary, but could find no evidence to prove that this had actually happened.⁴⁴

Despite the high level of media attention around Savile's alleged sexual abuse of the deceased in hospital mortuaries, Mr Scott told the Inquiry that the possibility of necrophilia was not considered a risk in the NHS:

"I worked in the NHS a long time and I am absolutely sure that people do, people have not before this case really considered, not really considered it as a risk. You know people joke about it but people haven't really considered this [necrophilia] as a risk, and even though we know the, you know, it's just like you know the word, we know the meaning of the word and yet we don't connect that with the fact that we're looking after dead bodies and, and I don't think that's unique to MTW [Maidstone and Tunbridge Wells NHS Trust] and I don't think it's even unique to the, four hospitals I have been Chief Executive of or the however many 10 hospitals I've worked in. It, it is something I think is not considered or hasn't been until this case."⁴⁵

In 2015, the Lampard report, which brought together the lessons learned from a number of NHS investigations into matters relating to Jimmy Savile,⁴⁶ did not carry through the specific recommendations made by the Leeds investigation in relation to safeguarding the deceased and security in NHS mortuaries; nor did it refer to allegations of necrophilia. The recommendations that the Leeds investigation urged NHS leaders to consider included extending safeguarding policies to the deceased, and ensuring that policies and controls were in place (and regularly audited) covering security in NHS mortuaries. The Leeds investigation drew attention to the vulnerability of the deceased to abuse while in NHS care. It urged NHS leaders to *"consider if such events could happen in their organisation, and what controls they have in place to assure themselves that patients, visitors and staff in their organisation are protected from harm"*.⁴⁷

The Lampard report did not include these specific recommendations from the Leeds investigation. However, it did recommend that NHS organisations review their safeguarding practices and the effectiveness of them in light of Savile's activities. The report states:

43 'Revealed: The glass eye Jimmy Savile stole from a corpse and made into a necklace that he wore on final Top of the Pops – where he also groped a child', *Daily Mail*, 27 June 2014; 'Savile told hospital staff he performed sex acts on corpses in Leeds mortuary', *The Guardian*, 26 June 2014; 'Jimmy Savile had sex with DEAD BODIES in mortuary, shocking NHS report reveals', *The Mirror*, 26 June 2014; 'Boasted about having sex with corpses and "wheeling them around" at night', *Daily Mail*, 26 June 2014; 'Five things you need to know about the NHS's Jimmy Savile report', *The Spectator*, 26 June 2014.

44 Health and Social Care Advisory Service, *Investigation into the Association of Jimmy Savile with Stoke Mandeville Hospital*, February 2015.

45 Witness transcript of Miles Scott, Trust Chief Executive since 2018.

46 Ms Kate Lampard and Mr Ed Marsden, *Themes and Lessons Learnt from NHS Investigations into Matters Relating to Jimmy Savile*, February 2015.

47 Media statement by Dr Sue Proctor.

*"[T]he Savile investigations showed that all hospital staff, including managers, must keep their minds open and be vigilant about the potential for harm and abuse in the hospital."*⁴⁸

NHS organisations were required to review and comply with the recommendations of the Lampard report. The Trust's response to the Lampard report stated that it had specific safeguarding committees which would provide assurance on these recommendations to the Board.⁴⁹

In the context of the Savile investigations, the Inquiry was concerned to hear the Chief Executive of the Trust explain that the risk of abuse of deceased people in hospital mortuaries was not one considered by the NHS.

9.6 Commentary

The Inquiry wanted to understand the reasons why it was difficult for the Trust and some individuals who had worked in the mortuary to acknowledge and recognise their role, however unintentional, in creating the environment in which David Fuller's offences took place. We commissioned a forensic psychologist to undertake a literature review to provide insight into how this culture of denial can arise.

The literature review recognised that:

*"Given the nature and scale of the crimes committed by David Fuller, there is no direct comparison and therefore no direct body of research that can fully explain the reactions of those involved in the Inquiry into David Fuller's behaviour. However, there is a wealth of literature relating to both individual and organisational denial, with relevant findings that can be applied to enable some understanding of the psychological processes that may be relevant to this case."*⁵⁰

The literature reviewed illustrated that, after a negative event has been uncovered (in this case, David Fuller's offending), those involved in the situation may continue to distance themselves and avoid any association with what has happened. The Inquiry observed this behaviour in the readiness by some at the Trust to accept and promote the idea that nobody could have done anything to prevent David Fuller's actions.

The literature review found that:

*"Within organisations, denial may come through a shared language; individuals within the organisation may use the same phrases and anecdotes when conversing about what happened, indicating the influence that being part of the organisation has on the individual. This could also indicate that through discussion, they have come to a shared view with colleagues ... which may not represent the reality of the situation at the material time."*⁵¹

48 Ms Kate Lampard and Mr Ed Marsden, *Themes and Lessons Learnt from NHS Investigations into Matters Relating to Jimmy Savile*, February 2015.

49 MTW NHS Trust, *Annex A: Report on Trust Progress in Response to Kate Lampard's Lessons Learnt Report*.

50 Ms Claire Barker, *Forensic Psychologist's Report to Aid the Fuller Inquiry*, February 2023.

51 Ibid.

The Inquiry observed this shared language at the Trust, particularly among those who had been closest to the mortuary and/or David Fuller. One example was the readiness to accept that the APTs had been ‘groomed’ by him. We also heard shared descriptions of David Fuller from the APTs, with two who worked in the mortuary at the time of his arrest describing him as “*meek and mild*”.⁵²

The literature review found that one of the driving factors behind denial is to protect both the organisation as a whole and the individuals within it from criticism.

The literature review concluded:

*“There are a number of reasons why organisations and individuals may wish to distance themselves from negative events, as well as ways in which they may do this. These can be both conscious and unconscious processes, arising from the need to defend against risk, either professionally for the individual or reputationally for the organisation.”*⁵³

It found that denial is less likely where organisational culture is open and learning. The Inquiry would urge NHS trusts to reflect on this and to learn from it. The Inquiry will consider this issue further in Phase 2.

David Fuller’s offending was discovered six years after a high level of media coverage of the allegations that Jimmy Savile abused the deceased. The investigation into Savile’s activities recommended to the Leeds Teaching Hospitals NHS Trust Board that the Trust’s safeguarding policies should extend to the care of the deceased. While the recommendation was made specifically to the Leeds Board, in its accompanying press statement the Leeds investigation urged leaders in every NHS hospital trust to read its report and consider if such events could happen in their organisation; they should also ask themselves what controls they had in place to ensure that patients, visitors and staff in their organisation were protected from harm.⁵⁴ This did not happen with regards to the mortuary at Maidstone and Tunbridge Wells NHS Trust.

What we have found

- There was a lack of curiosity about David Fuller among both his NHS and Interserve colleagues.
- There was little evidence of them questioning his role and presence in the mortuary.
- This absence of critical thinking extended into the period following his arrest, when his offending in the mortuary came to light.
- Those around him at all levels were unable to comprehend what had happened and any role they might have played in the environment and circumstances in which he offended.

52 Witness transcripts of N130, APT, worked in mortuaries at the Trust, 2014–2023; and N131, APT, worked in mortuaries at the Trust since 2012.

53 Ms Claire Barker, *Forensic Psychologist’s Report to Aid the Fuller Inquiry*, February 2023.

54 Press statement, ‘Investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust’, June 2014.

Chapter 10:

Conclusions and recommendations

David Fuller was employed by, or worked as a contractor for, the NHS for 31 years, from 1989 to 2020. His employment started only two years after he committed the brutal murders of two young women in Kent, whose deceased bodies he sexually assaulted. There can be no doubt that responsibility for the 140 known offences against deceased women and girls in the mortuaries at Maidstone and Tunbridge Wells NHS Trust (the Trust) lies with David Fuller. The question the Inquiry was set up to examine is how on earth was David Fuller able to commit these offences and remain undetected over such a prolonged period? What went wrong to allow this to happen and what needs to be in place to prevent it ever happening again?

The NHS was and remains a caring organisation, into whose hands millions of people entrust their care each year. During the years of David Fuller's offending, the NHS was subject to legislation, regulation and standards on how to ensure safe care for all patients. These requirements were supported by extensive guidance to organisations on how to deliver best practice. Over the 15 years that David Fuller was known to offend, many of these regulatory requirements increased and evolved, but the basic principle remained that patients admitted under the care of NHS organisations should be able to expect the best treatment the NHS is capable of, provided with care and compassion. The public's reasonable expectation was that the same care and compassion would be shown by the NHS to the deceased as to the living.

However, despite a plethora of regulation, David Fuller was able to offend undetected until his arrest. The idea of a necrophiliac murderer seeking employment in the NHS to be better able to pursue his predilections is such an unlikely scenario that most would consider it incredible. However, it happened. Why did the legislative and regulatory shield not protect the deceased in Maidstone and Tunbridge Wells?

Over the years, the regulatory requirements that should have protected the deceased in the care of Maidstone and Tunbridge Wells NHS Trust were either insufficient or were not followed by those in a position of responsibility. It seems to be an unfortunate fact that gaps in safety or regulatory shields are often only identified and closed after somebody has taken advantage of them. History has shown that this even occurs in the most regulated of environments, such as the airline and nuclear industries. Regulations and their associated standards of policy and practice are designed not only to deliver best practice but also to provide effective discouragement of bad or inappropriate practice whether deliberate or accidental. As well as being effective, regulation needs to be proportionate and to recognise the existence and management of risk.

In making findings and recommendations, the Inquiry identifies gaps in regulation, in governance and in management that together allowed David Fuller to offend. The national regulatory framework and its effectiveness will be reviewed in Phase 2 of the Inquiry.

David Fuller's known offending took place over 15 years, during which time NHS and Trust governance and management structures and responsible personnel changed many times. We received information during the course of the Inquiry that suggested internal controls may have been lacking in the mortuary in one of the predecessor organisations of the Trust seven years before David Fuller's first known offence. The Inquiry has named individuals whom we have identified as being directly involved in the running and management of the Trust, the private facilities management provider and the mortuary service, as well as managing David Fuller himself. We have also named those in senior management or governance positions in these services who had opportunities to identify or correct the systemic weaknesses that allowed David Fuller to commit his crimes.

The recommendations that follow arise from the evidence that we have heard and reviewed in the course of the Inquiry.

10.1 David Fuller's offending

David Fuller was able to sexually abuse the bodies of deceased women and girls in the mortuaries of Kent and Sussex Hospital and Tunbridge Wells Hospital because he was allowed unaccompanied access to the mortuaries in his role as an electrical maintenance supervisor. He was most likely to offend between 6pm and 8pm, and second most likely to offend between 4pm and 6pm, when mortuary staff had left for the day.

David Fuller also offended in the mortuary at Tunbridge Wells Hospital during working hours, when staff should have been on duty. The Inquiry has not been able to understand how David Fuller was able to commit his crimes during mortuary working hours when staff were scheduled to be on duty. Despite the potential explanations provided by the mortuary staff, the Inquiry does not consider it likely that staff could have been in the mortuary at these times.

The practice of allowing David Fuller unaccompanied access to the mortuary at the Trust was not compliant with the Human Tissue Authority standard 2017 relating to security, which states: *"Security arrangements should ensure oversight of visitors and contractors who have a legitimate right of access."* It was also not compliant with the conditions of the Kent County Council contract with the Trust for post-mortem services.

Recommendation 1

- **Maidstone and Tunbridge Wells NHS Trust must 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.**

The bodies of deceased people were left out of the mortuary fridges overnight at Kent and Sussex Hospital and at Tunbridge Wells Hospital. This practice does not safeguard the dignity of the deceased, and increased David Fuller's opportunities to offend. David Fuller was allowed to undertake maintenance tasks in the post-mortem room while deceased people were out of the fridges: a practice that was entirely inappropriate and contrary to Human Tissue Authority standards.

Recommendation 2

- **Maidstone and Tunbridge Wells NHS 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.**

10.2 David Fuller's employment and work practices

When David Fuller applied for his first substantive NHS role and when he applied for promotion to the role of supervisor in 2002, he falsely claimed that he had no convictions to declare on his application form.

David Fuller did not disclose his criminal convictions directly to the Trust, and Interserve (Facilities Management) Ltd (Interserve) did not notify the Trust of his convictions when it became aware of them in 2011 and again in 2015. This was in breach of the contract between Interserve and the Special Purpose Vehicle and the agreement with the Trust. There was no process of review in 2011 and 2015 that would have shown David Fuller's previous failure to disclose his convictions when he was appointed to his NHS role in 1989 and promoted in 2002. Although he might not have been barred from continuing his employment, we consider that knowledge of his convictions could have led to questions about his honesty and closer scrutiny of his actions when taken together with his other behaviour.

Recommendation 3

- **Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.**

The Inquiry will consider the wider issue of the use and effectiveness of criminal record checks for employment that involves access to the deceased in Phase 2 of its work.

10.3 Mortuary management and oversight by Maidstone and Tunbridge Wells NHS Trust

The management and supervision of the mortuary service at the Trust between 2005 and 2020 was woefully inadequate and failed to safeguard or protect the dignity of the deceased.

Problems in the mortuary were known to members of the Trust executive team from as early as 2008. The Inquiry heard that there was virtually no on-site supervision, limited oversight and limited assurance by the management arrangements. A member of the mortuary staff who was strongly criticised in an independent report in 2009 was actually appointed as the lead anatomical pathology technologist to implement the programme of improvement. This was an inexplicable decision. The Inquiry considers that the lack of oversight allowed a culture to develop in the mortuary where Standard Operating Procedures were routinely ignored and security breaches were not thoroughly investigated. This culture created the environment in which David Fuller was able to offend.

Anatomical pathology technologists are not a regulated profession. The leadership of the anatomical pathology technologists at the Trust was inadequate and they adopted working practices that were not in line with recognised good practice or Human Tissue Authority requirements. Mortuary staff felt isolated from the rest of the Trust, received minimal supervision, did not have access to Continuing Professional Development and felt that senior management ignored them.

Recommendation 4

- **Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.**

Recommendation 5

- **The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.**

The Inquiry will consider the issue of regulation of mortuary staff in Phase 2 of its work.

10.4 Security arrangements at Maidstone and Tunbridge Wells NHS Trust

The security systems in place at the Trust between 2005 and 2020 were inadequate. The Trust failed to put in place adequate security systems to monitor staff access to restricted areas. David Fuller was given access to a key to the mortuary at Kent and Sussex Hospital from his appointment as an electrical maintenance supervisor in 2002. His access to the mortuary was not monitored as there was no system of monitoring in place for those who had keys. After 2007, there was no system of monitoring access to the mortuary for those who were signing keys out of the switchboard.

From 2011, David Fuller was given full access to the mortuary at the new Tunbridge Wells Hospital site via his individual swipe card. This swipe card enabled him to access the mortuary 444 times in just one year, between December 2019 and December 2020. Data on those accessing the mortuary via their swipe cards was collected but never reviewed. As a result of these inadequate systems, David Fuller was given unchecked and unmonitored access to the mortuary, which allowed him to commit sexual offences against deceased people.

The Trust did not recognise the importance of ensuring the security of its estate, nor the potential safety impact that security lapses might have on those for whom it held responsibility, including the deceased.

Recommendation 6

- **Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.**

Recommendation 7

- **Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.**

Recommendation 8

- **Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.**

The Inquiry considers that the Trust senior executives failed to listen to mortuary staff and successive Designated Individuals regarding the necessity of installing CCTV in the mortuary. The Inquiry has identified that discussions about the installation of CCTV in the Kent and Sussex Hospital mortuary took place as early as 2008. Further discussions

about the subject continued in 2013/14 and again in 2017/18. We heard that CCTV was not installed in the mortuary until 2020. The delay in installing CCTV was for financial reasons. The Trust failed to prioritise the safety of the mortuary in a way that could have protected deceased people resting in it.

Recommendation 9

- **Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.**

Recommendation 10

- **Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.**

10.5 The wider system

There have been many external organisations involved in assessing the Trust's mortuaries over the years. The framework of external oversight did not detect and address serious issues at the Trust's mortuaries, including lax security, non-compliance with policies, and inadequate management arrangements.

NHS trusts are accountable to NHS England for the services they provide. In the case of Maidstone and Tunbridge Wells NHS Trust, NHS England took little interest in the licensed activity that was being undertaken in the mortuary at the Trust. It was easily reassured that all was well.

A variety of organisations assessed and inspected the mortuaries at the Trust during the time that David Fuller was offending, but they did not detect the lack of security and access controls that allowed it to happen, and they did not provide the necessary guidance to rectify these problems.

The Human Tissue Authority's focus is on licensed activity and seemed too ready to accept reassurance about compliance with its requirements rather than assurance. This can be summarised by the difference between 'tell me' and 'show me'.

The fact that the Care Quality Commission inspected the mortuary is unhelpful and confusing, given that its legislative framework does not refer to mortuary services (although its end of life pathway framework does).

The UK Accreditation Service (UKAS) assessments are designed for laboratories not mortuaries, concerned more with the process for handling tissue samples than the wider management of the mortuary.

These organisations did not work together and had no formal mechanism for sharing their reports and any concerns. The fact that three organisations inspected the mortuary gave the impression of effective external regulation, which reassured the Trust and other stakeholders, but none identified or addressed the systemic weaknesses that created the environment in which David Fuller offended.

The Health and Safety Executive did not have a process in place to share with the Human Tissue Authority its concerns about the lack of assessment of risk of injury to staff involved in the manual transfer of the deceased.

The current safeguarding legislation does not extend to the deceased and thus the Trust's safeguarding assessments excluded the mortuary.

Recommendation 11

- **Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.**

The Inquiry will consider the current legislation and system of regulation and oversight of mortuaries, the legislation in relation to safeguarding with regard to the deceased, and the responsibilities of the various regulators charged with ensuring the security and dignity of the deceased in more detail in Phase 2 of its work.

We understand that at least 79 of David Fuller's victims were under the legal control of the coroner when David Fuller sexually abused them. While coroners have legal control of the body of the deceased until their coronial functions come to an end, they do not have a duty or obligation to safeguard, monitor or otherwise ensure the proper treatment of the deceased in their control. The Inquiry will consider this situation in Phase 2 of its work.

Council officials involved in the placement of coroners' cases at the Trust relied on the Trust and the Human Tissue Authority as regulators of the Trust's mortuary services to ensure that sufficient processes were in place to safeguard the security and dignity of the deceased, and they therefore did not seek assurance on this. The Inquiry intends to consider the role and responsibilities of local authorities in respect of the provision of mortuary services in Phase 2 of its work.

Recommendation 12

- **Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.**

10.6 Board assurance

The governance structures in place at the Trust were overly complex. This complexity, lack of effective reporting mechanisms and ineffective delegation arrangements meant that serious issues regarding the mortuary and the Human Tissue Authority requirements received little focus at the Quality Committee and did not reach the Trust Board.

The Board did not consider the requirements of the Human Tissue Authority in sufficient detail. There was an over-reliance on the Designated Individual to ensure the requirements of the Human Tissue Authority were being met.

Concerns about the mortuary management and security outlined in Chapters 4 and 5 did not reach the Trust Board. The Board did not therefore have the opportunity to discuss these or to receive assurance on action to address the concerns. The Board did not receive assurance regarding statutory regulated activity in the mortuary.

Recommendation 13

- We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.

Recommendation 14

- Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.

Recommendation 15

- Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.

Recommendation 16

- **The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.**

Recommendation 17

- **Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.**

Appendix 1:

How we did our work

On 8 November 2021, the Rt Hon. Sajid Javid MP, the Secretary of State for Health and Social Care at that time, announced that there would be an independent, non-statutory inquiry into the issues raised by the actions of David Fuller, the electrical maintenance supervisor who committed sexual offences in the mortuaries of Kent and Sussex Hospital and Tunbridge Wells Hospital. Sir Jonathan Michael was to chair the Inquiry. In this section, we describe how the Inquiry was set up and how we carried out our work. We do this by looking at the following four areas:

- setting up the Inquiry;
- reaching out to the families of the deceased people against whom David Fuller offended;
- the Inquiry's Terms of Reference; and
- how we did our work.

Setting up the Inquiry

In November 2021, David Fuller was convicted of the historical murders of Wendy Knell and Caroline Pierce in 1987. At the same time, he also admitted 12 counts of sexual penetration of a corpse and four counts of possession of extreme pornography between 2007 and 2020. David Fuller was sentenced to two whole-life tariffs for the murders of Wendy and Caroline and given concurrent sentences of 12 years for the sexual offences committed in the mortuaries between 2008 and 2020.

In November 2022, he was charged and admitted a further 16 sexual offences committed against 23 deceased women in the mortuaries at the Kent and Sussex and Tunbridge Wells hospitals, with the earliest offence occurring in 2005. For these offences he was sentenced to a further four years in prison.

Given that David Fuller's offences were committed over an extended period of time and in his position as an electrical maintenance supervisor at Maidstone and Tunbridge Wells NHS Trust (the Trust), the Secretary of State recognised the public interest that existed in understanding the circumstances which enabled David Fuller to offend in the way he did. Mr Javid established an Inquiry and appointed Sir Jonathan Michael as Chair of the Inquiry.

The Inquiry is a non-statutory inquiry and therefore does not fall under the provisions of the Inquiry Act 2005. This means that the Inquiry does not have the power to compel individuals to attend and give evidence. It is commissioned and funded by the Department of Health and Social Care (DHSC) but is independent from it.

Following David Fuller's arrest in December 2020, the Trust began an internal investigation into how he was able to offend over such a long period of time. This investigation was closed when the Inquiry was announced. The Inquiry was able to have a broader focus than the internal investigation and look at the wider system of external regulation, the Trust management arrangements, and the interface between the Trust and its Private Finance Initiative providers of facilities services during this period.

Most importantly, the Inquiry was able to make recommendations to government rather than only to one organisation. If the Inquiry's recommendations are accepted and implemented by the DHSC, they have the potential to ensure that the dignity of the deceased is maintained and safeguarded prior to either cremation or burial.

Following his appointment as Chair of the Inquiry, Sir Jonathan Michael set up an Inquiry team to support the work of the Inquiry. Details of the Inquiry team can be found in Appendix 3. Members of the team had experience of working on other independent inquiries and national investigations into healthcare incidents. Sir Jonathan Michael also appointed two Independent Advisers who had extensive experience and expertise in the organisation and activities undertaken in mortuaries. Details of the Independent Advisers can be found in Appendix 3.

David Fuller worked in Kent and it was important that the Inquiry was easily accessible to relatives of his victims. For this reason, the Inquiry set up its Phase 1 operations in Maidstone town centre.

The Inquiry's Terms of Reference

On his appointment as Chair of the Inquiry, Sir Jonathan Michael made the commitment to seek the views of families affected by David Fuller's actions, and other interested parties, on the Inquiry's draft Terms of Reference. The Inquiry made contact with affected families who had given their consent to be contacted, or who had approached the Inquiry directly, and other interested parties during January and February 2022 to ask for their views.

Common themes that emerged from families and other interested parties that expressed a view include:

- the level of David Fuller's supervision and what mechanisms were in place to check his working practices;
- employment checks and whether there had been 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.

The Inquiry's Terms of Reference were amended to reflect these common themes. The Terms of Reference provided a guide for the Inquiry's work, and it is important to the Inquiry that they were informed by the experience of families who have been affected by the actions of David Fuller, and other interested parties.

The Terms of Reference were published on 23 February 2022 and can be found in Appendix 2.

In May 2023, the Inquiry published an addendum to the Terms of Reference, following the provision of new information to the Inquiry that suggested there may have been inappropriate behaviour in the mortuary at Kent and Sussex Hospital in the late 1990s.

The Inquiry investigated this new information in line with its Terms of Reference, which include assessment of the management of the mortuary, including the arrangements for security and access necessary to safeguard the bodies of the deceased.

This further investigation meant that the Inquiry was unable to publish its initial report on matters relating to the Trust before the autumn of 2023.

A final report, looking at the broader national picture and the wider lessons for the NHS and for other settings, is planned for publication in 2024.

The Inquiry will present the findings of both reports to the Secretary of State for Health and Social Care, who will make arrangements for their presentation to Parliament.

How we did our work

The Inquiry developed a methodology to investigate matters within its Terms of Reference. At all times the methods we used put the dignity of the deceased at the forefront of our considerations.

Detailed investigation of the offences committed by David Fuller was the role of Kent Police and the criminal courts, not the Inquiry. However, the Chair and his Independent Advisers considered it was important to the Inquiry's work to review a sample of the materials relied on by the police investigation relating to David Fuller's offending, to assist its understanding of the circumstances in which offences were committed. This was particularly important to understand whether there were missed opportunities to detect the offending when it was happening and missed opportunities to detect David Fuller's offending in any subsequent post-mortems. A selection of the offending material was considered by the Chair and Independent

Advisers under controlled conditions at Kent Police premises. Examination of the offending material was not available to, shared with or undertaken by the wider Inquiry team. The material is of great sensitivity and was only reviewed as far as strictly necessary to advance the Inquiry's work.

The involvement of the families of David Fuller's victims

The families and relatives of the victims of David Fuller were at the heart of the Inquiry and we began our work by talking with them. They were invited to private interview sessions at the Inquiry's hearing centre in Maidstone to tell us about how they had found out about David Fuller's crimes and the impact his offending had on them. If relatives were unable to come to the Inquiry's hearing centre, they were offered a session by video call or a visit to their home. The Inquiry recognised that listening to families would assist it in understanding how David Fuller's offending had affected them, and it wanted to seek their views on what needed to change to reduce the risk of similar offences happening again. Family members were offered access to a counsellor to support them to speak with the Inquiry. The Inquiry spoke to 54 family members, representing 33 of the victims.

Accounts of the impact of David Fuller's offending on the families of his victims are set out in Chapter 1. When we refer to the impact on families in this Report, we identify them by a unique number, rather than by their name. By this means, we protect them from being identified.

Witnesses

The Inquiry identified individuals it wanted to speak to so that they could provide evidence to assist it to fulfil its Terms of Reference. These individuals were identified either through their position at the Trust or other organisation, by others identifying them during interview, or by the Inquiry team identifying them through reviewing documentary evidence.

In addition to proactively identifying witnesses, the Inquiry undertook communications activity to encourage staff who worked at the Trust, including those employed by Interserve (Facilities Management) Ltd (Interserve) and then Mitie Group PLC (Mitie, the Trust's facilities management providers), to come forward if they had any information they thought would be of interest. This included a letter from the Chair to current and former staff who worked with David Fuller in the period 1989 to 2020, inviting them to get in touch with the Inquiry and including information about the Inquiry in the Trust's and Mitie's corporate communications to staff. The Inquiry team also contacted the chaplaincy team at the Trust and staff-side representatives, to let them know about the Inquiry's remit and to seek their support in encouraging staff to come forward. We also ran four drop-in sessions at the Trust, to give staff the opportunity to ask questions about the Inquiry's ways of working and find out more about how to contact us.

The Inquiry interviewed the following groups of people:

- those who came forward as a result of the Inquiry's communications activity;
- those who had worked alongside David Fuller in the Maintenance department;
- porters and domestics at the hospital;
- Interserve helpdesk staff;
- mortuary staff;
- senior staff at the Trust;
- senior staff at Interserve and Mitie; and
- representatives from the Human Tissue Authority, the Care Quality Commission, NHS England (the oversight and delivery organisation for the NHS), Kent County Council Coroner Service, East Sussex County Council Coroner Service and local funeral directors.

Interviews with witnesses were recorded and a transcript was subsequently made available to them, which they were asked to check for factual accuracy. The interviews were held in private to protect the dignity of the deceased and so witnesses could be candid in their evidence to the Inquiry. The Inquiry undertook 225 interviews during Phase 1. A list of witnesses can be found in Appendix 4. These evidence sessions were attended by at least two, usually three, members of the Inquiry team. Witnesses were asked questions in line with the Inquiry's Terms of Reference. Witnesses were also able to send documentary evidence to the Inquiry. We acknowledge that with the passage of time, the quality of the recollections of witnesses may vary. It is to be expected that individuals can recollect recent incidents and processes more clearly than those from a decade or more ago.

Witnesses were assigned a nominal number in order that their anonymity was maintained, to encourage them to be open with the Inquiry. Where possible we have maintained that anonymity, but in some cases where there are limited numbers of individuals occupying a position at any one time, the Inquiry recognises that it may be possible to identify a particular individual. In addition, where individual witnesses held or still hold positions which carry public or legal accountability for the organisation they represented at the Inquiry, they are named. Where witnesses were giving evidence on behalf of an organisation or corporate body, that organisation is named.

The Chair decided to name some individuals in the Inquiry's reports where there was good reason, and it was fair to do so. For those individuals whom we have named, we have included the role they held and the dates of tenure in the footnotes. In some cases, the dates of tenure given by the witness and the Trust, or the witness and Kent Police, have varied. In these cases, we have used the dates given by the Trust or Kent Police, as we considered these dates would be more accurate because of the information these organisations had available to them when compiling the dates.

We invited David Fuller to give evidence to the Inquiry and he agreed. His evidence to the Inquiry is included in the Inquiry's findings.

The Inquiry had no powers to compel people to give evidence, but the overwhelming majority of those whom we invited came and did so. The Inquiry's hearings being held in private may have encouraged this. A very small number of individuals refused to give evidence to the Inquiry and these are listed in Appendix 4.

Documentary evidence

The Inquiry reviewed over 3,700 pieces of documentary material in its investigations. This included Trust policies and procedures that were in place during the period David Fuller offended, Human Resources records, regulation and inspection reports, peer reviews of the mortuaries at the Trust, Trust Board and Trust Board committee papers, correspondence regarding David Fuller during his employment at the Trust and evidence provided to the Inquiry by Kent Police.

The Inquiry put information-sharing agreements in place with key organisations, for example, Maidstone and Tunbridge Wells NHS Trust and Kent Police, to ensure that documentation and other information was shared with the Inquiry securely.

Hindsight

In the course of writing this Report, the Inquiry has reflected on a time period from 1989 to 2020 to review the actions of David Fuller during his time working for the Trust.

This Report contains criticisms of a number of organisations and individuals. The Inquiry has conducted a Fairness Process which has involved writing to any individual or organisation who the Chair was minded to criticise in this Report, to provide them with an opportunity to respond to the summaries of the criticisms of them. The Chair carefully considered these responses and any information provided before making any final decisions on the Report text.

The criticisms within this Report include findings that individuals or organisations should or could have done certain things differently, or relate to omissions and failures to act which resulted in missed opportunities. In writing this Report and in making the findings within it, including the criticisms of individuals and organisations, the Inquiry has been careful to ensure that the judgements it has made are based on the information and evidence that was available at the time, not with hindsight. The Inquiry has therefore considered what an organisation or individual did or should have known at that time, as opposed to relying on the information and evidence that is now known and available.

The Inquiry has considered and assessed the evidence according to the applicable standards, processes and procedures in place at the relevant time, to inform its findings. We have not applied current standards, if they are different, to the time period which this Report covers.

The Chair acknowledges that in preparing this Report and making recommendations for the future, it is inevitable that a degree of hindsight will be applied to ensure that lessons are learned and that any mistakes made are not repeated.

The Inquiry cannot and does not make any findings that relate to civil and criminal liability, as this is not its role. The Inquiry has adopted the standard of proof as has been adopted by many other inquiries, which is a variable and flexible approach to determining factual issues.

Recommendations

All the evidence we gathered was analysed against the Inquiry's Terms of Reference and checked against the regulations, policy and NHS guidance in operation during the period of David Fuller's offending. Advice was sought from the Inquiry's Independent Advisers where necessary. The Inquiry's findings and recommendations are based on the analysis of the evidence we received.

The Chair of the Inquiry has made recommendations to the Secretary of State, the aim of which is to prevent a reoccurrence of these appalling offences. He has made these recommendations based on findings from the evidence that the Inquiry has collected and analysed.

Risks

We identified risks to the Inquiry throughout the course of our work. These were discussed by the Inquiry team at fortnightly meetings and mitigating actions were agreed. In its investigations, the Inquiry also identified some risks for the Trust and other organisations that compromised the safety of the deceased. These were escalated to the relevant organisation as soon as they were identified, in line with clause 10 of the Inquiry's Terms of Reference.

Appendix 2:

Terms of Reference

Background

1. 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 2008.
2. In January 2021, David 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.
3. Maidstone and Tunbridge Wells NHS Trust began an investigation into the activities of David Fuller 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 David Fuller'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 David Fuller'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 David Fuller's private sector employers who have been affected by David Fuller'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 David Fuller 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 David Fuller 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 David Fuller 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 David Fuller elsewhere on Trust premises.
- To review any evidence of complaints, concerns or incidents concerning David Fuller'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 David Fuller.
- 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 David Fuller.
- 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 David Fuller.
- 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 David Fuller'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.

Addendum

This is an addendum to the Terms of Reference that were published by the Inquiry on 23 February 2022. The addendum relates to points 4 and 11 of the Terms of Reference. New information has been provided to the Inquiry. The Inquiry will investigate this new information in line with its Terms of Reference which include assessment of the management of the mortuary, including the arrangements for security and access necessary to safeguard the bodies of the deceased.

This further investigation means that the Inquiry will now be unable to publish its initial report on matters relating to Maidstone and Tunbridge Wells NHS Trust before the Autumn 2023. A final report, looking at the broader national picture and the wider lessons for the NHS and for other settings is planned for publication in 2024. The Inquiry will present the findings of both reports to the Secretary of State for Health and Social Care, who will make arrangements for their presentation to Parliament.

Appendix 3: Team members

Members of the Inquiry team

Sir Jonathan Michael, Chair of the Inquiry (from November 2021)

Rebecca Chaloner, Secretary to the Inquiry (from November 2021)

Jane Campbell, Deputy Secretary to the Inquiry (from November 2021)

Kathryn Whitehill, Head of Investigations (from September 2022)

Louise Thatcher, Head of Investigations (November 2021 to June 2022)

Peter Burgin, Policy Lead (from December 2021)

Robert Duff, Head of Engagement (January 2022 to June 2023)

Yvonne Waring, Business Manager (from January 2022)

Henny Goddard, Policy Support Officer (from July 2022)

Carmen Elliott, Policy Support Officer (March 2022 to December 2022)

Legal representatives

Tim Suter, Partner, Public Regulatory, Fieldfisher

Laura Penny, Senior Associate, Fieldfisher

Alice Boydell, Associate, Fieldfisher

Liah Roberts, Solicitor, Fieldfisher

Independent Advisers

Professor Michael Osborn, MRCS FRCPath, President, Royal College of Pathologists
19 November 2020 to 16 November 2023, Clinical Lead Cellular Pathology, North West
London Pathology

John Pitchers, MSc, FAAPT, FRSPH, MIBMS, Chair, Association of Anatomical Pathology
Technology, Service Manager, Mortuary and Coroner Support, Legal and Democratic
Services, Bristol City Council

Communications

Simon Whale, Managing Director, Luther Pendragon

Jennifer Evans, Associate Director, Luther Pendragon

William Gray, Associate Director, Luther Pendragon

Tabitha Adams, Senior Consultant, Luther Pendragon

Adrian Dias, Head of Luther Studio, Luther Pendragon

Appendix 4: Witnesses

The Inquiry heard evidence from a total of 200 witnesses who knew David Fuller in an employment context, or who could offer insight on related matters. The 200 witnesses included current and former staff who worked in the relevant organisations during the 25-year period covered by the Inquiry. Some witnesses were interviewed more than once. A total of 225 sessions were held. The majority of sessions were held in person, with some taking place online. Three of the 200 witnesses did not attend an in-person session but provided a witness statement.

The 200 witnesses included:

- David Fuller;
- staff at Maidstone and Tunbridge Wells NHS Trust (the Trust) (and predecessor organisations), comprising:
 - 31 in senior positions;
 - 20 connected to the mortuary;
 - 25 porters and domestics;
 - eight pathologists;
 - 16 in security, estates and facilities;
 - 13 others (e.g. clinical staff); and
 - two non-Trust staff working on behalf of the Trust;
- 30 Interserve (Facilities Management) Ltd (Interserve) staff (including those whose employment transferred from the NHS to Interserve);
- eight senior Mitie Group PLC (Mitie) staff;
- 24 staff working for regulators and assurance bodies, comprising:
 - the Human Tissue Authority (15 witnesses);
 - the Care Quality Commission (three witnesses);
 - NHS England (two witnesses);
 - UK Accreditation Service (UKAS) (one witness);
 - NHS Kent and Medway (one witness);
 - the Health and Care Professions Council (one witness); and
 - the Health and Safety Executive (one witness);

- 11 coronial services staff at Kent County Council and East Sussex County Council, and senior coroners:
 - Ms Patricia Harding, Senior Coroner, Mid Kent & Medway;
 - Mr Roger Hatch, Senior Coroner, North West Kent; and
 - Mr Alan Craze, Senior Coroner, East Sussex;
- seven funeral directors and other funeral sector providers local to the Trust; and
- others, including the Special Purpose Vehicle Project Manager, an agency nurse and an Executive Director from South East Coast Ambulance Service NHS Foundation Trust.

Almost all the witnesses invited to give evidence to the Inquiry did so. Those below were invited to provide evidence to the Inquiry, and could have provided useful insight, but declined to come forward:

- Karen Calder – former mortuary technician, Maidstone and Tunbridge Wells NHS Trust;
- Ronnie Horton – Interserve engineer; and
- Neil Bridges – Interserve helpdesk.

The organisations that provided evidence included:

- Maidstone and Tunbridge Wells NHS Trust;
- the Human Tissue Authority;
- UK Accreditation Service (UKAS);
- the Health and Care Professions Council;
- Mitie (including former Interserve);¹
- Kent and East Sussex Weald Hospital Ltd;
- the Care Quality Commission;
- NHS Kent and Medway Clinical Commissioning Group (now NHS Kent and Medway Integrated Care System);
- NHS England;
- South East Coast Ambulance Service NHS Foundation Trust;
- Kent County Council Coroner Service;
- East Sussex County Council Coroner Service; and
- the Health and Safety Executive.

¹ David Fuller was employed by Interserve from 2011 to 2020. In December 2020, Interserve's facilities management business was acquired by Mitie. Given that David Fuller's employment was with Interserve (save for two days at the end of his contract), the Inquiry refers to Interserve rather than Mitie in this Report. However, as Interserve's facilities management business has now been acquired by Mitie, the Inquiry engaged with Mitie where necessary in relation to its work on the Report.

Appendix 5:

Glossary of terms

Definitions of terms used within this Report.

Sources for the following definitions are: Association of Anatomical Pathology Technology (AAPT); Courts and Tribunals Judiciary; GOV.UK; Health and Safety Executive (HSE); House of Commons scrutiny paper; Human Tissue Act 2004; Human Tissue Authority (HTA); International Organization for Standardization (ISO); NHS; NHS Confederation; NHS England; NSPCC; Royal College of Pathologists; UK Accreditation Service (UKAS).

A&E – Accident and Emergency department.

AAPT Level 3 standards – Level 3 Diploma in Healthcare Science (Anatomical Pathology Technology) awarded by the Royal Society for Public Health.

Anatomical pathology technologist (APT) – Carries out a range of tasks related to different aspects of mortuary work, including assisting pathologists during a post-mortem examination to determine cause of death.

Association of Anatomical Pathology Technology (AAPT) – The professional body for APTs employed in hospital and public mortuaries.

Automatic barring offences – Certain serious offences for which anyone convicted or cautioned will be barred from working in regulated activity with children and/or vulnerable adults, subject to the consideration of representations where permitted.

Bariatric bodies – Larger deceased people.

Bariatric trolley – Mortuary trolley designed for the movement of bariatric bodies.

Biomedical science – Scientific tests to support the diagnosis and treatment of disease. Biomedical scientists conduct these tests in laboratories.

Body store – A mortuary that is used for the storage of deceased people.

Building management system (BMS) – A computer-based system installed to control and monitor building services, such as electrical equipment.

Care Quality Commission – The independent regulator of health and adult social care in England.

Cellular pathology – The study of organs and tissues to diagnose illness. Cellular pathologists analyse the causes of certain diseases and the effect they have on the body.

Clinical commissioning group (CCG) – A clinically led organisation with responsibility for commissioning healthcare services for a locally defined population. Superseded from July 2022.

Clinical Pathology Accreditation (CPA) – Provided accreditation to medical laboratories performing testing for the purpose of clinical diagnosis, prior to becoming a wholly owned subsidiary of the UK Accreditation Service (UKAS).

Clostridium difficile – A bacterium that can infect the bowel and cause severe diarrhoea, bowel damage and even death. The infection most commonly affects people who have recently been treated with antibiotics but can spread easily to others.

Consent – Under the Human Tissue Act, consent is required for the storage and use of the body of a deceased person and the removal, storage and use of material from the body of a deceased person for use for all scheduled purposes, including determining the cause of death.

Consultant pathologist – A senior doctor who works in hospitals and laboratories on different areas of prevention, diagnosis and treatment of disease.

Continuing Professional Development (CPD) – The ongoing process of improving employees' skills to enhance workplace performance and career paths.

Coroner – Independent judicial office holders, with the legal authority to investigate any death if there is a reason to suspect that: the death was violent or unnatural; the cause of death is unknown; or the deceased died while in state detention.

Coronial cases – Deceased people whose death is under investigation by the coroner.

Coronial post-mortem examination – A post-mortem examination to determine the cause of death instructed to take place by the coroner investigating the death.

Corrective and Preventative Action (CAPA) Plan – Corrective action plan following HTA inspection.

Criminal Records Bureau (CRB) – Established in 2002 providing wider access to criminal record information through its Disclosure Service for England and Wales. It became part of the Disclosure and Barring Service in 2012.

Department of Health and Social Care (DHSC) – The UK government department responsible for government policy on health and adult social care.

Designated Individual (DI) – A person with a legal duty to ensure that the statutory and regulatory requirements of the Human Tissue Act are met. They are responsible for supervising licensed activities and ensuring that suitable practices are taking place.

Director of Infection Prevention and Control (DIPC) – A statutory role, required of all registered NHS care providers, with the authority and responsibility for ensuring that strategies are implemented to prevent avoidable healthcare-associated infections.

Disclosure and Barring Service (DBS) – An executive non-departmental public body, sponsored by the Home Office. Processes and issues DBS checks for criminal convictions.

Docket – A document or label that shows what is in a package and details the task to be completed.

End of Life Care (EoLC) – A core service that can form part of a Care Quality Commission inspection.

Evisceration – The process of removing organs from the inside of a body.

Executive non-departmental public body (ENDPB) – A body that has a role in the processes of national government but is not a government department or part of one, and which operates to a greater or lesser extent at arm's length from ministers.

Financial special measures – National-level support to NHS trusts in England to address unsustainable financial deficits.

Fitness to practise – The process that health and care regulators use to determine if a registered healthcare professional is competent and fit to practise.

Forensic fridges – A refrigerated unit in which the deceased are securely placed while investigations into deaths that may have been caused, or contributed to, by a criminal act are conducted.

Forensic post-mortem examination – A more detailed post-mortem examination conducted to assist the investigation of homicide or suspicious death, performed by a Home Office-registered forensic pathologist.

Forensic psychologist – Studies criminal behaviour and helps people who have committed crimes.

Grooming – When someone builds a relationship, trust or emotional connection with another person so that they can manipulate, exploit or abuse them.

Health and Care Professions Council (HCPC) – Statutory regulator of 15 health and care professions in the UK, including biomedical scientists.

Health and Safety Executive (HSE) – Statutory regulator of workplace health and safety.

Health and Safety Executive improvement / prohibition notice – Issued by the Health and Safety Executive under the Health and Safety at Work etc. Act 1974, where there is contravention of statutory provisions.

Health Building Note (HBN) – Gives best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

Healthcare Commission – The Commission for Healthcare Audit and Inspection, also known as the Healthcare Commission, was created in 2004. It was responsible for assessing standards of care provided by the NHS. Its responsibilities were taken over by the Care Quality Commission in 2009.

Histopathologist – A medically qualified doctor, trained as a pathologist, who specialises in the study of changes in tissues, organs and the body caused by disease.

Honorary contract – Where an employee of another organisation, or a self-funded person, undertakes a period of work, research or training at another organisation but will not be paid by that organisation.

Human tissue – Relevant material from a human body as defined in the Human Tissue Act 2004, section 53, as “*relevant material, other than gametes, which consists of or includes human cells*”, with the exception of embryos outside the human body and hair and nail from the body of a living person.

Human Tissue Act 2004 – An Act to make provision with respect to activities involving human tissue; to make provision about the transfer of human remains from certain museum collections; and for connected purposes.

Human Tissue Authority (HTA) – The regulator of human tissue and organs. A non-departmental public body of the Department of Health and Social Care.

Human Tissue Authority Codes of Practice – Guidance for professionals carrying out activities within the scope of the Human Tissue Authority’s remit.

Human Tissue Authority licence – The Human Tissue Authority licenses a number of activities relating to human tissue, including storage for the purposes of post-mortem examination.

Human Tissue Authority licence conditions – Actions which must be achieved (sometimes within a prescribed timescale) to reach the required standards. Conditions are statutory, standard or additional. Statutory conditions are set out in the Human Tissue Act 2004 and the Human Tissue (Quality and Safety for Human Application) Regulations 2007. Standard conditions are applied to all licences (or a subset of them) by the Human Tissue Authority. Additional conditions are specific to a licence.

Human Tissue Authority Licence Holder – A Licence Holder can be an individual or a corporate body. The role of Licence Holder does not impose the duties that are expected of the Designated Individual but does have the right to apply to the HTA to vary the licence.

Human Tissue Authority licensed activity / scheduled activity – Activities as set out in Schedule 1 of the Human Tissue Act 2004, ‘Scheduled purposes’.

Human Tissue Authority Reportable Incidents (HTARI) – Establishments licensed in the post-mortem sector are required to notify the Human Tissue Authority of serious incidents and near-miss incidents that may affect the dignity of the deceased and damage public confidence.

International Organization for Standardization (ISO) – Develops and publishes international standards.

ISO 15189 – Specifies requirements for quality and competence in medical laboratories and can be used by medical laboratories to develop their quality management systems.

Local Security Management Specialist (LSMS) – A role introduced by *Directions to NHS bodies on Security Management Measures 2004*, requiring each NHS body to appoint an LSMS.

Master key – A key that can be used to open any of several different locks.

Medical certificate of cause of death (MCCD) – Certified cause of death by the attending doctor. An MCCD enables the death to be registered.

Memorandum of Understanding (MoU) – Written agreement between two or more parties setting out mutually agreed ways of working or understanding.

Mortuary – A place where deceased people are placed. A mortuary can provide storage only, or conduct activities as set out in the Human Tissue Act 2004, such as post-mortem examination, where licensed by the Human Tissue Authority to do so.

Mortuary logbook – A register of deceased people brought to the mortuary.

Necrophile – A person who is sexually attracted to deceased people.

Necrophilia – Sexual activity with deceased people.

NHS Agenda for Change – The NHS pay system comprising nine pay bands. Covers all NHS staff except doctors, dentists and very senior managers.

NHS England (NHSE) – Provides national leadership for the NHS in England. It is an executive non-departmental public body of the Department of Health and Social Care, established in 2013.

Non-executive director – Provides independent oversight and challenge to the executive directors of an organisation.

Pathology – The study of disease, providing advice on the nature, cause and seriousness of a patient's illness.

Personal protective equipment (PPE) – Workers may need to use PPE (e.g. gloves, eye protection) to perform their work safely.

Persons Designated – Persons Designated assist Designated Individuals in ensuring compliance with Human Tissue Authority standards. Persons Designated can assist with developing procedures, as well as reporting incidents.

Pneumatic tube / pod system – A computerised tube-based system powered by compressed air to transport samples and specimens around a hospital.

Post-mortem examination (PME) – Examination of a body after death to determine the cause of death.

Primary care trust (PCT) – An NHS organisation that commissions healthcare services for a defined local population and works with local authorities and other agencies in a local community. Superseded by clinical commissioning groups from April 2013.

Private Finance Initiative (PFI) – A type of public-private partnership (PPP) used to fund major capital investments. With PFIs, the private sector is typically responsible for designing and building the asset, raising the necessary finance and then also operating a service that uses the asset. This type of arrangement is now common for roads, prisons, hospitals and schools.

Quality account(s) – A statutory requirement for an NHS healthcare provider to produce an annual report about the quality of services provided.

Retained tissue – Tissue that has been retained for a specific purpose under the Human Tissue Act 2004. A system of traceability should ensure that tissue is not retained beyond the purpose for which it was harvested.

Safeguarding – Protecting those whose needs mean that they are more vulnerable to abuse and neglect.

Satellite premises – Other locations covered by a Human Tissue Authority licence, often in a ‘hub and spoke’ model, with different premises carrying out different licensable activities.

Serious Untoward Incident (SUI) – A classification of safety incident, used by the NHS, with associated processes designed to help ensure that serious incidents are correctly identified and investigated, and the lessons for patient safety learned.

South East Coast Ambulance Service NHS Foundation Trust (SECAMB) – The ambulance service for the area covered by Maidstone and Tunbridge Wells NHS Trust.

Special Purpose Vehicle (SPV) – A third-party company established to implement a Private Finance Initiative project.

Standard Operating Procedures (SOPs) – Instructions to perform a specific task.

Strategic health authority (SHA) – An organisation that leads the strategic development of a local health service, including managing primary care trusts and NHS trusts. Superseded from April 2013.

Swipe card – A plastic card with magnetically encoded information to allow access to premises for authorised individuals.

Traceability – A system to ensure that tissue retained for a purpose under the Human Tissue Act 2004 is tracked through to repatriation with the body of the deceased or to disposal.

Transfer of Undertakings (Protection of Employment) (TUPE) – When a business changes owner, the terms and conditions of employment of its employees in the UK may be protected under the Transfer of Undertakings (Protection of Employment) Regulations 2006.

Trust Development Authority (TDA) – A special health authority responsible for overseeing the performance management and governance of NHS trusts, including clinical quality, and managing their progress towards foundation status. Became part of NHS Improvement in 2016. Merged with NHS England in July 2022.

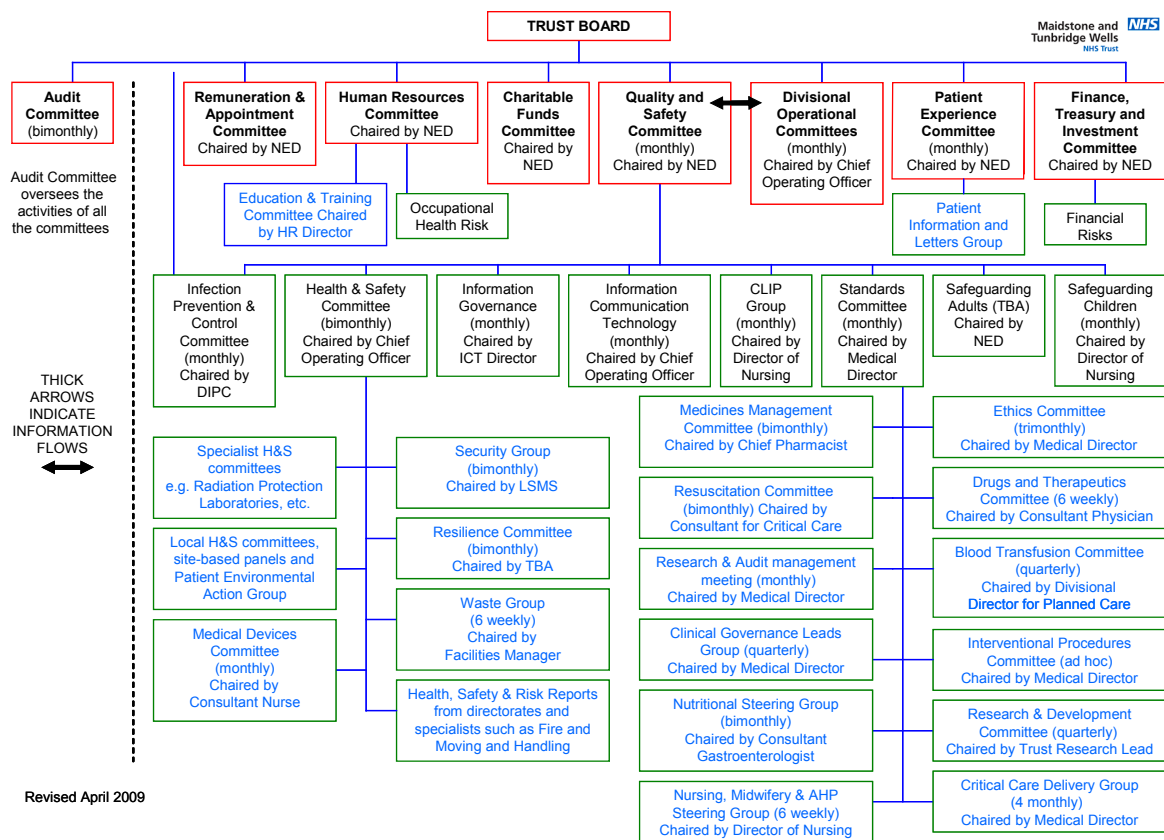
UK Accreditation Service (UKAS) – The national accreditation body for the UK that assesses and accredits organisations that provide services, including certification, testing, inspection and calibration.

Unitary board – Where at least half of the board is made up of independent non-executive directors, and all the directors are collectively and corporately accountable.

Verita – An investigations company providing advice to regulated organisations in the UK.

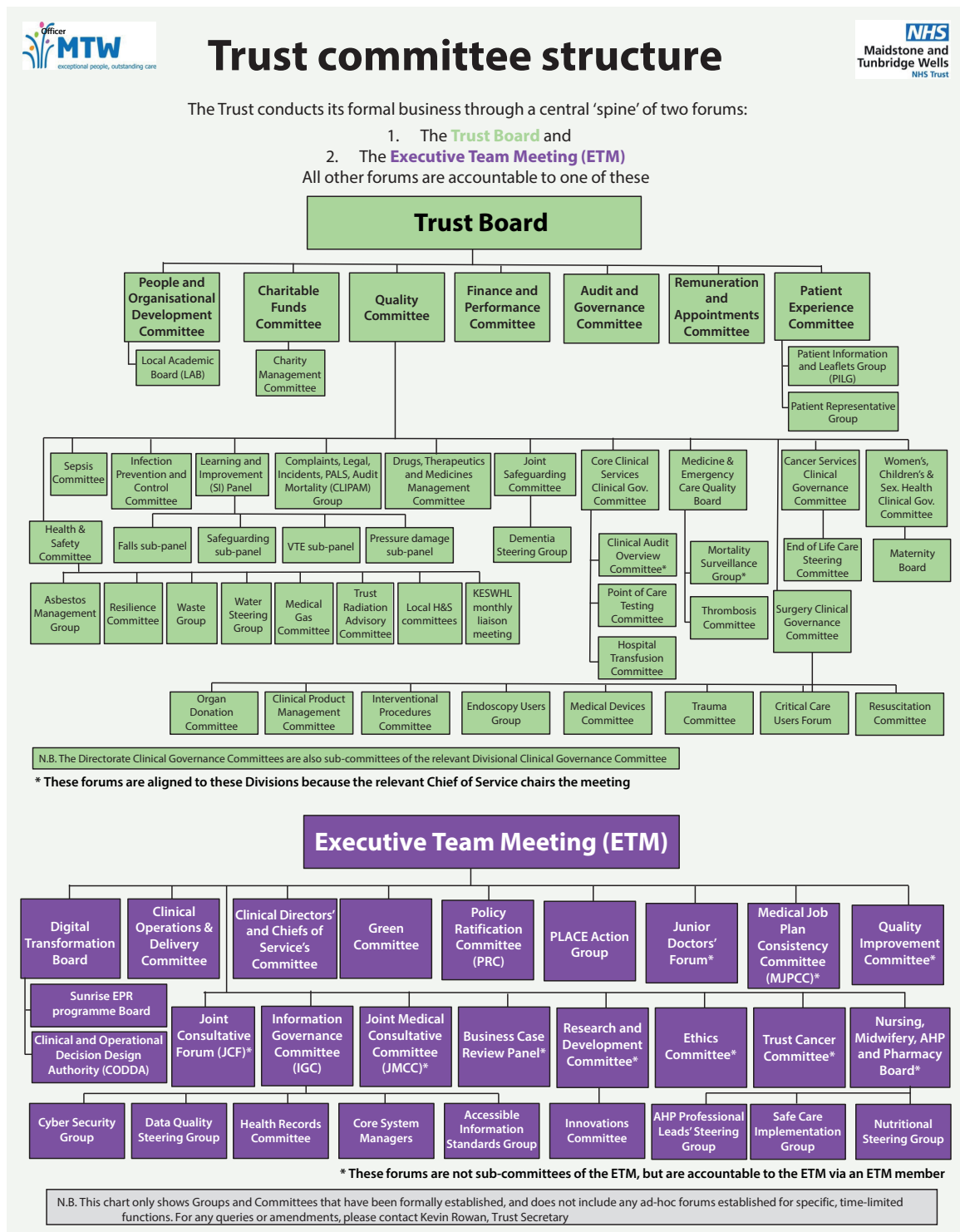
Appendix 6: Governance structures

Figure 7: Trust governance structure, April 2009



Source: Maidstone and Tunbridge Wells NHS Trust.

Figure 8: Trust Board committee structure, September 2017



Source: Maidstone and Tunbridge Wells NHS Trust, Risk Management Policy and Procedure, Appendix, as ratified by Board, September 2017.

