Item: Maidstone and Tunbridge Wells NHS Trust – mortuary security

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 17 July 2024

Subject: Maidstone and Tunbridge Wells NHS Trust – mortuary security

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Maidstone and Tunbridge Wells NHS Trust (MTW).

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1) Introduction

a) In November 2021, evidence came to light of many crimes committed by David Fuller whilst employed as a maintenance supervisor at Maidstone and Tunbridge Wells NHS Trust (MTW).

b) MTW initiated an independent investigation into the specific offences but on 8 November 2021 the Secretary of State announced this was being overtaken by an independent inquiry led by Sir Jonathan Michael. The Inquiry was to consider issues including:

i. the circumstances surrounding the offences committed at the hospital, and their national implications,

ii. understanding how these offences took place without detection in the trust,

iii. identifying any areas where early action by this trust was necessary, and

iv. consideration of wider national issues – including for the NHS.

c) The inquiry was initially expected to produce an interim report (into the activities carried out at MTW) in 2022 with a final report (into the broader national picture and wider lessons) in 2023. However, new information which came to light led to a delay in the interim report, and the final report is due for publication in 2024.

d) HOSC has received reports at both its March 2022 and December 2023 meetings. Whilst the inquiry has been ongoing, HOSC's scrutiny into this area has been necessarily limited. The Committee cannot investigate individual cases, but it can consider what steps the Trust has taken to prevent such events happening in the future.

e) The interim report was published on 28 November 2023, and representatives from the Trust attended HOSC on 7 December 2023. Below is a summary of the discussion:

i) A phase 2 report, looking at the broader national picture and the practices and procedures in place to protect the deceased in the NHS and other settings, is planned for publication at a later date.

ii) The phase 1 report had 17 recommendations (see appendix 1), 16 of which were for the Trust. The Maidstone and Tunbridge Wells Trust had accepted all the recommendations and 11 had already been implemented, with the remaining 5 being worked on. All recommendations were expected to be implemented by March 2024.

iii) Mr Scott, the Trust's Chief Executive Officer, offered to return to HOSC once all recommendations had been implemented.

f) The Trust are attending the meeting today so provide an update on the final action above.

2) **Recommendation**

a) RECOMMENDED that the Committee consider and note the response of the Trust to the interim inquiry report.

Background Documents

Independent Inquiry into the issues raised by the David Fuller case, https://fuller.independent-inquiry.uk/

Kent County Council (2023), Health Overview and Scrutiny Committee (07/12/23), https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9319&Ver=4

Kent County Council (2022), Health Overview and Scrutiny Committee (2/3/22), https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8762&Ver=4

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Appendix 1

List of recommendations from the Independent Inquiry into the issues raised by the David Fuller case - Phase 1 Report

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.
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.
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.
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.
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.
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.
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.
8. Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.
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.
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.

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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.
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.
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.
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.
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.
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.
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.

Source: Independent inquiry into the issues raised by the David Fuller case: phase 1 report (print ready) (publishing.service.gov.uk)