Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

An assurance report for
the Secretary of State for Health

June 2014

Author:
Kate Lampard

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Appendices

1. Foreword

1.1 The Secretary of State for Health asked me in late October 2012 to provide independent oversight of the NHS and Department of Health investigations into matters relating to the late Sir Jimmy Savile ("Savile"). My remit was to assure the Secretary of State that the investigations into Savile's relationships with NHS organisations and his activities on their premises had been properly conducted.

1.2 The NHS has commissioned more investigations into Savile's activities over the last 20 months as new information has come to light. My remit has been extended to cover this work. My primary role remains one of independent oversight and assurance.

1.3 My brief came directly from the Secretary of State for Health and this report is written for him.

1.4 A number of commentators have questioned the purpose and value of conducting investigations into the allegations of sexual abuses by Savile so long after they are said to have occurred and when the perpetrator is dead. My work overseeing the NHS investigations and in due course reporting on the themes and lessons arising from them has given me the opportunity to reflect on that issue and to explore it with a wide variety of individuals, professionals and organisations with relevant interests or expertise, including in sexual offending, and the criminal justice system.

1.5 Victims deserve an explanation of what happened to them. And the investigation reports make clear that most of Savile's victims in NHS settings have welcomed the opportunity to give evidence and contribute to the process of uncovering the nature and extent of his abuses and understanding how those abuses were allowed to happen.

1.6 The NHS investigations into Savile's activities are a public demonstration that allegations of sexual abuse and misconduct are taken seriously and will be sensitively, and thoroughly investigated. I believe this will help to encourage victims to report abuse in future, and may deter others who might be minded to commit abuse.

1.7 Furthermore, the investigations have allowed NHS organisations to understand how Savile was able to use his celebrity, volunteering and fundraising activities to gain the access and power which gave him opportunities to commit sexual abuses in NHS hospitals.

By investigating and exposing these matters NHS and other public organisations have an opportunity to learn how to guard against a repetition of the Savile affair. They have brought to light some important issues which are of relevance for the NHS of today and need to be addressed.

2. The background

2.1 On 3 October 2012 ITV broadcast a documentary in its Exposure series in which five women made allegations of sexual abuse against Jimmy Savile. They said the abuse had taken place between 1968 and 1974 when they were teenagers. After the broadcast, the Metropolitan Police Service (MPS) took responsibility for assessing the women's claims and invited any others who said Savile had abused them to report it. The police operation was named "Operation Yewtree". Hundreds of people have since made allegations and given information to Operation Yewtree about sexual abuse committed by Savile and others.

2.2 After the broadcast and the setting up of Operation Yewtree, reports surfaced that Savile had committed sexual abuses at Stoke Mandeville Hospital, Leeds General Infirmary and Broadmoor Hospital. In the light of these reports and of the hospitals' long-standing associations with Savile, the NHS trusts responsible for the three hospitals, Buckinghamshire Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust and West London Mental Health NHS Trust/Department of Health began investigations[1].

2.3 The Secretary of State asked me at the end of October 2012 to oversee these investigations. My letter of appointment dated 29 October, which appears at appendix A, sets out the aim and purpose of my task:

> *"I would like you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interests of patients... It is planned that your advice on the robustness of the reviews undertaken and the reviews themselves will be made available to the public."*

2.4 MPS informed the Department of Health at the beginning of November 2012 about allegations that Savile had connections with and/or committed offences at other NHS hospitals and a non-NHS hospice named in the letter dated 6 December 2012 contained in appendix A .

[1] The Department of Health, previously the Department of Health and Social Security, ran Broadmoor from 1949 to 1989.

2.5 In February 2013 MPS passed to the Department of Health the details of the allegations and other information relating to Savile's alleged abuses at Stoke Mandeville, Leeds General Infirmary, Broadmoor and the 10 other hospitals and a hospice listed at appendix B. This information was passed by the Department of Health to the relevant NHS organisation in April 2013 and the investigations began.

2.6 MPS disclosed to me separately at the end of April 2013 that further reports and evidence from Operation Yewtree had yet to be processed and were likely to include allegations of abuses by Savile at other NHS hospitals. Police reviewed this material and passed it to the Department of Health in November 2013. It included a variety of information referring to further hospital sites. These sites are listed at appendix B. The Department of Health passed the material to the relevant organisations in November 2013. The investigation of information relating to The Royal Free hospital has disclosed that a purported victim denies she was abused by Savile and there are no further matters to investigate. As a result the hospital trust will not be publishing a formal report.

2.7 Information relating to Savile and Woodhouse Eaves Children's Convalescent Home, Leicester was passed to the University Hospital of Leicester NHS Trust in January 2014 and in April 2014 an allegation was made about Savile at Crawley Hospital.

2.8 Some of the information and evidence passed to the Department of Health at the end of 2013 referred to unidentified hospitals. The investigation team at Leeds Teaching Hospitals NHS Trust was asked to investigate the information and evidence in question. As a result of their investigations, the Leeds team were able to identify two further hospitals as being locations for alleged activities by Savile. These two hospitals are listed at appendix B. They set up investigations of their own in March 2014, but in the case of The Royal London hospital (Barts Health NHS Trust) further investigation has disclosed that there was no connection between Savile and the hospital and the hospital trust will not be publishing a formal report. The Leeds team's report of their work in relation to the allegations and evidence about unidentified hospitals is appended to their main report.

2.9 The Secretary of State wrote to me on 15 November 2013 asking for general assurance of the quality of the reports resulting from all the investigations beyond those at Leeds General Infirmary, Stoke Mandeville and Broadmoor. The letter to me appears at appendix A.

2.10 This report sets out the arrangements and processes by which my team(described in Chapter 3) and I have overseen the investigations into Savile's associations with NHS hospitals and assured ourselves of their rigour and robustness.

Further background

2.11 It became clear after my initial appointment to my oversight role that the number of allegations about Savile's behaviour and the likely scale and significance of the investigations into his activities would be greater than first thought. The Secretary of State wrote to me on 12 November 2012 and asked me to undertake further work to identify the themes to emerge from the investigations at Stoke Mandeville, Leeds General Infirmary and Broadmoor Hospitals and the Department of Health, and to look at NHS-wide procedures in that light.

2.12 After new NHS investigations had been set up, the Secretary of State asked me in letters dated 6 December 2012 and 15 November 2013 to ensure that my work to identify the issues and lessons for the wider NHS arising from the investigations into Savile's behaviour on NHS premises also took account of the conclusions of these new investigations.

2.13 The work on the themes and lessons learnt from NHS investigations about Savile will be the subject of a further report by me in due course.

3. The oversight team

3.1 I have been supported in my work by Ed Marsden, managing partner of Verita, a firm with experience of conducting complex investigations. We set up a sampling team led by Barry Morris, a partner of Verita, and including Jessica Martin, Tina Blaxill and Chloe Taylor. I detail the roles and work of the oversight and sampling teams later in this report.

4. Independent oversight

4.1 The Secretary of State wrote to the chair of the House of Commons Health Select Committee on 29 October 2012 in answer to a request for information about the investigations that at that stage had been set up by the three NHS trusts/Department of Health referred to in paragraph 2.2. His letter referred to my providing "independent oversight" of the investigations. The independent nature of my role was also emphasised in a further letter the Secretary of State wrote to me on 12 November 2012. He did not prescribe how I should fulfil my role, so my team and I have determined this for ourselves.

4.2 My team and I have taken it as our role to advise on the set-up and resourcing plans for the investigations and on the processes necessary to ensure that the investigations would be of a high standard and result in reliable and rigorous reports. We have set expectations, offered advice and tried to resolve any obstacles investigation teams have faced, particularly in their dealings with other agencies. However, we have been clear throughout that the NHS trusts and the Department of Health have retained responsibility for ensuring the performance management and progress of the investigations (although they have not been responsible for assurance of the process and content of reports). We have also been clear throughout that my obligation has been to give an independent and uncompromised assessment of the robustness of the investigations and the reports arising from them.

4.3 I realised when I was asked to undertake this work that the investigations I would have to oversee would encompass the nature and extent of the Department of Health's relationship with Savile. Accordingly I made plain to the Permanent Secretary of the Department of Health that I could take on this role only on an independent basis and would be accountable only to the Secretary of State for Health and not to Department of Health officials.

4.4 My team and I have however liaised with officials at the Department of Health to ensure that the investigations at Leeds, Stoke Mandeville and Broadmoor have been appropriately supported. The department has also worked with us to resolve common issues facing the investigation teams, such as the location of and access to historical NHS archives, and the sharing of information by the Metropolitan Police's Operation Yewtree. On occasions, I have had to provide advice to the Department of Health about actions that

could impinge on the quality of the investigations, including about matters to do with the timetable for completing the investigations.

4.5 In relation to all the other investigations, we have worked with the Department of Health to set out the expected standards of the investigations and the resulting reports and in identifying where investigation teams have been at risk of not meeting those expectations or have encountered particular obstacles.

4.6 I thank all those at the Department of Health who have worked with my team and me and have helped the investigation teams in the way I have described, in particular Richard Douglas, Isabel Letwin, William Vineall, Sheila Evans and Rowena Cahill.

5. Oversight arrangements for the different investigations

5.1 The three investigations set up to examine Savile's associations with Leeds General Infirmary, Stoke Mandeville and Broadmoor Hospitals have all been complicated, major investigations. They have considered very many allegations of abuse by Savile and the hospitals' associations with him over many years. The investigators have gathered and examined many documents and interviewed many witnesses. The work of the investigation teams at Leeds General Infirmary and Broadmoor Hospital has resulted in lengthy reports. My oversight of these investigations (which I refer to from now on as "the three main investigations") has involved my team and me in regular, in-depth engagement with the three trusts and their legal advisers (Capsticks), the investigation teams and the chairs of the panels providing local oversight of the investigations, to assess whether the investigations are progressing satisfactorily and to identify any risks and obstacles they might face.

5.2 The investigation team at Stoke Mandeville Hospital has recently received new evidence which has opened up further, important lines of inquiry. These need to be pursued before the investigation can be completed. The Stoke Mandeville investigation report will be assured by me in the same way as the Leeds General Infirmary and Broadmoor hospital reports.

5.3 The other 31 investigations at the hospitals listed at appendix B, (hereafter "the new investigations"), have in general been less wide-ranging and less complicated than the three main investigations. Many resulted from information, some of it anonymous, about Savile being seen at a hospital site and have not involved an allegation of abuse by him. Where an allegation of abuse has been involved, it is mostly a single allegation. The hospitals in question did not have close associations with Savile that the investigation teams have needed to examine and explain. My brief for these new investigations was to provide general assurance of the quality of the resulting reports. This oversight work has therefore been on a proportionately lesser scale and has largely consisted of offering advice to the investigators, obtaining general updates on their progress, and commenting on their reports.

5.4 I give more detailed accounts below of the different work done to date to oversee the three main investigations and the new investigations. This work continues in respect of the investigations that are not yet completed.

6. Oversight of the three main investigations

The investigation teams

6.1 When I started my work I wrote to the chief executives of Buckinghamshire Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust and West London Mental Health NHS Trust and the Department of Health enclosing:

- a broad description of how I intended to fulfil my role and the interventions that my oversight team would make in relation to their investigations
- high-level guidance on the conduct of investigations, setting out initial thoughts on the processes required to ensure that the investigations and the resulting reports would be robust
- an outline of the matters that I expected to be covered by the terms of reference for their investigations.

6.2 My letters, dated 5 November 2012, and their enclosures appear at appendix C to this report.

6.3 I suggested in my letters to the chief executives of the three NHS trusts and to the Department of Health (as a party to the Broadmoor investigation) that their investigations should be chaired by *"a non-executive director or equivalent"*. Each of the trusts identified a non-executive director to lead its investigation. However, as the scale and nature of the allegations and issues began to emerge, it became clear that it would be more appropriate for the investigations to be led and managed by people independent of the trusts and the Department of Health and with experience of undertaking high-profile, complicated investigations. The profiles of the investigation leads at Leeds General Infirmary and Broadmoor, are set out in their reports. The investigation leads, and the teams that have supported them, have the skills, experience and independence necessary for them to undertake their work and I am confident their work has been of a high standard.

6.4 The work of each investigation team has been supported and scrutinised by a local oversight panel chaired in the case of Buckinghamshire Healthcare NHS Trust and Leeds Teaching Hospitals NHS Trust by a non-executive director and in the case of the West

London Mental Health NHS Trust/ Department of Health investigation by the non-executive chair of the mental health trust.

6.5 My team and I have regularly met and spoken with the investigation leads. We have also met regularly with the chairs of the local oversight panels who agreed to ensure that the investigation leads would have the resources and the authority they needed to conduct their investigations rigorously and independently. I believe they have adhered to that agreement.

The assurance process: oversight activities

6.6 The oversight team has undertaken a series of activities designed to ensure that the three main investigations have been properly set up and adequately resourced, and have followed appropriate and thorough processes. Many of these activities were outlined in the attachment to my letter dated 5 November 2012 referred to above. We have done further work and intervened as required by the circumstances and issues that have arisen during the investigations. I describe below some of the activities we have undertaken so as to give a flavour of the oversight work. A full schedule of our work to date is at appendix D.

6.7 Very early on in the investigation process, and at regular intervals thereafter, we have met with MPS to ensure that we have understood the nature and extent of the matters that needed investigating, and to ensure that all relevant information has been shared between NHS investigation teams and MPS.

6.8 As the schedule of our work shows, the oversight team discussed and agreed with the chief executives of the three NHS trusts and the Department of Health (as joint commissioner for the Broadmoor investigation) the arrangements for the initial set-up of the investigations. The matters discussed and agreed included terms of reference, appointment of investigation leads and their teams and support for the investigation teams, such as the appointment of common legal advisers and the choice of document management systems. The appointment of Capsticks to act for the three NHS trusts and provide advice and support to the investigations has ensured a consistency of advice and approach. It has also avoided duplication of effort and the increased costs that would have arisen if each trust had employed different solicitors. Treasury Solicitors department also

provided independent advice to the investigation team for Broadmoor in view of the Department of Health/DHSS responsibility for the hospital in the relevant period under review. We held discussions with the chief executive of the NHS Litigation Authority to explore what would be done in relation to claims. This allowed the investigations to get underway.

6.9 The oversight team convened a workshop on 10 January 2013, attended by the trust chief executives, the investigation leads and teams, officials from the Department of Health, the non-executive chairs of the trusts' local oversight panels and Capsticks as well as representatives of the NHS Litigation Authority. The workshop discussed and agreed on roles and responsibilities; we clarified expectations for the investigations, including the need for them to be as comprehensive as possible; and we agreed on the methodology to follow. We also identified some common support needs, in particular in relation to interviewing and supporting victims of abuse.

6.10 We set out a timetable for the necessary stages of the investigations. We have kept in contact with the investigation teams and their work throughout, with regular meetings and phone calls with the leads and Capsticks, as well as through feedback from the sampling team whose work I describe below. We have helped the investigation teams by identifying issues that have had to be resolved collectively to ensure consistency and where necessary by agreeing with the Department of Health the means for doing so. Such issues have included, information-sharing with the police (which I consider in greater detail below) and ensuring appropriate national arrangements have been in place to support victims and witnesses wherever they live.

6.11 We commissioned the History and Policy department[1] at King's College London to hold a discussion event to help the investigation teams and to inform my own work on the lessons for the wider NHS of the Savile affair. We had presentations from eight historians from universities across the country whose expertise covers the culture and issues that formed the background to Savile's life and his offending on NHS premises. We had the opportunity to question the historians. Among the topics covered were: the changing sexual culture of the period in question; the shift in attitudes to celebrity and privacy; the legal status of and attitudes to victims of child sex abuse; charitable fundraising and volunteering in the NHS; NHS management structures and culture in the relevant period. I

[1] History and Policy is a collaboration between King's College London and the University of Cambridge. It consists of a national network of some 500 academic historians and publishes historical research to demonstrate the relevance of history to contemporary policy making.

believe the event provided the investigation teams with valuable understanding of the historical context for Savile's associations with NHS organisations and his offending on their premises, and a sound factual and evidential basis from which to draw conclusions.

6.12 Each investigation team has developed its own communications strategy aimed at encouraging victims and witnesses to come forward and give evidence. The Leeds and Broadmoor investigation teams describe their strategies in their reports. The oversight team and I discussed with the investigation teams whether a general and national call for evidence should be made but we saw no obvious or cost effective means of doing so. However, on 2 May 2013 I wrote to the chairs and chief executives of all NHS trusts and NHS foundation trusts in England and to clinical commissioning group (CCG) clinical leaders (see appendix E). I asked them to pass on to their staff a call for evidence in relation to my own work on the lessons for the NHS of the Savile affair and for any information relating to the existing investigations into alleged abuses by Savile that had not yet been shared with the investigation teams. This call for evidence was the subject of an article in the Health Service Journal on 2 May 2013.

6.13 Another workshop took place on 18 July 2013, attended by all the investigation leads and Capsticks. The investigation leads spoke about the themes and issues emerging from the separate investigations. We also discussed and advised on questions such as progress with information-sharing by MPS and other police forces, the extent to which victims and witnesses should be named or otherwise identified and the approach for interviewing witnesses common to all three main investigations. The workshop also discussed planning for the publication of the investigation reports and how victims and other witnesses should be involved.

6.14 In September 2013 the Broadmoor and Leeds investigation teams supplied drafts of their reports to the oversight team and in November 2013 the Stoke Mandeville investigation team supplied theirs. The oversight team offered comments on the structure and style of the reports, whether they adequately fulfilled the investigations' terms of reference, and whether the evidence as set out adequately supported findings and conclusions. We did not seek to question or influence the conclusions or judgements of the investigation teams.

6.15 Early in 2014 we discussed and agreed with the investigation teams a detailed plan and timeline for the required processes leading up to finalising and publishing the three

main reports, including fact-checking, the process for giving witnesses facing criticism the opportunity to answer those criticisms and the process by which commissioning trusts' boards would sign off reports.

6.16 We received final drafts of the Leeds and Broadmoor reports in late May and early June 2014. We approved the reports as a thorough and an appropriate response to the terms of reference but responsibility for the reports lay with the hospital trusts in question. The trust boards accepted the reports in June 2014.

The assurance process: sampling

6.17 The oversight sampling team has been concerned with ensuring that the investigation teams have followed due process. They have undertaken a structured programme for monitoring the work of the investigation teams, concentrating on areas of particular risk. Their programme was agreed with the investigation teams. The sampling team devised its programme by identifying the resources and processes needed to conduct a robust investigation within a reasonable time, and the risks to delivering such an investigation. The sampling team drew up a log for each investigation, setting out the matters on which they would seek evidence from the team and the type of evidence they would require. The purpose has been to provide assurance that the investigation teams have been appropriately resourced, that they have been following robust and reliable processes, and that the investigations have been progressing in a timely fashion. The sampling team's pro forma log is at appendix F.

6.18 The sampling team has visited each investigation team every four to six weeks, after which the logs have been updated. The sampling team's comments and observations have been discussed at each meeting and notes have been sent after the meetings to each investigation team. The visits have also been an opportunity for the investigation teams to discuss emerging themes and any procedural issues and difficulties and for the sampling team to offer advice and share information.

6.19 The sampling team has provided Ed Marsden and me with regular updates on progress by the investigation teams and any issues of concern. These updates have informed us about actions needing to be taken locally or collectively on behalf of all the

investigation teams to ensure that they have received the support and information they have needed.

6.20 The sampling team read the methodology section of the final drafts of the Leeds and Broadmoor investigation reports to ensure that process and risk issues are accurately reflected in the reports.

The availability of evidence and witnesses

6.21 The length of time since most of Savile's abuses occurred has presented those investigating Savile's activities in NHS hospitals with a difficulty. Much of the documentary evidence has been destroyed in line with relevant legislation and NHS policy, or has been dispersed to unknown or obscure locations. Nevertheless, the investigation teams have gone to great lengths to ascertain what documentary archives still exist and to locate and retrieve them. Where possible, they have also used non-NHS documentary resources such as the National Archives, local archives, and national and local media.

6.22 The Leeds and Broadmoor investigation teams describe in their reports their comprehensive work to identify and locate witnesses. Many witnesses who might have provided valuable and relevant evidence of Savile's time and activities in the NHS are dead, but most who are still alive have been interviewed. The investigation teams give details in their reports of any witnesses they have been unable to interview and the reasons for this.

The treatment of allegations

6.23 The terms of reference for the investigations required the investigation of allegations of abuses by Savile. The Secretary of State's letter appointing me asked me to satisfy myself that "*the Department and the relevant NHS organisations [were] taking all necessary steps to establish the truth*". In the circumstances, I have taken the view that the investigation teams should examine all available evidence relating to the alleged abuses and, so far as possible, come to conclusions about whether particular incidents of abuse did or did not occur.

6.24 My team and I emphasised to the investigation teams that they needed to keep in mind that Savile is dead and unable to offer a defence to the allegations against him. This has placed an added burden on them to ensure that they have considered the allegations in a fair and even-handed way, weighing up all the evidence in coming to their conclusions. In order to demonstrate that they have taken a fair, reasonable and robust approach, I asked the investigation teams to set out in their reports the evidence relied upon and the tests applied to that evidence in deciding whether allegations are or are not accepted.

The naming of victims and witnesses

6.25 The victims of Savile's abuse are not named in the Leeds and Broadmoor reports unless they asked to be identified. Senior NHS managers, and those in senior public roles, are named. Other witnesses, including junior NHS staff, are named only if they played a significant part in the events narrated.

Legal assurance

6.26 Capsticks solicitors, acting for Buckinghamshire Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust and West London Mental Health NHS Trust have provided advice and support to the investigation teams these trusts established. They have reviewed all documents gathered and relied upon by the investigation teams, as well as the transcripts of the witness interviews undertaken by the investigation teams. They have reviewed this material in order to provide assurance that the investigation reports and the findings in them accurately reflect and are supported by the documents and the witness evidence. Capsticks' assurance on these matters is set out in their letters/advice at appendix G. The lead investigator at Broadmoor has assured me that he has also received advice from Treasury Solicitors department that the conclusions expressed by him in his report are ones that, on the evidence, are properly open to him to come to.

7. Assurance of the reports of the 31 new investigations

7.1 This section describes what the oversight team and I have done to assure the quality of the reports of the new investigations, in line with the Secretary of State's request to me of 15 November 2013.

7.2 On 9 April 2013, Ed Marsden and I attended a meeting organised by the Department of Health for the 10 hospital trusts and one non-NHS hospice required to undertake investigations as a result of information provided by MPS to the Department of Health in February 2013. We outlined what we expected of a robust and rigorous investigation. We answered a number of individual queries from the hospital trusts. We offered the trusts the opportunity to speak with the sampling team if they wanted further advice at a later stage.

7.3 A further meeting of the 10 hospitals and the hospice took place at the Department of Health on 4 October 2013. The trusts gave updates on the progress of their investigations and the oversight team and I again offered advice and help with specific queries.

7.4 The 10 hospitals and the hospice submitted the first drafts of their reports for review by our sampling team by October 2013. The sampling team particularly looked at whether the reports described a thorough and robust approach to process and whether the reports themselves were of a high standard. The team completed peer-review forms for each investigation. The sampling team had phone discussions with the report authors to discuss specific issues or concerns. The sampling team then returned the draft reports to their authors annotated with their comments, completed peer-review forms and a suggested list of current hospital policies that should be reviewed as part of their investigations.

7.5 The sampling team checked second drafts of reports to see if their earlier comments had been dealt with appropriately. They shared with Ed Marsden and me any continuing concerns about the progress of these investigations or the quality of the reports. Where necessary we outlined to the Department of Health, in its performance management capacity, what needed to be done to remedy matters.

7.6 I reviewed the final draft reports. I made my own further comments on them where necessary.

7.7 A further 16 trusts were required to undertake investigations as a result of the information passed to the Department of Health by MPS in December 2013. In light of experience with the 10 hospitals and the hospice that had started their investigations earlier, it was agreed by my oversight team and the Department of Health that these further hospitals needed more specific written guidance about how to conduct their investigations to ensure that they were thorough and proportionate and their reports were of a high quality. The oversight sampling team helped the department in drafting this guidance (which is appendix H to this report). The guidance pack was also sent to the other 10 hospitals and the hospice to ensure a consistency of approach.

7.8 The Department of Health organised three meetings of these further 16 hospital trusts at which the oversight team was present. The hospitals gave updates on their progress. The oversight team offered general advice and answered specific queries. As with earlier investigations, the sampling team has offered help and support to the further 16 hospital trusts and to the other two hospitals, listed in appendix B, which were not identified or did not receive information connecting them with Savile until sometime after December 2014. The sampling team has also alerted Ed Marsden and me to concerns about the progress of the investigations so that we have been able to agree on remedial action with the Department of Health.

7.9 The sampling team and I have reviewed the draft reports of the further investigations in the same way as I describe above for the earlier 11 investigations.

7.10 The new investigation reports have been reviewed with a view to offering assurance that the investigations and the reports have been rigorous and thorough. The oversight team has not sought to influence the content or conclusions of the reports. In some cases, where the writing style of the reports has been deemed to hinder the understanding of the reader, the report writers have been asked to submit their reports for editing.

7.11 The arrangements for the naming of victims and witnesses adopted in the Leeds and Broadmoor reports apply to the reports of the new investigations.

7.12 The investigations at Rampton, Springfield and Crawley hospitals have not yet been completed. The reports of these investigations will be published in due course. As already explained, The Royal Free and The Royal London hospitals will not be publishing formal reports. Barnet, Enfield and Haringey Mental Health NHS Trust was asked to investigate an allegation relating to Friern Barnet hospital received by the Department of Health as part of the information handed to the Department by MPS in February 2013. The trust concluded that there were no matters that needed investigating. That decision has recently been reviewed by the Department of Health and, in discussion with me, it has been agreed that the trust will be asked to undertake further investigations which will be overseen and assured as part of the legacy arrangements referred to in paragraph 8.5 below.

8. Information-sharing and liaison with other organisations conducting investigations

8.1 When it became clear that the scale of Operation Yewtree would be significant, Yewtree officers decided to pass allegations about offences and information relating to Savile to police forces covering the locations at which the alleged offences took place. Some allegations have been made directly to local police forces, who have been responsible for ensuring that the details are also given to Operation Yewtree. Other allegations have been made directly to the three main investigation teams and these too have been passed to Operation Yewtree.

8.2 The joint MPS and NSPCC report of Operation Yewtree *Giving Victims a Voice,* published in January 2013, gave various figures for the number of Savile's offences in hospitals and hospices. Many further alleged victims and witnesses came forward and provided information to the police after the publication of the *Giving Victims a Voice* report, which resulted in the setting up of further NHS hospital investigations in the way I describe above. Detective Superintendent Gray of MPS has written a letter, contained in appendix I, which provides assurance that the police passed to the Department of Health all the allegations and information about Savile relating to NHS premises collected by Operation Yewtree up to November 2013, except where it might have compromised live police investigations to do so or where the informant did not consent to information being passed to an NHS review team. Detective Superintendent Gray's letter sets out the numbers of informants whom MPS identified as being able to provide relevant information to the Department of Health. Appendix J also contains a letter from William Vineall, Deputy Director, Department of Health which provides a breakdown of where that information was passed to and an assurance that the Department of Health handed to the relevant NHS trust investigation teams any relevant evidence from Operation Yewtree.

8.3 In 2012 the BBC commissioned Dame Janet Smith to carry out an independent review into the activities of Savile while he was employed by the BBC. My team and I have met the legal advisers to the BBC review team a number of times. This has allowed us to keep abreast of each other's progress and share any common concerns.

8.4 My team and I, the three main investigation leads and Capsticks met the legal advisers to the BBC review in late 2013 to discuss the general themes emerging from the investigations.

8.5 Further information relating to Savile has been given to MPS's Operation Yewtree since November 2013 and allegations about Savile continue to be made. The Department of Health has assured me that all allegations and information about Savile's activities on NHS premises that come to light will be properly and consistently investigated by the NHS to the same standard as has been followed to date.

9. Conclusion

9.1 This report describes the arrangements by which I, with the help of others, have overseen the investigations undertaken by Buckinghamshire Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, West London Mental Health NHS Trust/the Department of Health into matters relating to Jimmy Savile. The oversight process has been comprehensive. It has entailed a systematic evidencing and assessment of the capacity of the investigation teams and the robustness of their processes. I also describe the processes followed to allow me to offer general assurance on the quality of the investigation work undertaken at other hospitals. I conclude that the NHS investigations completed to date into matters relating to Jimmy Savile have been conducted in an appropriate and robust fashion and that the resulting reports should be published.

9.2 My report on the lessons to be learnt by the NHS from the Savile investigations will be published in due course. It will draw on the findings and conclusions of the NHS investigations with the intention of strengthening patient care and safety.

Letters from Right Honourable Jeremy Hunt MP, Secretary of State for Health, to Kate Lampard

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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Kate Lampard
[redacted]

29 October 2012

Dear Kate,

OVERSIGHT OF THE DEPARTMENT OF HEALTH AND NHS REVIEWS INTO JIMMY SAVILE

You have been in discussion with Una O'Brien about providing oversight of the Stoke Mandeville, Leeds General Infirmary and Broadmoor inquiries as well as the Department of Health's inquiries into the appointment and role Savile held at Broadmoor Hospital. I am very grateful that you have agreed to take on this important role.

I would like you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interests of patients.

Your appointment will end once internal inquiries in the Department of Health and the trusts have been pursued, an agreed conclusion and account of events has been reached and you have assured me as to the robustness of the process that was followed to reach these conclusions. Any potential other work beyond that will be determined at the time. It is planned that your advice on the robustness of the reviews undertaken and the reviews themselves will be made available to the public.

I have instructed officials to give you the support you need on this and I will make myself available to you should you so wish.

Yours ever

Jeremy Hunt

JEREMY HUNT

SC2910123

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department of Health

POC1_738163

Kate Lampard
Verita
53 Firth Street
London
W1D 4SN

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

Dear Kate,

12 NOV 2012

Thank you for sharing the letters that you sent to Stoke Mandeville Hospital, Leeds General Infirmary, Broadmoor Hospital and the Department of Health, outlining your expectations of them in their reviews into Jimmy Savile's role and conduct in the organisations.

When I appointed you, I asked you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interest of patients. The framework that you have produced provides useful detail on how you will work with the organisations to do this. It clearly sets out your expectations and begins to shape the robust process that is required for this essential work.

It is inevitable that as you sample and assure yourself that the processes the organisations have followed are robust, you will identify themes. I would therefore like to ask you to look too at NHS wide procedures in the light of the findings and recommendations of the reviews you are overseeing once they have been completed, seeking expert advice as necessary, and see whether they need to be tightened. If so, I would very much like you to advise me on how any relevant guidelines or procedures need to be changed.

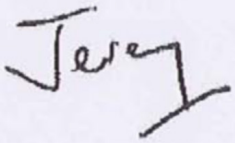
I am particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role.

Some individuals have recently raised concerns about whether your processes will be sufficiently independent. I am a clear that you are the right person for the job and you have my full confidence but I want to

make it explicit that I have appointed you in an independent capacity and I want to receive your independent views.

At the end of the process, I will publish your reports to me on both issues.

Yours ever,



JEREMY HUNT

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department of Health

POC1_743970

CA: 29325

Kate Lampard
NHS South of England
York House
18-20 Massetts Road
Horley, Surrey
RH6 7DE

NHS South East Coast
10 DEC 2012
Chairman

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

- 6 DEC 2012

Dear Kate,

The Police have recently brought it to the Department's attention that Jimmy Savile may have offended in a number of NHS institutions in addition to Broadmoor, Stoke Mandeville and Leeds General Infirmary.

From the very limited information they have shared at this stage, it appears that these involved one or two alleged incidents at each trust and they happened at institutions where Jimmy Savile did not have the responsibilities or access afforded to him at the organisations who are already conducting investigations. The Trusts, who have only recently been notified, are contacting the Police and will be investigating any allegations passed to them.

Unless further information subsequently comes to light I am not asking you to oversee these further investigations, but I would like to ask you to make contact with the organisations to ask for their conclusions about the circumstances of any abuse. I believe these may form an important part of your report into common themes relating to the abuse in the NHS. I attach a list of the information that we have at this stage and I will ask my officials to keep you updated if the police share further information.

Yours ever

Jeremy

JEREMY HUNT

Annex: Details provided by the police on 29 November regarding additional abuse in the NHS

	Institution	Number of offences
1	St James Teaching Hospital - same trust as the LGI	1
2	High Royds Psychiatric Hospital (closed 2003 and services moved into Leeds community services)	1
3	Dewsbury Hospital (now part of Mid Yorkshire NHS Trust)	2
4	Wycombe General Hospital (now part of Buckinghamshire Healthcare NHS Trust) – same trust as Stoke Mandeville	1
5	Great Ormond Street Hospital NHS FT	1
6	Ashworth Hospital NHS High Secure Unit*	1
7	Exeter Hospital (part of Royal Devon & Exeter Hospital NHS FT)	1
8	Portsmouth Royal Hospital (now closed and facilities part of Portsmouth Hospitals NHS FT)	1
9	Springfield Hospital (now closed and facilities part of South West London and St George's Mental Health NHS FT)	2 - *Offences were carried out by Johnny Savile (brother). Jimmy Savile is not known to involved.*

*At the time of the offence, Asworth Hospital NHS High Secure Unit was run by the Department of Health

One allegations only at this stage at each of the following

- Royal Victoria Infirmary, part of Newcastle Hospitals NHS FT
- Bethlem Royal and Maudsley Hospitals, part of South London and the Maudsley FT
- St Catherine's Hospital, Birkenhead, part of Wirral Community Trust
- Saxondale Mental Health Hospital, Notts (closed 1988)

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

POC1_822439

Kate Lampard
NHS South of England
York House
18 – 20 Massetts Road
Horley
Surrey RH6 7DE

15 NOV 2013

Dear Kate,

JIMMY SAVILE INVESTIGATIONS: REVISED TERMS OF REFERENCE

I am writing to you with revised terms of references for your remaining work on the Jimmy Savile investigations in relation to the NHS, to reflect the recent announcement of potential further evidence relating to other hospitals.

On 14 October, I announced a further review of evidence by the Metropolitan Police in a Written Ministerial Statement (WMS). The review is nearing completion and in the WMS we committed to publish a list of further hospitals involved. In addition to the three main NHS investigations you are currently overseeing, I would be grateful if you could provide general assurance of the quality of all the reports relating to any new investigations, as well as the 10 NHS investigations on-going since April, in your final assurance report.

The Department of Health will be sending out guidance to the new Trusts about how they should proceed with their investigations shortly.

Verita has been asked to review reports for the 10 NHS investigations plus the investigation by Sue Ryder commissioned since April, as well as for any new investigations, in order to ensure a consistent and thorough approach is adopted.

As I made clear in the Written Ministerial Statement, the final reports of all the investigations will aim to be completed by June 2014, with publication sooner if that is possible.

I would also be grateful if your final summary report of lessons learned also included any learning from the 10 investigations and the new investigations.

I am grateful for your on-going work to ensure the investigations about Jimmy Savile's activities are as thorough as possible.

Yours ever

Jeremy

JEREMY HUNT

Appendix B

List of further investigations into allegations relating to Jimmy Savile

Hospitals identified by the MPS in December 2012

- St Catherine's Hospital – Wirral Community NHS Trust
- Saxondale Mental Health Hospital – Nottinghamshire Healthcare NHS Trust
- Rampton Hospital – Nottinghamshire Healthcare NHS Trust
- Portsmouth Royal Hospital – Portsmouth Hospitals NHS Trust
- Dewsbury and District Hospital – Mid Yorkshire Hospitals NHS Trust
- High Royds Psychiatric Hospital – Leeds and York Partnership NHS Foundation Trust
- Wheatfields Hospital – Sue Ryder
- Cardiff Royal Infirmary – Cardiff and Vale University Health Board
- Great Ormond Street – Great Ormond Street Hospital for Children NHS Foundation Trust
- Exeter Hospital – Royal Devon and Exeter NHS Foundation Trust
- Ashworth Hospital – Mersey Care NHS Trust

Hospitals identified by the MPS at the end of 2013

- Barnet General Hospital – Barnet and Chase Farm Hospitals NHS Trust
- Booth Hall – Central Manchester University Hospitals NHS Foundation Trust
- De La Pole Hospital – Hull and East Yorkshire Hospitals Trust
- Dryburn Hospital – County Durham and Darlington NHS Foundation Trust
- Hammersmith Hospital – Imperial College Healthcare NHS Trust
- Leavesden Secure Mental Health Hospital – Hertfordshire Partnership University NHS Foundation Trust
- Marsden Hospital – Royal Marsden NHS Foundation Trust
- Maudsley Hospital – South London and Maudsley NHS Foundation Trust
- Odstock Hospital – Salisbury NHS Foundation Trust
- Prestwich Psychiatric Hospital – Greater Manchester West Mental Health NHS Foundation Trust

- Queen Victoria Hospital, East Grinstead – Queen Victoria Hospital NHS Foundation Trust
- Royal Free Hospital – Royal Free London NHS Foundation Trust
- Royal Victoria Infirmary – The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Queen Mary's Hospital – Epsom and St Helier University Hospitals NHS Trust
- Whitby Memorial Hospital – York Teaching Hospital NHS Foundation Trust
- Wythenshawe Hospital – University Hospital of South Manchester NHS Foundation Trust

Allegations received in 2014

- Woodhouse Eaves Children's Convalescent Homes – University Hospitals of Leicester NHS Trust
- Crawley Hospital-Sussex Community NHS Trust

Two hospitals identified by Leeds team

- Springfield Hospital – South West London and St George's Mental Health NHS Trust
- The Royal London Hospital - Barts Health NHS Trust

Appendix C

Kate Lampard's letters to the trusts responsible for the Leeds, Stoke Mandeville and Broadmoor investigations

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Maggie Boyle
Leeds Teaching Hospitals NHS Trust
Chief Executive
Great George Street
Leeds
West Yorkshire
LS1 3EX

5 November 2012

Dear Maggie

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

As you will be aware I have been appointed to provide independent oversight of the Stoke Mandeville, Leeds General Infirmary, Broadmoor and Department of Health investigations into the allegations about the activities of Jimmy Savile. I am being supported in my role by Ed Marsden, the managing partner of Verita, a firm with considerable experience of complex investigations.

For your information and guidance I enclose with this letter:

1. A description in broad terms of the process by which I intend to fulfil my oversight role and the interventions that Ed Marsden and I will be making in relation to your investigation.

2. High level guidance on the conduct of the internal investigations setting out my initial thoughts on the processes required to ensure that your investigation and report is appropriately robust.

3. An outline of the matters that I would expect to be covered by the terms of reference for your investigation.

4. My initial thoughts on what issues your investigation needs to cover. This list is not intended to be exhaustive: it is based on the matters that have come to my attention to date. I have also included a list of the matters likely to need investigation by the other organisations involved in this matter.

I believe that the terms of reference for your investigation need to be drafted and discussed with me and Ed Marsden as a matter of urgency. My PA Denyse Lea will be in touch to agree meeting dates this week. If we cannot arrange a face-to-face meeting then I suggest we hold a tele-conference.

As part of the investigation process your team will of course wish to talk with those who have made allegations about Jimmy Savile's behaviour at Leeds General Infirmary. I have been assured by Detective Superintendent David Gray, Metropolitan Police, who is handling the allegations relating to Jimmy Savile that, at your request, he will seek the consent of alleged victims and witnesses to pass on their details to you. I therefore suggest that you make contact with Detective Superintendent Gray about this matter as soon as possible. His contact details are:

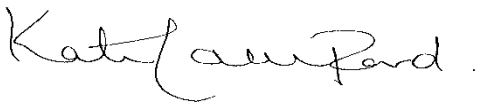
David Gray
Detective superintendent
Child Abuse Investigation Command
16th Floor West
Empress State Building
Lillie Road
London
SW6 1TR

Phone: 020 7161 3834 Email: dave.gray@met.police.uk

I am copying this letter and the attachments to Mike Collier.

Ed Marsden and I look forward to meeting you later this week.

Yours sincerely



Kate Lampard

Copy: Mike Collier, Chairman

Enclosures: Process for oversight
Process for investigations
Issues for NHS organisations
Guidance on terms of reference

Kate Lampard, appointed to oversee the NHS and Department of Health investigations

Ed Marsden, managing partner of Verita, appointed to support the oversight work

Diary management c/o Denyse Lea
Telephone: 01293 778801 Email: denyse.lea@southeastcoast.nhs.uk

Secretariat support c/o Verita, 53 Frith Street, London, W1D 4SN
Telephone: 020 7494 5670 Fax: 020 7734 9325

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Anne Eden
Chief Executive
Buckinghamshire Healthcare NHS Trust
Amersham Hospital
Whielden Street
Amersham
Bucks
HP7 0JD

5 November 2012

Dear Anne

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

As you will be aware I have been appointed to provide independent oversight of the Stoke Mandeville, Leeds General Infirmary, Broadmoor and Department of Health investigations into the allegations about the activities of Jimmy Savile. I am being supported in my role by Ed Marsden, the managing partner of Verita, a firm with considerable experience of complex investigations.

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As part of the investigation process your team will of course wish to talk with those who have made allegations about Jimmy Savile's behaviour at Stoke Mandeville Hospital. I have been assured by Detective Superintendent David Gray, Metropolitan Police, who is handling the allegations relating to Jimmy Savile that, at your request, he will seek the consent of alleged victims and witnesses to pass on their details to you. I therefore suggest that you make contact with Detective Superintendent Gray about this matter as soon as possible. His contact details are:

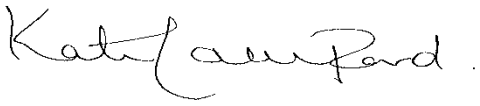
David Gray
Detective superintendent
Child Abuse Investigation Command
16th Floor West
Empress State Building
Lillie Road
London
SW6 1TR

Phone: 020 7161 3834 Email: dave.gray@met.police.uk

I am copying this letter and the attachments to Fred Hucker.

Ed Marsden and I look forward to meeting you later this week.

Yours sincerely



Kate Lampard

Copy: Fred Hucker, Chair

Enclosures: Process for oversight
Process for investigations
Issues for NHS organisations
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Ed Marsden, managing partner of Verita, appointed to support the oversight work

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Secretariat support c/o Verita, 53 Frith Street, London, W1D 4SN
Telephone: 020 7494 5670 Fax: 020 7734 9325

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Bruce Calderwood
Director of Mental Health and Disability
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

5 November 2012

Dear Bruce

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Thank you very much for your time last Friday afternoon. I thought we had a helpful discussion and it was good to meet Helen and Clare. As promised, here is the letter and attachments that I said I would send to you.

As you will know I have been appointed to provide independent oversight of the Stoke Mandeville, Leeds General Infirmary, Broadmoor and Department of Health investigations into the allegations about the activities of Jimmy Savile. I am being supported in my role by Ed Marsden, the managing partner of Verita, a firm with considerable experience of complex investigations.

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I believe that the terms of reference for your investigation need to be drafted and discussed with me and Ed Marsden as a matter of urgency. My PA Denyse Lea will be in touch to agree meeting dates this week. If we cannot arrange a face-to-face meeting then I suggest we hold a tele-conference.

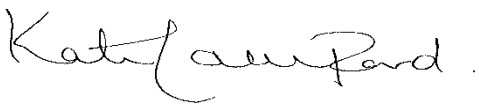
As part of the investigation process your team will of course wish to talk with those who have made allegations about Jimmy Savile's behaviour at the Department of Health. I have been assured by Detective Superintendent David Gray, Metropolitan Police, who is handling the allegations relating to Jimmy Savile that, at your request, he will seek the consent of alleged victims and witnesses to pass on their details to you. I therefore suggest that you make contact with Detective Superintendent Gray about this matter as soon as possible. His contact details are:

David Gray
Detective superintendent
Child Abuse Investigation Command
16th Floor West
Empress State Building
Lillie Road
London
SW6 1TR

Phone: 020 7161 3834 Email: dave.gray@met.police.uk

I am copying this letter and the attachments to Jeremy Hunt and Una O'Brien.

Yours sincerely



Kate Lampard

Copy: Rt Hon Jeremy Hunt MP, Secretary of State for Health
Una O'Brien, Permanent Secretary, Department of Health

Enclosures: Process for oversight
Process for investigations
Issues for NHS organisations
Guidance on terms of reference

Kate Lampard, appointed to oversee the NHS and Department of Health investigations

Ed Marsden, managing partner of Verita, appointed to support the oversight work

Diary management c/o Denyse Lea
Telephone: 01293 778801 Email: denyse.lea@southeastcoast.nhs.uk

Secretariat support c/o Verita, 53 Frith Street, London, W1D 4SN
Telephone: 020 7494 5670 Fax: 020 7734 9325

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Steve Shrubb
Chief Executive
Trust Headquarters
West London Mental Health NHS Trust
Uxbridge Road
Southall
UB1 3EU

5 November 2012

Dear Steve

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Thank you very much for your time last Wednesday afternoon. I thought we had a helpful discussion and it was good to meet Nigel and some of the management team. As promised, here is the letter and attachments that I said I would send to you.

As you know, I have been appointed to provide independent oversight of the Stoke Mandeville, Leeds General Infirmary, Broadmoor and Department of Health investigations into the allegations about the activities of Jimmy Savile. I am being supported in my role by Ed Marsden, the managing partner of Verita, a firm with considerable experience of complex investigations.

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I believe that the terms of reference for your investigation need to be drafted and discussed with me and Ed Marsden as a matter of urgency. I would be grateful if you would let me know your timetable for this task.

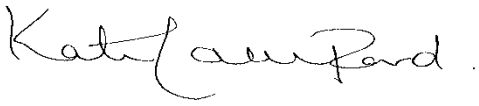
As part of the investigation process your team will of course wish to talk with those who have made allegations about Jimmy Savile's behaviour at Broadmoor. I have been assured by Detective Superintendent David Gray, Metropolitan Police, who is handling the allegations relating to Jimmy Savile that, at your request, he will seek the consent of alleged victims and witnesses to pass on their details to you. I therefore suggest that you make contact with Detective Superintendent Gray about this matter as soon as possible. His contact details are:

David Gray
Detective superintendent
Child Abuse Investigation Command
16th Floor West
Empress State Building
Lillie Road
London
SW6 1TR

Phone: 020 7161 3834 Email: dave.gray@met.police.uk

I am copying this letter and the attachments to Nigel McCorkell.

Yours sincerely



Kate Lampard

Copy: Nigel McCorkell, chair

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Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Process for oversight

The following describes in broad terms the interventions we intend to make. Our processes may be subject to amendment as the investigations progress.

- We will meet all trusts and discuss our role and expectations.

- We will discuss and advise trusts and the Department of Health about terms of reference and investigation resourcing plans.

- We will provide high-level advice about the conduct of the internal investigations (though individual organisations are responsible for their own investigative process and final content).

- We will make ourselves available to offer advice about the conduct of individual investigations and the process they follow.

- At the outset we will discuss with each team how investigations are to be conducted.

- We will meet each team at the point they have concluded their evidence-gathering and before they start writing.

- We will receive an early draft of each report for comment and provide structured feedback via a written process. We will share our assessment criteria in advance.

- We will sample the evidence base of each report to test robustness. We will agree with each investigation team how this will be done.

- We will scrutinise the final reports after they have been signed off by trust boards and their legal advisers.

Individual organisations are responsible for ensuring that any relevant information on child and/or adult safeguarding matters is communicated and discussed with local safeguarding boards. Local boards will be responsible for determining what needs to be done to meet local procedures and requirements.

Kate Lampard Ed Marsden

1 November 2012

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

High-level initial guidance on the conduct of internal investigations

The Secretary of State for Health has confirmed to us that the internal investigations carried out by the NHS and the Department of Health will be made available to the public.

The investigations need to be undertaken with this in mind.

We offer the following guidance to organisations conducting these pieces of work.

- Each investigation will have written, customised terms of reference – these will be agreed with the trust board, the police (either the Metropolitan Police or the local force) and the local safeguarding boards.

- Each investigation must be fully resourced and chaired by a non-executive director or equivalent.

- Each investigation should have a dedicated team able to pursue the investigation proactively, keep a grip on the issues, liaise with relevant parties, undertake the search for documents and witnesses, examine documents, undertake interviews of witnesses, produce a report and recommendations for follow up actions.

- The initial scoping of issues and approach to dealing with them should be discussed with police, local safeguarding board and oversight team.

- Document gathering will be comprehensive. This should include examination of documents relating to policy and procedure, relevant staffing and HR documentation, disciplinary proceedings, whistle-blowing, complaints and complaints handling, PALs and other patient support organisations, finance papers, relevant correspondence with the Charity Commission, board and committee papers.

- Staff, former staff, board members and former board members, volunteers, known complainants and all other relevant witnesses will be invited to interview. We would like to be informed if significant witnesses refuse to participate.

- Interviewees will receive written notification including a guide to giving evidence.

- Interviews will be recorded and proper typed transcripts made. Audio recordings should be kept for the duration of the investigation.

- Reports will be produced to a common template and separate facts from opinion.

- Difficult investigative issues – either about process or content – will be discussed with oversight team and a view reached about how to proceed.

- Unexpected concerns, and issues with wider implications, will be discussed with management teams/oversight team and, if necessary, with external organisations e.g. police, safeguarding board.

- Draft reports will be subject to legal review by trust lawyers – hopefully Capsticks in each case.

- Those who are to be criticised in a report are to be given the opportunity to see the potential criticism and respond to it. This should be done well in advance of the report being finalised so that individuals have time to take advice and respond and investigation teams have sufficient time to give proper consideration to any comments.

Kate Lampard Ed Marsden

1 November 2012

Issues for consideration and investigation common to the three NHS trusts' and to Department of Health's investigations

Jimmy Savile's association with the organisation:

- How it came about?
- Nature of JS involvement and his team/associates
- Dates and a full narrative chronology
- JS's access and accommodation
- What checks were made on JS? What safeguards were put in place?

Policy, practice and procedure throughout the time of Jimmy Savile's association with the organisation re:

- Volunteer staff, their role/s, their access, vetting and other safeguards in place in relation to volunteers
- Staff vetting
- Child and adult protection and safeguarding
- Whistleblowing
- Complaints handling and investigation (staff and patient complaints)

Previous incidents and sexual allegations:

- Details of allegations made and of any other significant sexual abuse allegations that might have links to Jimmy Savile
- How these allegations came to light
- The extent to which others in the organisation knew of allegations against Jimmy Savile and/or his team and/or associates and did/did not report of act upon them
- The organisation's response to these

Current incidents and allegations:

- Details of incidents and allegations and how they came to light
- The extent to which others in the organisation knew of allegations and did/did not report of act upon them
- The organisation's response to these including:
    - Appeals for witnesses/ further reports of Jimmy Savile's abuse
    - Liaison with the police, local safeguarding board, and other bodies, KL and EM. Reviews of relevant policies and procedures

Jimmy Savile's fund raising activities:

- Governance arrangements
- Any issues that arose in relation to the governance, accountability for and use of Jimmy Savile's charitable funds
- Liaison with the Charity Commission

Present practice and procedures – assurance as to why incidents indentified could not happen again:

- Lessons learned
- Response to lessons learned

Kate Lampard Ed Marsden

1 November 2012

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

Terms of reference

Your terms of reference should:

- Set out who is commissioning the investigation and by what authority e.g. trust board under its general responsibilities for oversight of the organisation

- Explain the purpose of the investigation but also the limitations, for example, if the investigation has no disciplinary remit

- Set out the main tasks of the investigation i.e. the ground to be covered

- Make it clear that the investigators are expected to produce a written report with recommendations

- Describe in general terms how the investigation is to be conducted and what safeguards are offered to those who participate e.g. right to be accompanied to interview, opportunity to comment and amend transcript and right of reply to the facts associated with potential criticism

- Include a timetable and state whether the outcome of the investigation is to be published and whose decision and responsibility this is

- Make clear the obligation of the investigation team to work closely with the independent oversight team

The terms of reference should be approved by the trust board and discussed with the police and LSCB. They should also be discussed with your legal advisers and the independent oversight team.

Kate Lampard Ed Marsden

2 November 2012

Appendix D

Work undertaken by Kate Lampard and the oversight team to oversee and assure the investigations carried out at Leeds General Infirmary, Stoke Mandeville Hospital and Broadmoor Hospital/The Department of Health

Verita engaged to provide support and administrative resources for Kate Lampard's oversight role.

Issued initial high level guidance on:

- the expected conduct of the investigations
- initial thoughts on matters that needed to be considered and investigated
- matters to be covered by terms of reference
- outline of the process for oversight.

Met with Secretary of State for Health to consider emerging issues and gain understanding of his expectations of the oversight role.

Visited the chair and chief executive of each NHS organisation and Department of Health officials to discuss expectations of the investigations to be undertaken, to air some of the issues facing the individual investigation teams, to consider the shape and resources of the individual investigation teams. Met with or talked to chairs and chief executives of the relevant strategic health authorities (SHA) to advise them of expectations and challenges and the performance management that would be sought from SHAs.

Ongoing discussions with and advice to the chief executives and Department of Health about the staffing and set up of their investigation teams. Advised on need for experienced, impartial and independent investigation leads and senior personnel in the light of the number and significance of the allegations, the time span of the allegations, the emerging volume of documents and numbers of witnesses.

Advice given to chief executives and investigation teams about developing, where possible, the infrastructure and approaches to ensure consistency and efficiency including:

- instructing a single firm of solicitors to act for the three trusts and support the investigations
- common solutions to document searches and document management
- common documentation for dealing with witnesses and arrangements for interviews.

Commented on and agreed terms of reference for the investigations.

Regular meetings and discussions with Operation Yewtree to ensure information and intelligence sharing where appropriate, and common understanding of issues and challenges.

Regular meetings with the Department of Health to advise on the progress of the three investigations, and to agree the resources needed and actions required to ensure that the investigations proceeded appropriately and at pace.

Took part with Capsticks in negotiations with MPS Operation Yewtree on the issue of information sharing. Reported back to DH, DH legal advisers, and Secretary of State for Health's Office.

Meetings and discussions with BBC investigation team (Dame Janet Smith) and its advisers, to ensure, a common understanding of issues and challenges. Information and intelligence shared where appropriate.

Convened a workshop (10 January 2013) for the investigation teams of the three main investigations, chief executives of trusts, representatives of Department of Health, SHAs, NHSLA to agree on roles and responsibilities; clarify the expectations for the investigations; to agree on the methodology that needed to be followed; to agree plans for dealing with common issues including commissioning work on the historical background, obtaining witness support services, purchasing document search and management services.

Established a sampling team and devised a programme of work by them to provide assurance that the investigations were properly resourced and managed, that their work

was robust and comprehensive and that areas of risk in relation to the investigations were properly addressed.

The sampling team visited the investigation teams on a regular basis and gave feedback on their findings.

Met with chairs of the local oversight panels established by each of the trusts to provide advice and support to the investigation teams.

Commissioned a discussion event from the History and Policy (King's College London/Cambridge University) (7 May 2013) for the investigation leads of the three main investigations and the oversight team to learn about the culture and issues that formed the background to Savile's life and his offending on NHS premises. Among the topics discussed: the changing sexual culture of the period in question; the shift in attitudes to celebrity and privacy; the legal status of and attitudes to victims of child sex abuse; charitable fundraising and voluntarism in the NHS; NHS management structures and culture in the relevant period.

Wrote to all NHS trusts and NHS foundation trusts (3 May 2013) with a call for relevant evidence and information from NHS staff. Followed up with interview in the Health Service Journal.

Liaised with Department of Health on issues of support for victims living outside the area of the support services arranged by individual investigation teams.

Ongoing meetings/discussions on progress and sticking points with investigation leads and Capsticks including on enquiries about requests for anonymity for witnesses and confidentiality of transcripts.

Drafted plan for the processes for the checking, approval and publication of draft investigation reports. Discussed and agreed the same with investigation team leaders, the NHS trust chairs and chief executives and Capsticks.

Meeting/discussion with investigation leads (including personnel from the Hillsborough inquiry) to consider plans for publication of the investigation reports and the implications for victims, witnesses and their families.

Discussions with Capsticks on data protection issues in relation to the oversight team's review of documentary evidence and transcripts of evidence.

Subject to appropriate arrangements for anonymity and confidentiality, received and reviewed sample transcripts of witness interviews [and sample documentary evidence] from each of the three investigation teams.

Meeting/liaison with NHS England on planning for publication of reports and NHS England responses including arrangements for support of victims and witnesses of abuse.

Kate Lampard/Ed Marsden undertook review of all the three main investigation reports. Met with the investigation teams to offer feedback on draft reports.

Meetings with MPS/DH/Capsticks to understand what further evidence and allegations relevant to the investigations was held by MPS and how this could be made available to the investigation teams.

Advised on treatment of allegations of abuse in investigation reports and the need for investigation leads to set out the evidential basis and tests on which they would reach judgments about individual allegations.

Devised and agreed with DH, Local Oversight Panels and investigation leads, the timetable for finalising, checking and publication of reports.

Discussed with investigation teams, Capsticks and DH (as commissioner of the Broadmoor investigation) their process for sending warning letters to witnesses facing criticism. ("Scott letter" process).

Appendix E

Kate Lampard's letter to all NHS trusts, foundation trusts and clinical commissioning groups (CCG) clinical leaders

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

NHS England Publications Gateway Ref No: 00056

To:
All Chairs and Chief Executives of

- NHS Trusts in England
- NHS Foundation Trusts in England
- CCG Clinical Leaders

Copies to:

- Chief Executives of Local Authorities in England
- CCG Accountable Officers
- NHS England Regional Directors
- NHS England Area Directors
- Barbara Hakin, NHS England

2 May 2013

Dear colleagues

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

You may recall that Sir David Nicholson wrote to you in December about my role in overseeing the NHS investigations into allegations of sexual abuse by Jimmy Savile at Stoke Mandeville Hospital, Leeds General Infirmary and Broadmoor Hospital. Sir David asked you to review your own arrangements and practices relating to vulnerable people, particularly in relation to safeguarding, access to patients including that afforded to volunteers and celebrities and listening to and acting on patient concerns.

As the second stage of my oversight work, the Secretary of State for Health has asked me to identify the themes and issues arising from the three investigations and look at NHS-wide procedures in the light of the findings of those investigations.

I am therefore interested to hear from NHS staff about the following matters:

- safeguarding - how policies, procedures and practice take account of and affect patients, visitors and volunteers within NHS settings
- governance arrangements in relation to fundraising by celebrities and others on behalf of NHS organisations

- celebrities – the use and value to NHS organisations of association with celebrities, including in relation to fundraising, and the privileges, including access, accorded to them by NHS organisations
- complaints and whistle blowing – how and to what extent do policies and procedures and the culture of NHS organisations encourage or discourage proper reporting, investigation and management of allegations of the sexual abuse of patients, staff and visitors in NHS settings.

I would also like to hear from NHS staff if they have evidence or information about their own or their organisation's dealings with Jimmy Savile that has not yet been shared with any of the teams investigating the alleged sexual abuses by Jimmy Savile on NHS premises. Such evidence or information might include local factors or matters relating to the culture of the organisation that might have facilitated Jimmy Savile's abusive behaviour.

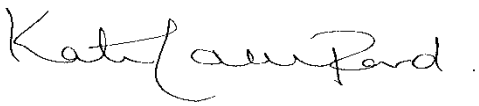
I should be grateful if you would use your own communication networks to let your staff know that they can contact me with information on the following email account:

lampardcomments@dh.gsi.gov.uk

It would be appreciated if you could send in any information by 30 June 2013.

Many thanks for your cooperation.

Yours sincerely



Kate Lampard

Kate Lampard, appointed to oversee the NHS and Department of Health investigations

Ed Marsden, managing partner of Verita, appointed to support the oversight work

Diary management c/o Denyse Lea
Telephone: 01293 778801 Email: denyse.lea@southeastcoast.nhs.uk

Secretariat support c/o Verita, 53 Frith Street, London, W1D 4SN
Telephone: 020 7494 5670 Fax: 020 7734 9325

Appendix F

Sampling team's proforma log

Ref:	Question	Example of evidence required	Date	Risks	Date criteria met
	Preparation				
IT	***Investigation team***				
IT1	How has the investigation team ensured that there is an appropriate degree of independence amongst team members?	Review who is in the investigation team and governance arrangements			
IT2	What has been done to ensure the investigation team does not have any conflicts of interest?	Signed conflict of interest forms			
IT3	Have all members of the investigation team signed confidentiality agreements?	Signed confidentiality agreements			
IT4	Are the roles and responsibilities, and accountability in the investigation team clear?	Discussion with investigation team, governance & accountability document and role descriptions			
IT5	Are there any skills needed for the investigation that the investigation team doesn't already have?	Discussion with investigation team			
IT6	Is the time the investigation team members have committed to the investigation adequate to meet the timescales? What is their contingency plan?	Discussion with investigation team (full time/part time)			
G	***General***				
G1	Does the investigation team have a detailed project plan?	Project plan			
G2	Is the timeline in the project plan realistic? Does the investigation team have sufficient resources to meet the timeline?	Discussion around the project plan			
G3	Are milestones in the project plan being met? If not what is the knock on affect to the timeline?	Discussion around the project plan and milestones that should have been met			

Ref:	Question	Example of evidence required	Date	Risks	Date criteria met
G4	Is the project plan aligned with other investigating trusts?	Verbal confirmation that this has been considered and comparison with other investigation project plans			
G5	What is the process for recording methodology, decisions and the reasons behind them?	Process chart/document			
G6	Is there adequate administration staff to support the investigation team and meet the timescales?	Discussion with investigation team (full time support, team size?)			
G7	How do the investigation team propose to QA their own processes?	Audit plan			
G8	How does the investigation team plan to liaise with police? (Information flow to & from police)	Information sharing agreements/verbal confirmation			
G9	What information has the investigation team received from the police? What is the plan for ongoing communication with the police?	Discussion with investigation team			
G10	How do the team propose to engage with patients (and ex-patients) and other victims and encourage them to report any abuse?	Communications plan			
G11	How do the investigation team propose to engage with staff (and ex-staff) and encourage them to be open with the investigation team?	Communications plan			
G12	What is the process for liaison and checking facts/findings with other investigation teams - health, police & BBC?	Discussion with investigation team			
G13	How are the investigation team going to ensure their report and the judgements contained in it reflect the social context (benchmarked against practice in 1970s for example)? Have the investigation team thought about both local and national context?	Discussion with investigation team/expert advise			

Ref:	Question	Example of evidence required	Date	Risks	Date criteria met
G14	What aspects of the work has the investigation team agreed to do jointly with the other investigation teams? Who has been sighted on this work?	Discussion with investigation team			
G15	Is the investigation team outsourcing any aspects of the work? If so to whom and to do what?	Discussion with investigation team			
G16	How is the investigation team going to ensure that the brief for external organisations is right so that they look at what is needed/draw right conclusions and information is appropriately shared throughout the process?	Review briefs/ToRs given to external providers. Ask investigation team how they are overseeing the work			
G17	How is the investigation team assured that the investigation into charitable funds will include the following: - governance arrangements (inc the basis on which the hospital's name was used in fundraising, the charitable trust structure, the relationship with the Charity Commission, and the accounting and auditing arrangements) - the usual arrangements adopted by the hospital and whether there were any special arrangements in place for JS raised funds - any irregularities in relation to the accounting for funds raised by JS?	Check brief/ToR for external review			
G18	Has the report structure been planned properly?	Report structure and template			
G19	How do the investigation team propose to review the adequacy of current policies and procedures?	Discussion with investigation team			
G22	Is the relationship between the local oversight panel and the investigation team clear? Are the different roles and responsibilities and reporting arrangements clear?	Local oversight panel ToR, governance arrangements between local oversight panel and investigation team			

Ref:	Question	Example of evidence required	Date	Risks	Date criteria met
G23	Do the investigation team have suitable facilities to carry out the investigation?	Evidence of dedicated rooms/office space			
G24	How will the two teams integrate into a coherent joint investigation? (Especially given the differing nature of the investigations and the political dimension to the DH part of the investigation) - *only relevant to the Broadmoor investigation*	Discussion with investigation team			
D	***Documents***				
D1	How are the investigation team sourcing all documents to be reviewed?	Discussion with investigation team			
D2	What steps are the investigation team taking to search for documents to review? (archive, site search, computer drives etc)	Review archive/site/ computer drives			
D3	How are the investigation team assured that they have access to all documents? e.g. how can the investigation team be sure that all relevant files have been passed over by third parties?	Verbal confirmation Investigation team to seek assurance from someone of significant seniority at third party organisation that they have done the appropriate search/verification.			
D4	Are the investigation team reviewing all documents identified? Or is a criteria being used to exclude some documents? What is the criteria?	Discussion with investigation team			
D5	For documents chosen for review is there a search criteria being applied?	Criteria and discussion with investigation team			
D6	Who is undertaking the initial review of documents (reading team)? Are they summarising their findings?	Discussion with investigation team			

Ref:	Question	Example of evidence required	Date	Risks	Date criteria met
D7	Is a document management system being used to search and organise documents? Will the document management system be used in conjunction with the reading team? What is the search criteria that will be used?	Discussion with investigation team			
D8	What is the investigation team's system for logging documents?	Document log (where documents have come from, where are they being stored etc)			
D9	How are documents stored/filed - paper?	See storage room			
D10	How are documents stored/filed - electronic?	View computer drive			
D11	How are the investigation team sampling documents that have not been chosen for review?	Evidence of a sampling methodology			
D12	How are all decisions relating to information reviewed/discarded being documented?	Audit trail of decisions and process map			
I	***Interviews***				
I1	What are the means of communication for inviting people to interview: -local paper/radio? -Staff and ex-staff communication (email/letters)? -Police - victims -national advert? (3 investigations could come together) -open house session	Verbal confirmation that adequate communication is planned			
I2	Is the investigation team experiencing any difficulties with communicating with people they want to meet with as part of the investigation?	Discussion with investigation team			
I3	How have the investigation team assured themselves that they have made sufficient attempts to contact people?	Verbal confirmation			

Ref:	Question	Example of evidence required	Date	Risks	Date criteria met
I4	How have the investigation team assured themselves that they have made reasonable efforts to speak to/meet all those who want to engage with the investigation?	Verbal confirmation			
I5	Have the investigation team encountered any problems in getting people to come forward for interviews?	Discussion with investigation team			
I6	How will people contact the investigation team in order to share information/ask to be interviewed? Does the investigation team have a dedicated phone number/address for potential witnesses to contact? If contacted by phone - does the team have a script? What will be the process after the call and what will the witness be told? How will details be recorded/stored?	Discussion with investigation team			
I7	How will the investigation team decide who to invite to make a statement?	Audit trail of decisions and process map			
I8	Who will be taking the statements? Are they appropriately skilled?	Verbal confirmation			
I9	What is the process from taking statements to inviting someone to interview?	See escalation process and criteria			
I10	Is the investigation team interviewing everyone that comes forward? If not - how are decisions made about who to invite for interview and what is the criteria for choosing interviewees?	Audit trail of decisions and process map, discussion with the investigation team			
I11	What attempts have been made to contact people to be interviewed that have been highlighted in documents as appropriate to interview?	Discussion with investigation team			
I12	How have the investigation team logged all interest in being interviewed?	Communication log			

	Investigation				
DR	***Documentary review***				
DR1	Is the investigation team assured that all documents identified have been reviewed thoroughly by the reading team/investigation team?	Sample some of the boxes that have been reviewed			
DR2	Is the investigation team assured that the documents that were identified but not chosen to be reviewed do not contain any useful information?	Sample some of the boxes that have not been reviewed			
DR3	What is the process for the lead investigators reviewing documentation? Have they set their own criteria for review of documents? What are they looking for?	Process chart/criteria			
DR4	How has information gleaned from documents been recorded?	Review log/record of information			
DR5	Has the timeline for reviewing documents been met?	Check progress against project plan			
DR6	Are all decisions relating to information reviewed/discarded being documented?	Audit trail of decisions and process map			
DR7	Is there a record of all documents that have been destroyed prior to the investigation being started? Has process for destruction been followed?	Record of destruction & process for destruction			
INT	***Interviews***				
INT1	Does the investigation team have an interview schedule and log for transcripts being sent out and checked?	Interview log			
INT2	How is an enduring note of the interviews being made?	Recording/ transcription/note taking/LiveNote			
INT3	What is the process for transcripts being sent to interviewees to check/amend?	Transcript log			
INT4	Have the investigation team developed guidance documents for interviewees?	Guidance documents			
INT5	Have the investigation team prepared questions for interviews? Are they different for allegation interviews or context? Victims/staff etc	Script/list of questions			

INT6	Does the investigation team have a standard introduction to read at the start of every interview?	Introduction			
INT7	What support are they giving interviewees? (victim support etc)	Discussion with investigation team			
INT8	How has the investigation team assured themselves that the interviewees' needs are being met (interpreter/capacity etc)?	Discussion with investigation team			
INT9	Are interviewers appropriately skilled? Do they require training?	Confirmation of experience/training			
INT10	Where will interviews take place? Are the facilities appropriate?	Discussion with investigation team			
INT11	How is the investigation team dealing with emerging investigation themes to be investigated?	Discussion with investigation team			
INT12	Has the timeline for interviews been met?	Check progress against project plan			
INT13	Has the investigation team reviewed all the transcripts? Has the information/analysis been recorded?	Review log/record of information			
A	**Analysis**				
A1	Have the investigation team met post interview, pre-drafting to discuss emerging findings and analysis?	Discussion with investigation team			
A2	Does the chronology match up with the BBC, the police, the other NHS investigations and any other published reports?	Evidence of cross checking and confirmation that there is no conflicting information (dates/times/ locations etc)			
A3	Have overall conclusions and recommendations been agreed?	Discussion with investigation team			
D	**Drafting**				
Dr1	Has the local oversight panel reviewed the draft report?	Discussion with investigation team			
Dr2	Has the national oversight team (Kate Lampard and Ed Marsden) reviewed the draft report?	Discussion with investigation team and national oversight team			
Dr3	Has legal advice on the draft report been sought?	Discussion with investigation team			

Dr4	Has the report been through the Scott letter process (if necessary)?	Sampling team to review Scott letters and responses. Log of any changes made as a result of Scott letters.			
Dr5	Has the report been professionally edited?	Evidence of editing			
Dr6	Has the final draft report been signed off by the trust board?	Evidence of report being signed off by board			
Dr7	Has the report been shared with the victims?				
Dr8	Is there a communications plan for publication?				

Appendix G

Capsticks' assurance letter/report

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London SW19 4DR

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DX 300118 – Wimbledon Central

www.capsticks.com

Kate Lampard

12th June 2014

Your ref:
Our ref: **GCH/069563**/10578613

Your contact:
Gerard Hanratty
T
F 020 8780 4604
E gerard.hanratty@capsticks.com

By Email Only

Email:

Dear Kate

Capsticks Assurance Letter
Investigation - Broadmoor Hospital

Capsticks were instructed by West London Mental Health NHS Trust ("the Trust") to provide legal assurance and support to the work of the Investigation Team ("the IT"), which had an independent investigator to lead it, in respect of the issues relating to Jimmy Savile's association with Broadmoor Hospital. Capsticks reported to the Local Oversight Panel ("the LOP") chaired by Nigel McCorkell, Chairman of the Trust, and to the Trust. This assurance letter covers both the processes and procedures followed by the IT and an evidence review to ensure that the conclusions and findings of the IT are justified by the evidence.

We are pleased to be able to give you this assurance in respect of the Trust and no doubt you will receive a similar assurance from the Treasury Solicitor who advises the Department of Health. As you are aware the investigation into Broadmoor was joint between the Trust and the Department of Health.

Process Assurance

As described in its report, the IT undertook extremely thorough searches for relevant documents and to identify and track down potential witnesses. This was far from easy, not least because the investigation had to cover events from the late 1960s.

We are also satisfied that the IT complied with its terms of reference, as modified at the request of the Department of Health, and had the necessary expertise to consider the issues properly. Where necessary, it sought appropriate independent expert evidence to assist it in its consideration of the evidence and its decision making. Equally important, we are satisfied that the IT has not exceeded its terms of reference, taking appropriate care not to do so.

We are satisfied that those giving written and/or oral evidence to the IT were managed and supported both in line with any legal requirements and also in accordance with current good practice. Due legal process was followed in relation to the living witnesses who were criticised in the draft report and their responses have been appropriately taken into account in the final version.

Evidence Review

As part of this exercise, Capsticks reviewed every witness statement and transcript of oral evidence. During this process where necessary we challenged and tested the IT's early findings and conclusions and the thinking behind them. We are satisfied that the findings and conclusions of the current version of the report are ones the IT is entitled to reach on the evidence available to it.

Finally, we would like to acknowledge the full support and help that Capsticks has received from Bill Kirkup, the investigation team and from the LOP, during the course of our work on this investigation.

Yours sincerely

Gerard Hanratty
Partner
Capsticks Solicitors LLP

CONFIDENTIAL LEGAL ADVICE
TO LEEDS TEACHING HOSPITALS NHS TRUST BOARD
RE THE "SPEAKING OUT" INVESTIGATION

Introduction

Capsticks were instructed by the Trust to provide legal assurance of the work of the Independent Investigation Team ("the IT"), reporting to the Local Oversight Panel ("the LOP") now chaired by Caroline Johnstone. This assurance covers both the processes and procedures followed by the IT and an evidence review to ensure that the conclusions and findings of the IT are justified by the evidence.

I am pleased to be able to give the Board this assurance.

Process Assurance

As described in its report, the IT undertook extremely thorough searches for relevant documents and to identify and track down potential witnesses. This was far from easy, not least because the investigation had to cover events from the early 1960s.

I am also satisfied that the IT complied with its terms of reference and had the necessary expertise to consider the issues properly. Equally important, I consider that the IT has not exceeded its terms of reference, taking appropriate care not to do so.

I am satisfied that those giving written and/or oral evidence to the IT were managed and supported both in line with any legal requirements and also in accordance with current good practice. Due legal process was followed in relation any witnesses who were criticised in the draft report, and their responses have been appropriately taken into account in the final version.

Evidence Review

As part of this exercise, Capsticks reviewed every witness statement and transcript of oral evidence, read every document referred to in the report, and some that are not. During this process, we challenged and tested the IT's early findings and conclusions and the thinking behind them. I am satisfied that the findings and conclusions of the current version of the report are ones the IT is entitled to reach on the evidence available to it.

Finally, I would like to acknowledge the full support and help that Capsticks and I have had both from Dr Sue Proctor and her colleagues on the Investigation Team, and from the LOP during the course of our assurance work.

David Firth
Capsticks Solicitors LLP
12 June 2014

Department of Health guidance

Investigating allegations and information about Jimmy Savile at NHS hospitals

GUIDANCE PACK

November 2013

CONTENTS

This pack contains the following guidance:

Appendices

Introduction

On 3 October 2012, ITV broadcast an Exposure programme '*The other side of Jimmy Savile'* featuring five women who reported that they had been abused by Jimmy Savile (JS). As a result of this programme individuals came forward to say that they too had been abused by JS and others. In response to these allegations the Metropolitan Police Services (MPS) set up Operation 'Yewtree'.

On 11 January 2013, the MPS jointly published a report with the NSPCC titled *'Giving Victims a Voice'*. Appendix G of this report lists NHS hospitals where Savile was reported to have offended.[1]

Separately in December 2012, Kate Lampard was invited by the Secretary of State for Health to oversee three investigations at Leeds Teaching Hospitals NHS Trust, Buckinghamshire Healthcare NHS Trust and Broadmoor Hospital with whom Savile was closely associated. Kate Lampard is a former practising barrister, former Deputy Chair of the Financial Ombudsman Service and also has significant experience of NHS procedures and practices.

As a result of the *Giving Victims a Voice* report and subsequent information provided by the Police, 10 further investigations were commissioned at NHS hospitals.

The MPS has recently given additional information to the Department of Health that identified further NHS organisations where investigations would need to be commissioned.

You have now received information relating to Jimmy Savile and a hospital or legacy hospital under the responsibility of your Trust. It will therefore be for your Trust to investigate thoroughly any matters arising out of this information as appropriate. *Your Trust will be responsible for conducting the investigation.* Where the information provided to you refers to other NHS hospitals, we have also passed this information on to those hospitals as well. We would ask that you liaise as appropriate with any other named organisations.

To ensure patient safety, your investigation should, as far as possible, establish the truth about the allegation or the information you have received and whether there is any implication for current policy and practice. Your investigation will need to publish a report which indicates what the investigation covered and, if possible, any conclusions. The Department is aware that any conclusions you make are likely to be qualified as, for example, Jimmy Savile cannot be questioned about the information you have.

[1] http://www.nspcc.org.uk/news-and-views/our-news/child-protection-news/13-01-11-yewtree-report/yewtree-report-pdf_wdf93652.pdf - please note, the list of Hospitals at Appendix G is not accurate or up-to-date

To ensure a consistent approach is taken, attached separately is a draft template report. We appreciate that some parts of the template report may not be relevant to your own investigation. It is anticipated that your own report will be modelled on this document, albeit amended in terms of house style etc.

As discussed within this guidance pack, it is recommended that you involve your legal advisers at the outset and that they should continue to be closely involved throughout the investigation process, including clearance of any report. Legal advisers will be able to identify issues that may not be readily apparent to the investigation team.

Kate Lampard is providing general assurance relating to all NHS investigations. She is being assisted by Verita who will review all reports to ensure thoroughness and consistency of approach. Your legal advisers should sign off the report before sending it to Verita. Kate Lampard's role (supported by Verita) is to ensure a consistent and thorough investigative approach has been adopted, no matter what the allegation or conclusion - but **not** to influence the report nor challenge its conclusions.

Draft reports should be assured by your legal advisers and to Verita by no later than **21 February 2014.** Your reports should be password protected, and sent to Barry Morris at Verita.london@nhs.net. Plans for coordinating publication will be discussed at the meeting on **9 December**; **it is crucial that your lead investigator and Trust solicitor attend this meeting.**

Once published, Kate Lampard has been asked to draw upon the findings of all NHS hospital reports to produce a comprehensive "lessons learned" summary report, identifying any themes, processes or guidelines more widely that need improving to assist the Department in ensuring that appropriate systems can be put in place. To support this, Ms Lampard wrote to all Chief Executives of NHS bodies in May 2013 calling for additional evidence to inform her review of any system wide improvements required in relation to safeguarding, access in relation to celebrities, fundraising and whistle-blowing.

This guidance pack has been formulated to assist your investigation but it is not intended to be exhaustive or prescriptive. It provides assistance on the type of issues your investigation may encounter and seeks to encourage consistency and thoroughness of approach across all NHS Investigations. But it is for your Trust, and your own legal advisers, to consider what is appropriate for the facts of your particular circumstances.

Initial guidance on the conduct of internal investigations

Reports of investigations carried out by the NHS and the Department of Health will be made available to the public unless exceptional circumstances apply.

We offer the following guidance to organisations conducting investigations:

- Each investigation should have written, customised terms of reference – agreed with the trust board. In addition, you may also wish to consider whether these should be agreed with the police (either the Metropolitan Police or the local force) and/or the local safeguarding boards **(see Appendix A);**

- Each investigation should be fully resourced; the lead investigator and members of the investigation team should have the necessary skills, knowledge and experience and should not have any conflict of interest;

- Each investigation should have a dedicated team able to pursue the investigation proactively, keep a grip on the issues, liaise with relevant parties, undertake the search for documents and witnesses, examine documents, undertake interviews of witnesses, and produce a report and recommendations for follow up actions;

- Document gathering should be comprehensive. This should include examination of documents relating to policy and procedure, relevant staffing and HR documentation, disciplinary proceedings, whistle-blowing, complaints and complaints handling, Patient Advice and Liaison Service ('PALs') and other patient support organisations, finance papers, relevant correspondence with the Charity Commission, Board and committee papers;

- Your investigation team may wish to draft a protocol to outline the support and care to be offered to victims and witnesses throughout the investigative process and thereafter;

- Each investigation should consider interviewing staff, former staff, board members and former board members, volunteers, known complainants and all other relevant witnesses should be invited to interview. Kate Lampard should be informed if significant witnesses refuse to participate;

- You may wish to consider giving Interviewees written notification – this may include a guide to giving evidence with information about your investigation **(see Appendix B);**

- Interviews should be recorded and typed transcripts made. Audio recordings should be kept for the duration of the investigation;

- Investigation reports should be broadly based on the draft template report provided separately and should separate facts from opinion;

- Difficult investigative issues – either about process or content – should be discussed with Verita and a view reached about how to proceed;

- Draft reports should be subject to legal review by lawyers. Verita should receive reports only **after** they have been signed off by legal advisers; and

- Those who are to be criticised in a report (or who might consider there to be implied criticism) must be given the opportunity to see the draft section of the report relating to them and respond to it (the "Scott process"). You must involve your legal advisers in this process. This should be done well in advance of the report being finalised so that individuals have time to take legal and other advice and respond and so that investigation teams have sufficient time to give proper consideration to any comments. ***However, letters should only be sent out after Verita has confirmed that it is content with the quality of the report.***

Terms of reference (ToR)

Your terms of reference should be the foundation for your investigation. Those doing the investigation need to understand their remit and what the commissioners of the investigation (the Trust) consider to be included in it and outside it. As such, we would recommend that the lead investigator is involved in drafting the terms of reference. Once drafted, you should clear the terms of reference with your legal advisers before they are finalised.

Your terms of reference should:

- Set out who is commissioning the investigation and by what authority e.g. the trust board under its general responsibilities for oversight of the organisation

- Explain the purpose of the investigation but also the limitations, for example, if the investigation has no disciplinary remit

- Set out the main tasks of the investigation i.e. the ground to be covered

- Make it clear that the investigators are expected to produce a written report with recommendations

- Include a timetable and state whether the outcome of the investigation is to be published and whose decision and responsibility this is

- Make clear the obligation of the investigation team to work closely with Verita who will be reviewing reports.

Where appropriate, you may also wish to consider discussing your terms of reference with the police and/or Local Safeguarding Children's Board ('LSCB') and/or Local Safeguarding Adults Board ('SAB').

Issues to consider when drafting your terms of reference

Incidents and allegations:

- Details of allegations made (sexual or otherwise) and of any other abuse allegations that might have links to Jimmy Savile
- How these allegations came to light
- The extent to which others in the organisation knew of allegations against Jimmy Savile and/or his team and/or associates and did/did not report or act upon them
- The organisation's response to these including:
    - Where appropriate, appeals for witnesses/ further reports of Jimmy Savile's abuse
    - Where appropriate, liaison with the police, local safeguarding board, and other bodies and Kate Lampard. Reviews of relevant policies and procedures.

Policy, practice and procedure throughout the time of Jimmy Savile's association with the organisation re:

- Volunteer staff, their role/s, their access, vetting and other safeguards in place in relation to volunteers
- Staff vetting
- Child and adult protection and safeguarding
- Whistleblowing
- Complaints handling and investigation (staff and patient complaints)

Present practice and procedures – steps taken to minimise the risk of this recurring?

- Lessons learned
- Response to lessons learned

Jimmy Savile's fund raising activities:

- Governance arrangements
- Any issues that arose in relation to the governance, accountability for and use of Jimmy Savile's charitable funds
- Liaison with the Charity Commission

Jimmy Savile's association with the organisation:

- How did it come about?
- Nature of JS involvement and his team/associates
- Dates and a full narrative chronology
- JS's access and (if applicable) accommodation
- What checks were made on JS? What safeguards were put in place?

<u>Any other</u> issues/topics relevant to your particular investigation

Carrying out an investigation

Guidance

Preparation

- Be clear who is commissioning the investigation

- Ensure that the trust board has set clear terms of reference (TOR) that explain the scope of the investigation. Consider whether TOR need to be agreed with any stakeholders (such as victims, families, relatives or local safeguarding boards). TOR should broadly deal with investigation of the allegation first, then historic policies (i.e. what were the 'rules' at the time of the incident) and thirdly, current policies.

- Consider whether a project plan is needed

- Ensure that the investigation team have the necessary experience and skill set and they are independent of the incident/allegations. Ensure there are no conflicts of interest and investigators have time to complete the work.

- Be clear about the nature of the incident or the allegations or the event being investigated and any consequences

- Be clear about what information came from the police and seek their permission to speak to victims and witnesses and to use any statements that they may have made.

Gathering evidence

- Gather all relevant documentary evidence from the time of the incident, for example, board minutes, policies and procedures, complaints documentation and patient records etc. You may need to look through electronic data bases or archives.

    a) It is recommended that a log is kept of what has been recovered and where from.

    b) Likewise, a log should be kept of documentation/information/individuals that has been sought and the steps undertaken to source it, even if the end result is negative.

- Gather all relevant current policies **(see Appendix C)**

- Develop as comprehensive a chronology as possible of events leading up to the incident or the time of the allegation

- Keeping a record of the investigation methodology, any decisions you make in relation to the methodology and the reasons behind them

- Develop a list of people who need to be interviewed

- Ensure that relevant patients, families and staff have the opportunity to be engaged and are supported during the investigative process

- Ensure that you interview the victim if possible. If this is not possible then explain what you have done to try and meet with them.

- Interview relevant people ensuring that there is an enduring record of the interview.

Analysis

- Analyse all evidence received against benchmarks of good practice where possible (benchmarks should be from the time the incident/allegation took place)

- In reaching your findings, take into account the cultural context at the time of the incident. Bear in mind the different attitudes towards abuse, towards celebrities and the implications of this for the investigation.

- Review relevant current policies and conclude whether they are adequate to safeguard against a similar incident happening now.

Report writing

- Write the report in simple English.

- Consider the draft template report

- Where relevant, the report should include the following information.
    - The terms of reference
    - An introduction, background information and context to the incident/allegations
    - Approach and methodology
    - A comprehensive chronology of events leading up to the allegation/incident

- A list of the interviews conducted
- An explanation of actions taken to locate and communicate with relevant staff, patients and witnesses
- Details of the documents and other evidence consulted
- An explanation of actions taken to identify and locate documents and any limitations on that process
- How the incident/allegations were treated in comparison with national, local policies from the time of the incident/allegation if possible
- An explanation of whether known risks were identified and managed or not (against national good practice and trust policy at the time of the incident/allegation). Say if benchmarks, criteria or documentary evidence is no longer available
- An explanation if there is not enough evidence to investigate the incident/allegations
- Identification of any service deficiencies at the time of the incident/allegations
- An explanation of the policies, procedures and measures in place that would help prevent the type of incident/allegation happening today
- An appropriate amount of testimonial and documentary evidence to support the points it makes.
- Evidence of how patients/victims and families have been engaged and supported during the investigation
- Necessary personal information but no more than is required, e.g. no comments about sexuality when it is not required to tell the story
- Information which makes it clear that the report or extracts of it were sent out to those criticised (or of whom criticism could be implied) for any matters of accuracy/fact-checking (Scott process)
- Findings and conclusions clearly linked to the evidence
- An analysis or consideration of where the truth lies where there is a conflict of evidence
- An assessment of whether the victim is credible or not and therefore whether the incident took place – you may decide this is based on whether they stood up to challenge at interview, whether their statement matched the statement they made to the police, whether you had any corroborating evidence etc. For example, you could say that on balance, you believe the incident took place because the victim was credible, regardless of the fact that there is no other corroborating evidence. You would want to be clear that the investigation is limited by lack of evidence.
- Recommendations where appropriate.
- Consideration of any other issues particular to the facts and circumstances of your investigation

Report finalisation

- Allow time for the Scott process if it is applicable – which is where there is any express or implied criticism of any individual or organisation; see page 6 above for further details and timings on this point.

- Ensure that the report is proof read and peer reviewed by an appropriate person in your organisation **(see Appendix D for example check list).**

- Ensure that the report is legally reviewed before sending to Verita.

- Send the draft report to Verita for assurance of thoroughness with other NHS investigations.

Victim and Witness Support

A crucial part of an effective investigative process is ensuring the proper treatment of all who give information, particularly vulnerable witnesses. Your investigation team may be seeking information of a sensitive nature; it may not be easy for victims and witnesses to come forward or to detail abuse. We recommend that special consideration be given to ensuring that vulnerable witnesses are appropriately cared for and those who have alleged abuse are treated sensitively and appropriately.

There should be effective collaboration with local health services and independent counselling agencies to ensure that referrals to counselling and other mental health services can be made.

Sir Bruce Keogh wrote to all NHS chief executives in May 2013 to ask them to ensure that all GPs were alert to the possibility of victims and witnesses presenting for help and support so that the victims and witnesses could have their support needs, of whatever degree, met in a timely and appropriate fashion.

It is recommended that:

- A clear victim and witness support strategy/protocol is established at the outset before your investigation begins
- That support is made available before, during and after your investigation
- Victims and witnesses (as far as this is possible) remain in contact with the same individual throughout the investigative processes
- Victims and witnesses are kept informed of developments

In addition to local services, victims and witnesses may wish to contact one of the following:

NAPAC	**NSPCC**	**SAMARITANS**
Association for people abused in childhood 0800 085 3330 www.napac.org.uk	0800 800 5000 www.nspcc.org.uk	08457 909 090 www.samritans.org (Helpline to provide a safe place to talk where all conversations are private)

Good practice guidance for interviewing

The following approach is recommended:

1. Decide who needs to be interviewed.

2. A letter should be sent to each interviewee explaining the purpose of the investigation and the interview process.

3. The interviewee should be offered the opportunity to bring a friend or representative to their interview, though it should be made clear that the investigators' questions will be directed at them.

4. The interview should be recorded or transcribed to provide an enduring record.

5. The PEACE method for interviewing should be adopted:
   - **P**reparation and planning
   - **E**ngage and explain
   - **A**ccount, clarification and challenge
   - **C**losure
   - **E**valuation.

6. The interviewer should ask open questions and not lead the interviewee.

7. A copy of the transcript should be sent to the interviewee for checking. The interviewee should sign and send it back to the investigation team with any amendments.

8. Any urgent concerns arising during the interviews e.g. to do with safeguarding or safety of a patient should be reported to the appropriate person in the trust.

9. An extract of the draft report should be sent to those expressly or impliedly criticised for any matters of accuracy/fact-checking (Scott process – see page 6 above for further details about how this should work).

Legal assurance

As the Commissioning Trust, you hold responsibility for ensuring your investigation and its report are legally assured.

Procedural and legal issues arise in all investigations. It is important to get these right so that the investigative process runs smoothly, individuals are treated fairly and lawfully, the integrity of the investigation is preserved and the timetable is maintained.

We recommend that all Trusts conducting an investigation seek legal advice throughout the investigative process, from inception to the report's publication.

This list below is illustrative of the kind of issues your investigation team may encounter; it is *not* intended to be exhaustive; you and your legal advisers will need to consider carefully the particular circumstances relating to your trust.

Examples:

1. Defamation

Those conducting investigations, and any individual giving evidence in such investigations, are as open to an action for slander or libel as anyone else in respect of oral and written statements.

2. Scott Letters / Maxwellisation / Warning letters

Investigations should obtain advice on issuing warning letters to any individuals or organisations likely to receive criticism (or about whom criticism may be inferred) in their report, setting out, for example, the substance of that criticism and providing them with an opportunity to respond. It is important to involve lawyers in this process. See page 6 above for further details.

3. The Data Protection Act 1998

You need to check at all stages with your legal advisers that you are acting in compliance with data protection legislation. The Data Protection Act 1998 requires, for example, that personal information should be processed fairly and lawfully; should only be disclosed in appropriate circumstances; should not be held any longer than necessary; and should be kept securely etc. You will need to give careful consideration as to the publication of personal information in your report.

4. Anonymity and Naming Names

The approach to the publication of the reports should be for *openness* and *transparency* as far as possible. The following general guidance may be helpful as a broad framework (subject however to the particular circumstances of your investigation and to any independent legal advice you may obtain):

- Anyone in a public facing role should be named (examples include: board director, senior professional, consultant etc);

- Victims should be anonymised in the report, *unless* they wish to be identified – some may do and we recommend that you ask them and obtain appropriate written consent etc if they do wish to be named);

- Witnesses should be named if they are *integral* to your investigation. If they have only agreed to cooperate on the basis of anonymity then obviously they should not be named;

- Others (usually more junior staff etc) should only be named if they are *integral* to your investigation. If not, then use of their job title is sufficient but you may need to consider whether they can be identified from such use.

- *You should obtain consent from all those you interview or speak to about the terms in which they will be referred to in the report*

We emphasise however that <u>you should seek independent advice from your legal advisers on anonymity and naming of names in your report and any other legal issues.</u>

APPENDIX A
Sample Terms of Reference

Independent Investigation commissioned by The Leeds Teaching Hospitals NHS Trust

Please note that these ToR are provided for illustrative purposes only. Consideration must be given to the individual facts and circumstances of your own investigation and your ToR drafted accordingly.

TERMS OF REFERENCE

Investigation into matters relating to Jimmy Savile

The Board of Leeds Teaching Hospitals NHS Trust (LTHT) has commissioned this investigation into Jimmy Savile's association with the Leeds General Infirmary, and other institutions under the management of LTHT and its predecessor bodies (all such institutions herein referred to as LTHT), following allegations that he sexually abused patients and staff during his voluntary or fund-raising activities there.

LTHT will work with independent oversight from Kate Lampard, appointed by the Secretary of State for Health to oversee the investigations carried out by the three NHS bodies with which Jimmy Savile was associated, to produce a written report that will:

1. Thoroughly examine and account for Jimmy Savile's association with LTHT and its predecessor bodies, including approval for any roles and the decision- making process relating to these;

2. Identify a chronology of his involvement with LTHT and its predecessor bodies;

3. Consider whether Jimmy Savile was at any time accorded special access or other privileges, and/or was not subject to usual or appropriate supervision and oversight;

4. Consider the extent to which any such special access and/or privileges and/or lack of supervision and oversight resulted from Jimmy Savile's celebrity, or fundraising role within the organisation;

5. Review relevant policies, procedures and practices throughout the time of Jimmy Savile's association with LTHT and its predecessor bodies and compliance with these;

6. Review past and current complaints and incidents concerning Jimmy Savile's behaviour at any of the hospitals owned or managed by LTHT and its predecessor bodies including:

   - where the incident(s) occurred;

   - who was involved;

   - what occurred;

   - whether these incidents were reported at the time and whether they were investigated and appropriate action taken.

   The investigation does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability. Where evidence is obtained of conduct that indicates the potential commission of criminal offences, the police will be informed. Where such evidence indicates the potential commission of disciplinary offences, the relevant employers will be informed.

7. Where complaints or incidents were not previously reported, nor investigated, or where no appropriate action was taken, consider the reasons for this, including the part played, if any, by Jimmy Savile's celebrity or fundraising role within the organisation;

8. Review Jimmy Savile's fundraising activities and any issues that arose in relation to the governance, accountability for and the use of funds raised by him or on his initiative/with his involvement;

9. Review LTHT's current policies and practice relating to the matters mentioned above, including employment checks, safeguarding, access to patients (including that afforded to volunteers and celebrities) and fundraising in order to assess their fitness for purpose. Ensure safeguards are in place to prevent a recurrence of matters of concern identified by this investigation and identify matters that require immediate attention.

10. Identify recommendations for further action.

Appendix B

INTERVIEWEE INFORMATION

INDEPENDENT INVESTIGATION – BROADMOOR HOSPITAL

Please note that this document is illustrative only. Consideration must be given to the individual facts and circumstances of your own investigation and the information intended for interviewees should be drafted accordingly.

Introduction

1. The independently led investigation was set up by the West London Mental Health NHS Trust and Department of Health following allegations of misconduct including sexual abuse by Jimmy Savile during his activities at Broadmoor Hospital.

2. The objective is to investigate the allegations made against Jimmy Savile concerning the time that he was involved with the hospital, to understand how this could have happened and to establish what must be done to stop this happening again. This includes examining fully what happened, establishing what procedures and safeguards were in place then and whether current policies and procedures are adequate to ensure that these events cannot happen again. Further details are set out in the Terms of Reference.

3. An independent investigator, Dr Bill Kirkup CBE will lead the investigation, assisted by Paul Marshall. The investigation is subject to local scrutiny by a Local Oversight Panel and national oversight from Kate Lampard, who was appointed by the Secretary of State for Health to ensure that the NHS investigations into Jimmy Savile's conduct at Stoke Mandeville, Broadmoor and Leeds General Infirmary are comprehensive and follow good practice.

4. The investigation will be conducted in private. This means that only members of the investigation team and interviewees will be present at the interviews. The media and public will not be allowed to attend.

5. Information will be sought from anyone with relevant information about Jimmy Savile's association with or activities at Broadmoor Hospital. In particular, the investigation team is keen to hear from anyone who:

a) was the subject of misconduct including inappropriate sexual behaviour by Jimmy Savile at Broadmoor Hospital or in connection with his involvement there;

b) knew of or suspected misconduct including inappropriate sexual behaviour by Jimmy Savile at Broadmoor Hospital or in connection with his involvement there;

c) raised concerns about Jimmy Savile's conduct with a member of staff at Broadmoor Hospital or elsewhere in the local NHS or Department of Health/Department of Health and Social Security (DHSS), whether formally or informally;

d) worked at Broadmoor Hospital (or the Department of Health/DHSS branch who were responsible for its management) during the time that Jimmy Savile was involved there and had contact with him; this is whether or not you were aware of any inappropriate behaviour;

e) worked with or for Jimmy Savile in relation to his involvement at Broadmoor Hospital or elsewhere in the local NHS;

f) was familiar with the culture or practices of Broadmoor Hospital during that time;

g) held a senior position at Broadmoor Hospital (or the Department of Health/DHSS responsible for its management) and may have relevant information which will assist the investigation.

6. The investigation team will seek out documentary and other material that could assist in fulfilling the terms of reference. This may include the collection and analysis of records relating to the time and reports and assistance from experts or professional advisers.

7. The investigation team may make such amendments to this procedure as appear to be necessary.

How can you help?

8. You are encouraged to contribute by:

a) sending relevant documentation
   - for example, a letter of complaint or policies and procedures in place at that time;

b) providing a written account of what you know.
   - guidance on what to include or assistance with preparing the account, if required, will be provided by the investigation team;

c) attending an interview with the investigation team.

Interviews

9. The investigation team may not need to interview all those who provide a written account; however, it is likely that in many cases further clarification would be helpful and if so, you will be invited to attend for an interview. In some cases, the investigation team may ask you to attend for interview without having obtained a written account first.

10. The investigation team will always treat interviewees fairly and sensitively.

    a) If you are unable to travel then we can discuss how best to obtain your account.

    b) If you were the subject of inappropriate sexual conduct by Jimmy Savile or others you may bring someone to support you. Patients at Broadmoor may bring a member of their clinical team, an advocate or their solicitor; staff at Broadmoor may bring a work colleague or staff side representative; people not at Broadmoor may bring a friend, family member, professional representative or any of the above, by prior agreement with the investigation team. However, they may not answer questions on your behalf and the investigation team may, at their discretion, exclude any person from interviews.

    c) If you are asked to attend for interview, the investigation will refund your reasonable standard class travel costs (and those of one friend or family member accompanying you) if travelling on public transport, or your reasonable fuel costs. However, we cannot pay any other costs, including fees of solicitors or other representatives.

11. If asked to attend an interview and you decide against it, it will not be possible to give the same weight to your account and this may hamper the investigation. Current and former NHS and Department of Health employees will be expected to attend if asked.

12. Interviews will last as long as necessary to clarify information, but are unlikely to last more than two hours.

13. All interviewees and persons accompanying them will be expected to keep confidential any information disclosed to them.

14. The information given at interview will be recorded (either digitally or by a stenographer) and, at the request of the interviewee or the investigators, may be transcribed; in which case the interviewee will be sent the record of the interview to check for accuracy and to sign.

Anonymity and publication

15. The investigation will not publish the name of anyone who was the subject of inappropriate sexual conduct without their consent. If we need to give details of your identity to anyone else (such as the police) this will be done in confidence. Other interviewees can ask to remain anonymous and we will consider these requests, especially for junior staff.

16. The information given will be used for the purpose of preparing the report of the investigation. The report will be made public and information from written accounts and interviews may be included. At this stage, it is not the intention to publish the evidence in its entirety but it is possible that some or all of the information you provide may be made public in due course.

17. The main objective of the investigation is as set out in paragraph 2 above and the investigation team has formed no view, provisional or otherwise, as to whether it is necessary to make any criticism of any individual or organisation. Should any points of potential criticism arise, the person or organisation concerned will be informed of them, either orally, when they are interviewed, or in writing. Before receiving written notice of the detail of any potential criticism, the recipient may be required to give an undertaking to keep the written notice and the information contained in it confidential, except for the purpose of taking advice or preparing a response.

Information sharing

18. What you say will be treated sensitively. However, it may be necessary to share relevant information (eg allegations of a crime by a living person) with the police, or with professional regulatory bodies or others; any information sharing will be done lawfully and in accordance with the Data Protection Act and other statutory obligations.

Support

19. The investigation team is extremely grateful to all those who feel able to help, but recognises that many witnesses will be re-living painful, difficult or stressful experiences and may need further support before speaking to us about these events. The following services are available:

    Trust – Via the Occupational Health Department and Staff Support Service
    Independent – Arrangements will be made via Staff Support for additional support outside of the Trust where appropriate.

Contacts

If witnesses would like further information about the investigation then please contact [ ]

Appendix C

Current policies to review

- Recruitment and selection
- Safeguarding children
- Volunteering
- Conduct and discipline
- Whistleblowing
- Violence and aggression
- Sanctioned visitor
- Safeguarding adults
- Complaints
- Dignity at work
- Information governance
- Security
- Standards of business conduct
- Retention of documents
- Visitors and VIPs
- **Any other relevant policies your investigation team identify**

Appendix D

Check list

- Your legal advisers should have cleared the report and Verita should have checked it for quality.

- The report is sensibly structured and written in a coherent fashion

- The report states the purpose of the investigation and contains explicit terms of reference which have been previously agreed with the trust board

- The report provides an introduction, background information and context to the incident

- The report explains the scope of the investigation;
    - how far back the investigation goes
    - which organisations are included
    - any known limitations
    - agreements with trust board about scope.

- The report provides a comprehensive chronology (as far as possible) of events leading up to the incident(s)

- The report clearly describes the incident(s) and its consequences

- The report provides a list of witnesses and interviews conducted

- The report provides details of the documents and other evidence consulted

- The report gives an appropriate amount of evidence, both testimonial and documentary evidence to support the points it makes

- The report provides evidence of how patients/victims and their relatives have been involved and supported and communicated with during the investigation and describes the processes followed in doing so. If no contact has been made, it describes the rationale for this.

- The report describes the investigation process and any investigative/analytical tools used

- The report highlights any good practice noted which might have reduced the impact of the incident

- The report explains the rationale for including information about staff or patients so that only relevant information is disclosed. If any interviewees are identifiable it needs to be made clear that the appropriate permission has been obtained including where necessary permission to quote from any witness statements or medical records.

- The report provides findings, conclusions and recommendations clearly linked to the evidence

- The report names explicit and objective criteria against which judgements are made. For example:
    - Policies and procedures
    - National guidance.

- The report reviews relevant current policies and procedures and makes recommendations about any changes needed.

- Where recommendations are made in the report they:
    - are clear and measurable
    - are based on findings
    - include the name of a lead person to take them forward
    - do not exceed the terms of reference
    - are appropriate and address underlying problems

- The report names the authors

- Where appropriate, the report provides a stand-alone executive summary which can be read independently of the main report which summarises the incident and its consequences and describes the investigation process and conclusions.

- The report states if individuals criticised by the investigation team have been given the opportunity to see the section of the report containing the criticism (or implied criticism), the right to comment on factual accuracy and offered the chance to add to evidence if necessary. The report provides evidence that any comments or evidence provided by individuals who have been criticised have been taken into account. If, exceptionally, individuals have not been given the opportunity to see the relevant section, the reasons for this should be outlined in the report.

Appendix E

Contact log

Oversight

Independent oversight	Kate Lampard	KateLampard@Verita.net

Report assurance

Verita Consultants	Barry Morris	BarryMorris@Verita.net
	Jess Martin	JessicaMartin@Verita.net

Metropolitan Police Service

Disclosure officer	DC Mandy Sparks	Mandy.Sparks@met.pnn.police.uk

Appendix I

Detective Superintendent David Gray's assurance letter dated 13 June 2014

Sexual Offences Exploitation and Child Abuse Command

Empress State Building
Lillie Road
London
SW6 1TR

Telephone:
Facsimile:
Email:
Dave.Graybafa8@met.police.uk
www.met.police.uk

Your ref:
Our ref:

13th June 2014

Kate Lampard
Verita
53 Frith Street
LONDON
W1D 4SN

Dear Ms Lampard

I understand that you may be reaching a point in time where the hospital trusts are close to submitting their reports. I would like to give you my assurance that relevant material held by the Metropolitan Police Service and collected under Operation Yewtree has been shared up to and including October 2013. This was the material that was reviewed as part of the Special Police Service provision and outlined in a report to the Department of Health, dated 7th November 2013.

Specifically material was considered appropriate for disclosure if it did not relate to a live criminal investigation and the individual gave consent to have their details passed to the review team.

I can confirm that as a result of the Special Police Service one hundred and fifty seven (157) individuals were identified as being able to provide relevant information, were suitable to be contacted by the op. Yewtree team and consented to their details being passed to the review teams.

Material gained after that time is still subject to review, but the timing of that process will be dependent upon other competing priorities, primarily the detection and prevention of crime. I therefore am not able to give you the same level of assurance that all documentation has been reviewed for the Department of Health purposes, from November 2013 onwards. Should anything relevant be found within this material it will of course be shared with the appropriate hospital trust through the Department of Health.

Yours faithfully

David GRAY

Detective Superintendent

Operation Yewtree

William Vineall's assurance letter dated 19 June 2014

William Vineall
Deputy Director
Department of Health
79 Whitehall
London, SW1A 2NS www.dh.gov.uk

Kate Lampard
C/O Verita
53 Frith Street
London
W1SD 4SN

20 June 2014

Dear Kate,

NHS and Department of Health Investigations into matters relating to Jimmy Savile

The Department of Health was informed by you in April 2013 that the Metropolitan Police Service 'MPS' held information relating to Jimmy Savile and health and care settings.

The Department of Health entered into a Special Police Services agreement with the Mayor's Office for Policing and Crime to enable this material to be reviewed and subsequently passed the information on to the relevant legacy health organisation. As you are aware, the MPS did not provide information that (i) related in whole or part to a live police investigation; and/or (ii) any information relating to nominals who did not consent to their information being provided to the NHS review teams (the term 'nominals' used by the MPS refers to both individuals and organisations).

Under the Special Police Services Agreement, the Department of Health received information from the MPS relating to **One Hundred and Fifty Seven (157) 'nominals.'**

The names of the nominals disclosed to the Department of Health are contained in the MPS' report dated 7 November 2013 (received by the Department of Health on 8 November 2013); you have been provided with a copy of this report. The report omits disclosure of nominal 157 which was disclosed to the Department of Health, after receipt of the MPS report, on 19 November 2013.

The Department received the information relating to nominals from the MPS as follows:

Nominals 1 – 25 (inclusive)	MPS disclosed nominals to DH on 8/10/13
Nominals 26 – 45 (inclusive)	MPS disclosed nominals to DH on 14/10/13
Nominals 46 – 70 (inclusive)	MPS disclosed nominals to DH on 14/10/13
Nominals 71 – 110 (inclusive)	MPS disclosed nominals to DH on 21/10/13
Nominals 111 – 122 (inclusive)	MPS disclosed nominals to DH on 24/10/13
Nominals 123 – 155 (inclusive)	MPS disclosed nominals to DH on 30/10/13
Nominal 156	MPS disclosed nominals to DH on 6/11/13
Nominal 157	MPS disclosed nominals to DH on 19/11/13

Of the information relating to 157 nominals received from the MPS:

(a) Information relating to four (4) nominals was passed back to the MPS as it fell outside the scope of the NHS investigations; the MPS did not wish for the Department of Health to pass this information on to the relevant organisation;
(b) Information relating to eighteen (18) nominals was passed to the Department for Education as it related (in whole or part) to children's homes and schools; and
(c) Information relating to three (3) nominals was sent to NHS Scotland.

Of the information received relating to 157 nominals, information concerning one hundred and thirty two (132) nominals was passed on to the relevant NHS organisation for investigation.

In addition to the information relating to 157 named nominals, the Department of Health also received anonymous information from the MPS. This was likewise passed on the relevant organisation for investigation as appropriate.

All relevant information received by the Department of Health from the MPS was securely passed to the relevant Trust/legacy Trust for investigation. The team at the Department of Health that received the information from the MPS have not been involved in any of the investigations. Where, on the face of the documentation provided by the MPS, the location was unclear, the Department of Health passed this information on to the independent investigation team at The Leeds Teaching Hospital NHS Trust ('the Leeds team') for them to conduct initial investigations. The Leeds team conducted initial enquiries to identify the correct location and, where possible, passed that information on to the relevant Trust for investigation. Where the information related or referred to more than one location, the Department of Health passed that information on to all named legacy Trusts.
Please do not hesitate to contact me if I can assist any further.

Yours sincerely

William Vineall

Deputy Director