OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 29 May 2024

Agenda item	Fuller Inquiry Phase 1 Report
Board Lead	Chief Operating Officer
Author	Joanna James, Trust Board Business Manager
Appendices	Phase 1 Inquiry Report *available in the Reading Room or via* https://fuller.independent-inquiry.uk/report/
Purpose	Information
Previously considered	n/a

Executive summary

The independent inquiry into the issues raised by the David Fuller case was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone & Tunbridge Wells NHS Trust (MTW) and why they went apparently unnoticed.

The first phase of the inquiry concluded in November 2023 with the publication of the Phase 1 Report. This focussed on matters relating to MTW and seventeen recommendations were made. Whilst the majority of these relate to the mortuary directly, others concern criminal record checking, safeguarding and dignity of the deceased more broadly as well as the need to review governance and assurance structures, for example.

Related to events at MTW and the subsequent Inquiry, mortuary services at Buckinghamshire Healthcare NHS Trust (BHT) have been subject to a number of reviews and have been required to provide information to various sources since 2021. The paper provides more detail of these but, in summary, where any gaps in controls or areas of non/partial compliance were identified, action plans were put in place. All such actions have either been completed or are track for completion by due dates.

Phase 2 of the Inquiry will look at the broader national picture and consider if procedures and practices in other hospitals safeguard the security and dignity of the deceased. Further information will be provided to the Trust Board once the Phase 2 report has been published.

Decision	The Board is requested to note the report for information.

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☐	Great Place to Work ☒	Net Zero ☐

Relevant objective

☐ Improve waiting times in ED ☐ Improve elective waiting times ☐ Improve safety through clinical accreditation	☐ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact

Patient Safety	The inquiry report highlights the importance of treating the deceased with the same regard to safeguarding as other patients
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards

	Principal Risk 8: Failure to learn, share good practice and continuously improve
Financial	There are no financial implications of this report.
Compliance	The Human Tissue Act 2004 sets out the legal framework for regulating the use of human tissue from the deceased The Human Tissue Authority is the independent regular of organisations that remove, store or use human tissue for research, medical treatment and post-mortem examination.
Partnership: consultation / communication	As per the information in the paper, the Trust has worked collaboratively with both the HTA and the Internal Audit team during recent reviews of practice.
Equality	The inquiry highlighted the importance of treating the deceased with the same regard to dignity as other patients.
Quality Impact Assessment [QIA] completion required?	n/a – report for information

1. **Introduction**
   The independent inquiry into the issues raised by the David Fuller case was established to investigate how he was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone & Tunbridge Wells NHS Trust (MTW) and why they went apparently unnoticed.

   The first phase of the inquiry concluded in November 2023 with the publication of the Phase 1 Report. This focussed on matters relating to MTW whilst Phase 2 will look at the broader national picture and consider if procedures and practices in other hospitals safeguard the security and dignity of the deceased. Phase 2 will also review the adequacy and effectiveness of regulatory arrangements for the care of the deceased.

2. **Timeline of events related to the independent inquiry**
   David Fuller was an electrical maintenance supervisor working at MTW, having joined Kent and Sussex Hospital in 1989. In December 2020, he was arrested for two murders committed in 1987. A related search of his home uncovered video and photographic events of wrongdoings in the MTW mortuary between 2005 and 2020.

   Following his arrest, in February 2021 the Board of MTW commissioned an independently chaired internal investigation which considered how the mortuary offences could have taken place without detection, lessons the Trust could learn and addressed those most likely questions of victims' families and key stakeholders. The investigation was limited to a desktop review due to constraints imposed by ongoing criminal proceedings.

   Following the receipt of an initial briefing from the investigation, in October 2021 NHS England (NHSE) contacted all NHS Trusts that provided either mortuaries or body

stores and asked them to ensure both compliance with existing guidance from the Human Tissue Authority (HTA) and implementation of four actions. These related to security and access arrangements for mortuaries, effective CCTV coverage of mortuary areas, completion of risk assessments related to the operation, security and construction of the mortuary/body store and appropriate DBS checks for all relevant employees/contractors. NHSE requested NHS Trust Boards formally reviewed evidence of compliance with these requirements and subsequently confirm to NHSE that they were satisfied appropriate responses had been taken.

In November 2021, the Trust-commissioned investigation was replaced by an Independent Inquiry to build on the work of the initial investigation. Phase 1 of the inquiry completed in 2023 and the report was published in November. The report summarises accounts of affected families, the nature and patterns of the offences that occurred, the employment and working practices of David Fuller, mortuary management and oversight, security, governance and accountability arrangements within the Trust and Trust culture.

The report can be found in full here www.gov.uk/government/publications/david-fuller-inquiry-phase-1-report

3. Summary of the recommendations

The findings of the inquiry were extensive and the majority related to activities undertaken in, or related to, the mortuary directly. For example, allowing individuals to undertake maintenance unaccompanied within the mortuary, access to the mortuary overall, appropriate use of CCTV, adequate leadership of mortuary staff, sharing of relevant reports and executive and board oversight.

Outside of the issues highlighted with the mortuary specifically, the inquiry highlighted a number of other points of concern.

a) Trust processes, and evidence of following such, related to DBS checks and the completion of risk assessments (where required).
b) Compliance with Trust Standard Operating Procedures (SOPs) more broadly.
c) Breach of contract between the Trust and the private company contracted to provide the 'hard' facilities management (FM) services. This was in relation to point (a).
d) Inadequate security arrangements across the hospital estate coupled with no understanding of such by the Trust Board.
e) Overly complicated governance structures and reporting arrangements.
f) Poor triangulation of information between departments of the Trust and externally between various organisations including regulators and those with oversight functions.

A total of 17 recommendations were documented within the report and are summarised below. These reflect the findings of the inquiry.

Sixteen of these recommendations related to the Trust. MTW must:

1) 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.
2) Assure itself that all regulatory requirements and standard relating to the mortuary are met and that the practice of leaving deceased people out of the mortuary fridges overnight, or whilst maintenance is undertaken, does not happen.

3) Assure itself that it is compliant with its own 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.
4) Assure itself that its mortuary managers are suitably qualified and have relevant anatomical pathology technological experience. The mortuary manager should have a clear line of accountability within the Trust management structure and must be adequately managed and supported.
5) Ensure the role of mortuary manager is 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 appropriate level of management attention.
6) Review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.
7) Audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.
8) Treat security as a corporate not local departmental responsibility.
9) Install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.
10) Ensure that footage from the CCTV is reviewed on a regular basis by appropriate trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.
11) Proactively share Human Tissue Authority (HTA) reports with organisations that rely on HTA licencing for assurance of the service provided by the mortuary.
12) Review its governance structures and function in light of the finding that the Trust relied on reassurance rather than assurance in monitoring its processes.
13) Have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual (DI) is actively involved in reporting to Board and is supported in this.
14) Treat compliance with HTA standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the DI.
15) Make the Chief Nurse explicitly responsible for assuring the Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.
16) Must treat the deceased with the same due regard to dignity and safeguarding as it does other patients.

One recommendation applied to local partners as follows:

17) Kent County Council and East Sussex County Council should examine their contractual arrangements with MTW to ensure they are effective in protecting the safety and dignity of the deceased.

4. Local context

Buckinghamshire Healthcare NHS Trust (BHT) undertook a gap analysis against the above recommendations (1-16) and confirm compliance with fifteen of these and partial compliance with the remaining one.

Since 2021, a number of reviews have been undertaken related to services at BHT and the table overleaf details these.

	Purpose	Conclusion	Actions
NHS England (NHSE) October 2021	Request made by NHSE (then NHS England & NHS Improvement) to undertake a review of practices within the mortuary and ensure a number of actions were implemented.	Internal review undertaken as requested.	Full/partial compliance with all actions presented to the Executive Management Committee in November 2021. This included an action plan to address the one area of partial compliance.
HTA Inspection October 2022	The Trust underwent an inspection as part of its five-year inspection cycle to review compliance with its licence (previous inspections undertaken in 2012 and 2017).	The inspection identified 7 'shortfalls' recognising this as a small number compared to organisations of a similar size. These were categorised as major, of which there were two and minor, five.	Major shortfalls are required to be completed within 2 months and minor shortfalls within 4 months. A Trust-led action plan was set and monitored by the HTA, DI and Executive Lead. All actions were completed accordingly.
Review by Internal Auditors (RSM) June 2023	An audit of mortuary security arrangements was undertaken as part of the internal audit plan for 2022/23. The purpose of the review was to assess the control framework in place at the Trust for its mortuary security arrangements	The review identified controls were well designed in relation to mortuary access and processes were in place to learn from mortuary related incidents as well as the dissemination of HTA reports. Overall 'reasonable assurance' opinion provided.	Where gaps in controls were identified, these were addressed with a number of 'management actions'. All high priority actions have been completed. Two medium priority actions remain outstanding but are on track for implementation in line with the due datea.
Fuller Inquiry Phase 2 Questionnaire February 2024	The questionnaire was sent to all NHS Trusts as part of phase 2 of the Inquiry. It was used to support an understanding of the processes and practices in place to safeguard the deceased within hospitals.	Questionnaire completed and submitted to the Inquiry team ahead of the March deadline.	n/a
HTA Inspection February 2024	The HTA made an unannounced visit to the mortuary at Stoke Mandeville Hospital following the raising of a concern related to body storage. This was outside of the five-year inspection cycle as listed above.	The inspection highlighted 3 'shortfalls'; two minor and one major. Overall, feedback was positive.	The final report was received by the Trust in April 2024. A detailed action plan, addressing the shortfalls, was subsequently submitted to the HTA and presented to the Executive Management Committee (May 2024)

5. **Action required from the Board/Committee**
   Trust Board are requested to note this paper for information. Further information will be provided to the Board on the publication of the Phase 2 report.

APPENDICES

Appendix 1: Independent Inquiry into the issues raised by the David Fuller case: Phase 1 Report