NHS SAVILE LEGACY UNIT: OVERSIGHT REPORT

FEBRUARY 2015

SR Proctor, C Jones, R Galloway

An assurance report

for the Secretary of State for Health

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Appendices

Acknowledgements

On behalf of the NHS Savile Legacy Unit, we wish to thank the following:

All those who felt able to come forward following the publication of the NHS trust investigation reports in June 2014, and give accounts of abuse at the hands of Jimmy Savile on NHS premises.

All those at the Department of Health who have assisted us in our work.

Kate Lampard and her team at Verita for their advice.

All NHS Trusts involved in the preparation and conduct of investigations into allegations of abuse, or the potential risk of abuse by Savile on NHS premises, and in the production of their subsequent reports.

Those agencies outside the NHS who have assisted us in our work overseeing the investigations. These include the NSPCC, Victim Support, NAPAC, the Metropolitan Police, Thames Valley Police, West Yorkshire Police, Greater Manchester Police, Northumbria Police, Kent Police and Merseyside Police.

Executive Summary

The NHS Savile Legacy Unit (SLU) was established by the Department of Health in July 2014 to provide assurance and oversight of NHS investigations arising from new allegations of abuse concerning Jimmy Savile in the NHS. The SLU is independent of the Department of Health and its role is to ensure that any new allegations of abuse by Savile, or allegations of the risk of abuse by him on NHS premises are properly and consistently investigated by the relevant NHS trusts. The SLU will conclude its work in February 2015.

A threshold for investigations to be conducted was agreed with the Department of Health as part of the terms of reference for the SLU as follows:-

- Cases alleging specific or general abuse by Savile and information to indicate a risk of abuse by him were documented by the SLU, discussed with the relevant trust chief executive and support and guidance provided to the trust lead investigator throughout the investigative process.

- Cases where unspecific information concerning Savile in an NHS organisation where no risk of abuse was mentioned were also recorded by the SLU and the relevant trust notified. The decision as to whether an investigation took place in these cases was left to the discretion of each individual trust.

The SLU has provided oversight and assurance to twelve new NHS investigations of new allegations of abuse or the risk of abuse by Savile. In the case of two trusts, these concerned allegations of abuse from more than one victim. Twelve reports are published at the same time as this report by the trusts concerned. A further three investigations have commenced and will be published separately.

Unspecific information concerning Savile's presence or involvement with NHS organisations where no abuse or risk of abuse was mentioned related to two additional trusts.

The SLU received final versions of the twelve NHS trusts' investigation reports in January 2015. Each report was approved on the basis of it being a record of a thorough and robust investigative response to the allegations. Further, each case was deemed to have fulfilled their terms of reference and met the agreed assurance process.

1.0 Introduction

1.1 James Wilson Savile was a national celebrity from the 1960s until his death in 2011. From an early career in wrestling and running dance halls, he developed a career as a successful radio disc jockey and television presenter of hugely popular programmes regularly watched by millions. Alongside this he also sustained a high public profile as a charitable fund raiser, running marathons to raise funds for good causes which included hospitals and charities for disabled people.

1.2 In October 2012, a year after his death, ITV broadcast a documentary 'The other side of Jimmy Savile' in which five women gave accounts of abuse at the hands of Savile. A subsequent investigation by the Metropolitan Police took place, known as Operation Yewtree. This suggested approximately 450 specific allegations against Savile, which took place when he worked at the BBC and also in a number of NHS organisations.

1.3 In October 2012, Kate Lampard was invited by the Secretary of State for Health to independently oversee three major investigations into matters relating to Savile in the following NHS trusts; Leeds Teaching Hospitals, West London Mental Health (which runs Broadmoor Hospital), and Buckinghamshire Healthcare (which runs Stoke Mandeville Hospital). The reports for the Leeds and Broadmoor investigations were published in June 2014 (Proctor et al, 2014; Kirkup & Marshall, 2014). The report for the Stoke Mandeville hospital investigation is to be published in February 2015.

1.4 As a result of Operation Yewtree, a number of additional allegations were made about abuse perpetrated by Savile on NHS premises. Kate Lampard provided oversight of these smaller investigations and 28 further reports were published in June 2014. This included 27 hospitals and one hospice. Kate Lampard's assurance report was published alongside these NHS reports and confirmed a robust process was followed by each investigation team (Lampard, 2014).

1.5 To ensure that lessons are learned across the NHS from these investigations, in November 2012, the Secretary of State asked Kate Lampard to look at NHS wide procedures in the light of their findings. The purpose of this was to see whether relevant guidelines or procedures need to be changed, to identify emerging themes and make recommendations for action. That report is being published alongside this assurance report.

1.6 In June 2014,the publication of the reports concerning Leeds Teaching Hospitals Trust and West London Mental Health Trust, along with the 28 smaller reports led to significant media coverage in respect of their findings. This publicity encouraged more individuals to come forward with new information or allegations about abuse carried out by Jimmy Savile on NHS

premises. It was felt to be important that any such new allegations of abuse were investigated properly and thoroughly by the trusts concerned.

2.0 NHS Savile Legacy Unit

2.1 The NHS Savile Legacy Unit (SLU) was established by the Department of Health in July 2014 to provide independent assurance and oversight of NHS investigations arising from any new allegations of abuse by Savile received since July 2014**.** The Unit is independent of the Department of Health and its role is to ensure that any new allegations of abuse by Savile, or risk of abuse by him on NHS premises, are properly and consistently investigated by the relevant NHS trusts.

2.2 The role of the SLU aligns with that of Kate Lampard and her team at Verita, in that it provides oversight and assurance of the investigation of any new allegations of abuse in NHS premises notified from July 1 2014. The four outstanding investigations that had commenced prior to this date have been assured by Kate Lampard.

2.3 The SLU is led by Professor Susan Proctor, the former independent investigator for the Leeds NHS Savile investigation. Together with Ray Galloway and Claire Jones, also former members of the Leeds investigation team, the SLU has provided advice and guidance to all NHS trusts required to conduct investigations into new allegations of abuse by Savile on their premises.(Appendix A presents biographies of the SLU team)

2.4 The terms of reference for the SLU are:

1. To ensure any victims or witnesses coming forward since the publication of the NHS investigation reports in June 2014 are referred appropriately via a dedicated email and telephone contact point; including onward referral to the relevant NHS Trust for thorough investigation;
2. To provide a single point of NHS contact for any external parties for Savile-related enquiries;
3. To establish clear referral pathways to address the potential investigation of cases identified from reports to the police, from charities (such as NSPCC, Victim Support, NAPAC), from legal representatives of victims, from NHS trusts, and from individuals themselves; and to refer for investigation by NHS trusts information or reports of abuse, including where there was a risk that abuse had occurred;
4. To provide guidance to relevant NHS trusts in the conduct of investigations into new allegations, and through robust oversight processes, to assure the quality and consistency in their standards of investigations and subsequent reports;

5. To establish regular liaison with the police and charities working to support Savile's victims; and
6. To produce a factual summary report of all new NHS investigations undertaken by NHS trusts by February 2015.

2.5 New allegations concerning abuse in NHS trusts who have previously conducted investigations into matters relating to Savile are also expected to be properly investigated by the trusts concerned.

2.6 Information about the role, purpose and contact details of the SLU was shared with the police and the main national charitable organisations engaged in working with victims of Savile. (These were the NSPCC, NAPAC and Victim Support).

2.7 Information letters were also sent via the Trust Development Authority and Monitor to all NHS trusts and NHS foundation hospital trusts, and via NHS England, to Clinical Commissioning Groups. Information about the SLU was also placed on the www.gov.uk website.

2.8 The SLU met with senior officials at the Care Quality Commission, Monitor, NHS England, Trust Development Authority and NHS Providers.

2.9 Regular contact was maintained with Kate Lampard throughout the duration of the SLU's term of office to keep her abreast of new information or any significant new allegations.

2.10 Appendix B presents a summary of the work undertaken by the SLU

2.11 The SLU will conclude its work with publication of the new reports in February 2015. If further allegations of abuse by Savile on NHS premises are made which require investigation, these will be investigated by the relevant NHS trust, with oversight provided via statutory local safeguarding arrangements.

3.0 The role of the SLU in respect of new allegations

3.1 The SLU provided advice to trusts on the design and resource needs of their investigations and publication of subsequent reports to ensure they were of a high standard. This has included advice on the skills required of the investigators and the need for appropriate support for those involved in the investigations. In dialogue with the trust lead investigators, the SLU offered advice on the progress of investigations and on the local resolution of any emerging obstacles to progress.

3.2 The trusts and the Department of Health have retained responsibility for the performance management of the investigations, but are not responsible for the assurance of the process and content of reports. At the invitation of the Department of Health, the SLU has attended and participated in meetings with trusts concerning the progress of their investigations and reports. The independent role of the SLU has been maintained in providing a clear and uncompromised assessment of the robustness of the investigations and reports

3.3 The SLU has provided the Department of Health with regular (fortnightly) progress updates. This has included disclosure of emerging areas of risk to the quality of the investigation process and the robustness of reports.

3.4 The SLU received information relating to new allegations through a number of routes:

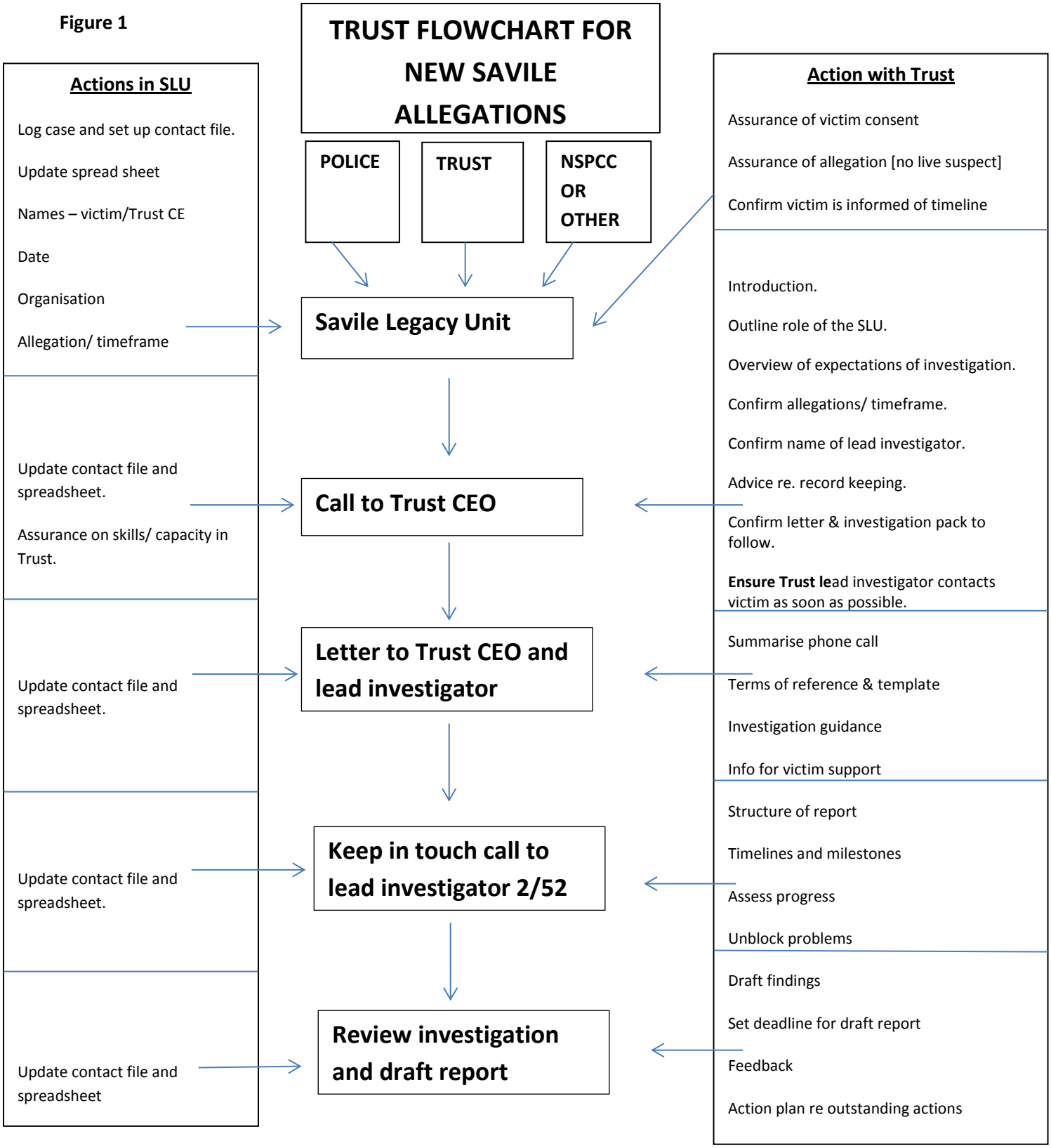
Under the information sharing agreement between the Metropolitan Police and the Department of Health;

Individuals who contacted the SLU helpline or NHS trust directly; and

Referrals from the NSPCC or other organisations.

3.5 New information notified to the SLU was processed in the following stages (illustrated in the flowchart in Figure 1)

Figure 1


TRUST FLOWCHART FOR NEW SAVILE ALLEGATIONS
POLICE
TRUST
NSPCC OR OTHER
Actions in SLU
Log case and set up contact file.
Update spread sheet
Names – victim/Trust CE
Date
Organisation
Allegation/ timeframe
Savile Legacy Unit
Update contact file and spreadsheet.
Assurance on skills/ capacity in Trust.
Call to Trust CEO
Update contact file and spreadsheet.
Letter to Trust CEO and lead investigator
Update contact file and spreadsheet.
Keep in touch call to lead investigator 2/52
Update contact file and spreadsheet
Review investigation and draft report
Action with Trust
Assurance of victim consent
Assurance of allegation [no live suspect]
Confirm victim is informed of timeline
Introduction.
Outline role of the SLU.
Overview of expectations of investigation.
Confirm allegations/ timeframe.
Confirm name of lead investigator.
Advice re. record keeping.
Confirm letter & investigation pack to follow.
Ensure Trust lead investigator contacts victim as soon as possible.
Summarise phone call
Terms of reference & template
Investigation guidance
Info for victim support
Structure of report
Timelines and milestones
Assess progress
Unblock problems
Draft findings
Set deadline for draft report
Feedback
Action plan re outstanding actions

All information received was classified into one of four categories:

1. Specific or general allegation of abuse;
2. Information to indicate risk of abuse;
3. Unspecific information concerning Savile's presence or involvement with an NHS organisation where no abuse or risk of abuse was mentioned; and
4. General information relating to Savile.

3.6 A threshold for investigations to be conducted was established in the following manner:

- Cases falling into categories 1 and 2 above were documented by the SLU and discussed initially with the relevant trust chief executive with a full explanation of the expectations of how an investigation should proceed (Appendix C lists these trusts). The SLU then provided support and guidance to the nominated trust lead investigator, as their investigation proceeded; and

- Cases falling into categories 3 and 4 were also documented by the SLU and notified to the relevant trust, but whether or not further investigation took place was determined at the discretion of the trust. If they decided to conduct an investigation, the SLU provided oversight and guidance as required. The table in Appendix D lists the trusts where such unspecified information was received.

3.7 The SLU is satisfied that in each case where a full investigation was not conducted, that each trust response was proportionate and relevant to the information received.

4.0 Oversight of new investigations

4.1 Twelve investigations of new allegations of abuse or the risk of abuse have been conducted by NHS trusts since July 2014. The hospitals affected are listed in Appendix C. In all but two cases, they concerned one allegation. In the remaining two trusts, numerous allegations were received. Leeds Teaching Hospitals NHS Trust were notified of a further six allegations, along with contextual accounts from two new witnesses; and five allegations were made in respect of Buckinghamshire Health Care NHS Trust, (which runs Stoke Mandeville Hospital) along with contextual information from a new witness. These allegations were received *in addition* to those disclosed to the major investigations conducted in these organisations and have resulted in the publication of additional reports by these trusts.

4.2 Since the ministerial statement in November 2014 which outlined the twelve new investigations into allegations of abuse by Savile in NHS trusts, the SLU has been advised of three further allegations in additional NHS trusts. Investigations have now commenced in these organisations (Appendix C) and oversight will be provided in line with the arrangements described in 2.11.

4.3 The reports of the twelve investigations are published at the same time as this report. All reports are available on the relevant trust website and, via a web link on the Department of Health website. The reports of the additional three investigations will be published by the relevant trust as soon as they are completed.

4.4 Allegations of abuse

The SLU undertook the following tasks in response to every allegation made relating to abuse by Savile working alone (category 1):-

- Every case was recorded and a contact file established;
- The full database of all new allegations was updated on a weekly basis;
- Names and contact details of the source of the information, the individuals concerned, and the hospital where the abuse took place (or current organisation with nominated legacy responsibilities for hospitals no longer in operation) were checked for accuracy and recorded;
- Introductory call to the trust chief executive. This was made to outline the role of the SLU, to explain the expectations for their investigation and to provide other relevant advice. Each trust was requested to identify a named lead investigator who would be responsible to the chief executive;
- A confirmation letter containing all the above details and guidance pack (Appendix E) for the conduct of the investigation was then forwarded to the Trust;
- The lead investigator was strongly advised to make early contact with the victim, or the person making the allegation;
- The full database of all cases was updated with all salient information after every contact with each trust;
- Assurance was sought from each lead investigator as to the local arrangements in place to support victims and witnesses;
- Meetings were held with the relevant trust lead investigator and the SLU to monitor progress and provide guidance as necessary;
- The SLU continued to have contact with the lead investigator on at least a fortnightly basis until the submission of their report;
- Reports were received in draft form and commented on by the SLU in terms of the rigour, clarity and assurance of approach, and returned to the trust for amendment as required; and

- Final versions of reports, subject to legal assurance by trust legal advisors were approved by the SLU prior to being formally received by trust boards (Appendix F).

4.5 Allegations of **the risk** of abuse

Where the SLU received information that suggested a risk of abuse (category 2) by Savile on NHS premises, the actions set out in 4.4 above were enacted

4.6 The management of general information

Unspecific information concerning Savile's presence or involvement with NHS organisations where there was no report of abuse or risk of abuse, was reported in relation to two named hospitals (Appendix D) (category 3)

- Where the SLU received information about Savile's engagement or visits to NHS premises, after being recorded in the full database, this was passed to the relevant trust. Discussion took place with the trust chief executive or the executive director with responsibility for safeguarding. Any action or investigation of such information was taken at the discretion of the Trust concerned. The SLU was available to provide advice and guidance as necessary. The trust was asked to inform the SLU of their decision and rationale for our records.

4.7 Any general information about Savile where abuse was not specified, nor a named hospital or NHS organisation identified, was recorded in the SLU database but not subject to any further action.

5.0 Assurance of investigation reports

5.1 At the invitation of the Department of Health, the SLU attended their meetings with the investigating NHS trusts. The purpose of this was to outline expectations of the rigour and robustness of the investigations, and to answer any questions. At subsequent meetings, trust lead investigators gave updates on the progress of their investigations and on the production of their reports. The SLU was able to offer advice and guidance on the progress of investigations at these meetings, particularly where trusts were facing similar issues of concern. The final meeting confirmed local and national arrangements for publication and media communications.

5.2 The SLU appraised whether the draft reports described a thorough and robust approach to the investigation, and whether they were of an acceptable standard. Detailed feedback on the draft reports was provided to the lead investigators.

5.3 The SLU met with the Department of Health at least fortnightly, and provided updates on the progress of investigations and the draft reports. This was for the purpose of information sharing on the process, not the content of the reports.

5.4 Regular dialogue was maintained between the SLU and Kate Lampard about the progress of the new investigations, emerging issues and themes

5.5 When updated draft reports were received, the SLU reviewed these and checked to ensure that earlier comments or queries had been appropriately addressed. Any concerns about either the investigations or the quality of the reports were discussed with the lead investigators in the first instance. If resolution could not be found, then the Department of Health was informed and agreed the actions required to resolve the issue, in its performance management capacity.

5.6 The investigation reports have been reviewed in order to offer assurance that the investigations and the reports have been rigorous and thorough. The SLU has not sought to influence the content or conclusions of any of the reports.

6.0 Overall Assurance

6.1 The SLU received final versions of the NHS trusts' investigation reports in January and February 2015. In each case, the reports and investigations were considered to be appropriate and rigorous responses to the allegations. In each case, they were deemed to have fulfilled their terms of reference.

6.2 Responsibility for the quality of the reports and their publication rests with the relevant trust boards. The trust boards accepted their reports during December 2014 and January 2015. (Appendix F presents the template document completed by all trust boards in respect of their approval of their investigation report).

7.0 Conclusion

7.1 This report describes the arrangements which were put in place in July 2014 to ensure thorough and robust oversight of all new NHS investigations into allegations of abuse by Jimmy Savile.

7.2 The oversight process was based on the processes established by Kate Lampard and her team, and was comprehensive.

7.3 This report has described the details of the processes undertaken by the Savile Legacy Unit. These processes have enabled us to provide general assurance on the quality of the investigations and the subsequent reports.

7.4 We therefore conclude that the NHS investigations referred to in this report and completed to date have been conducted in an appropriate, professional and robust manner, and that their reports should be published.

8.0 References

Kirkup W Marshall P Jimmy Savile Investigation: Broadmoor Hospital. Report to the West London Mental Health NHS Trust and the Department of Health. 2014

Lampard K: Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile. An assurance report for the Secretary of State. 2014

Proctor SR Galloway R Chaloner R Jones C Thompson D. The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust. 2014

Appendices

Appendix A

NHS Savile Legacy Unit team biographies.

Sue Proctor – Chair

Sue is a Director of SR Proctor Consulting Ltd. Until 2010 she worked in the NHS for over 25 years in a variety of nursing, midwifery and management posts, culminating in the position of chief nurse/ Director of Patient Care & Partnerships for NHS Yorkshire and Humber. In this position she had responsibility for clinical governance, professional standards and commissioning independent inquiries into serious adverse incidents of care delivery and overseeing the implementation of their recommendations. An experienced board director, she is also Vice Chairman at Harrogate and District NHS Foundation Trust, Chair of the LEAF Multi Academy Trust in Leeds, a member of the Council of the University of Leeds and Visiting Professor at Leeds Beckett University. Sue has an MSc in nursing and a PhD in health service research. She led the recent independent investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust.

Claire Jones – NHS Relationship Manager

Prior to becoming a partner in her own consultancy – Kuredu Consulting Ltd, Claire had 30 years' experience of working in the NHS. Claire has a broad portfolio of experiences relating to secondary care, the ambulance service, the Department of Health and NHS Yorkshire and Humber. Most recently, she was a senior investigation advisor on the Savile NHS investigation at Leeds Teaching Hospitals NHS Trust. Claire has worked for a number of acute providers in the role of a senior nurse, whilst moving on to undertake a number of national and regional large scale change programs, relating to strategic service redesign and improvement. Claire has urgent care and ambulance service experience and has led system wide improvement programs spanning the acute, primary, community and social care sectors. Claire maintains her professional nursing registration and has a BSc [Hons] and MA in leadership, innovation and change.

Ray Galloway – Director of Investigation

Ray retired from the police service in January 2013, having served as a senior Investigating Officer with both Merseyside Police and North Yorkshire Police, during a career that spanned 30 years and included a wide variety of investigative roles. Ray has extensive experience of dealing with major investigations, including serious and organised crime and sensitive investigations in healthcare settings. He was also a professionally accredited Senior Investigating Officer and a member of the Association of Chief Police Officers' National Rape Working Group, which identified and embraced best practice in terms of investigating sexual offences. Ray was Director of Investigation for the Savile NHS investigation at Leeds Teaching Hospitals NHS Trust. Ray has a BA [Hons] in applied social sciences.

Summary of oversight activity of the NHS Savile Legacy Unit

Development and refinement of guidance pack (Appendix G) for the conduct of investigations relating to Savile and the production of subsequent reports.

Established initial contact and sustained dialogue with the Metropolitan Police (Operation Yewtree), West Yorkshire Police, Greater Manchester Police, Northumbria Police, Thames Valley Police Kent Police and Merseyside Police.

Established initial contact and clarification of investigative arrangements with key national charities concerned with the support of victims of sexual abuse; including NSPCC, NAPAC and Victim Support.

Contact and discussion with NHS trust chief executives responsible for organisations where there were allegations of abuse or the risk of abuse by Savile.

Contact and regular discussion (at least fortnightly) with nominated lead investigators in each NHS trust.

Attended five meetings held by the Department of Health for the NHS trusts conducting investigations.

Attended fortnightly meetings with the Department of Health to report on progress.

Ensured regular liaison with Kate Lampard on new allegations.

Provided briefings on the role of the NHS Savile Legacy Unit to the Care Quality Commission, Monitor, the Trust Development Authority and NHS England.

Invited to give presentations on the NHS Savile Legacy Unit and the learning from the Leeds investigation to various NHS and other health care organisations including NHS England South, NHS England North, NHS Providers, National Conference for NHS Auditors, HfMA Conference, Belfast, Audit North and partners, and safeguarding officers in Wakefield, Barnsley and Bradford District Care Trust

Appendix C

List of new investigations in to allegations relating to Jimmy Savile

Announced November 2014

Trust	Hospital/Predecessor Organisation
Leeds Teaching Hospitals NHS Trust	Leeds General Infirmary
Pennine Acute NHS Trust	Birch Hill Hospital
Buckinghamshire Healthcare NHS Trust	Stoke Mandeville Hospital
Calderstones NHS Trust	Scott House Hospital
South London and the Maudsley NHS Foundation Trust	Bethlem Royal Hospital
Central and North West London NHS Trust	Shenley Hospital
Yorkshire Ambulance Service NHS Trust	West Yorkshire Metropolitan Ambulance Service
Kent and Medway NHS and Social Care Partnership Trust	St Martins Hospital
Newcastle Upon Tyne NHS Foundation Trust	Royal Victoria Infirmary
Leeds and York Partnership NHS Foundation Trust	Meanwood Park Hospital
Calderdale and Huddersfield NHS Foundation Trust	Calderdale Royal Hospital
Queen Elizabeth Hospital Gateshead NHS Foundation Trust	Queen Elizabeth Hospital

New investigations (reports to be published separately)

Mersey Care NHS Trust	Moss Side Hospital and Ashworth Hospital
Guys and St Thomas's NHS Foundation Trust	Guys and St Thomas's Hospital
Humber Mental Health Foundation Trust	De La Pole Hospital

List of other Trusts involved

Trust	Predecessor Organisation
Salford Royal NHS Foundation Trust	Salford Royal Hospital.
Peterborough and Stamford NHS Foundation Trust	Peterborough District Hospital and Edith Cavell Hospital.

NHS Savile Legacy Unit

Investigating allegations and information about Jimmy Savile at NHS hospitals

GUIDANCE PACK

August 2014

CONTENTS

This pack contains the following guidance:

Appendices

Introduction

Background

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 independently 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 during the course of 2013, further investigations were commissioned at NHS hospitals. Kate Lampard was also tasked with providing general oversight of these smaller investigations, supported by Verita (consultants specialising in investigations).

Of the NHS investigations commissioned by hospital Trusts in 2013, 28 reports were published on 26 June 2014, this included 27 NHS hospital Trusts and one hospice. Kate Lampard's assurance report was published alongside these NHS reports; her report confirmed a robust process was followed by each investigation team.

All of the NHS reports published in June are now publicly available and can be accessed via the relevant Trust website. A copy of Kate Lampard's independent assurance report can be found on the Department of Health website which also houses links to all Trust websites containing their JS report.[2]

[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

[2] https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile

Kate Lampard will continue to provide assurance of any ongoing investigations including the investigations at Stoke Mandeville and Rampton. These reports are expected to be published in the autumn.

To ensure that lessons are learnt, findings from the ongoing NHS investigations referred to above, as well as findings from the NHS reports published in June will feed into Kate Lampard's second phase of work where she will report back to the Secretary of State in the autumn on any themes emerging in relation to safeguarding, access and fund-raising. Kate Lampard's "lessons learned" summary report will identify any themes, processes or guidelines more widely that need improving.

NHS Savile Legacy Unit

The publication of the NHS reports in June, and the significant media coverage in respect of their findings, has encouraged further individuals to come forward with information or allegations of abuse by Jimmy Savile on NHS premises.

It is important that any new allegations of abuse are investigated properly and thoroughly by the Trusts concerned.

The NHS Savile Legacy Unit (SLU) has been established to provide general assurance relating to all new NHS investigations. The Unit is independent of the Department of Health and will ensure that any new information or reports of abuse, by Savile on NHS premises, including where there was a risk that abuse had occurred, are properly and consistently investigated by the relevant NHS hospital Trust to the same standard that has been followed to date. The independent unit is led by Dr Sue Proctor, the former independent investigator of the Leeds investigation. Dr Proctor is being assisted by Ray Galloway and Claire Jones. The terms of reference for the SLU have been published on the Department of Health website.

You have now received new 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. We are

aware that any conclusions you make are likely to be qualified as, for example, Jimmy Savile cannot be questioned about the information you have.

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.

The SLU will review all reports to ensure thoroughness and consistency of approach. Your legal advisers should sign off the report before sending it to the SLU. At the same time, you should also complete and return the assurance proforma (see Appendix E).. The SLU's role 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. The SLU's terms of reference can be found on the Department of Health website.

Draft reports should be assured by your legal advisers and *securely* sent to the SLU. Your report should be password protected, and sent to Ray Galloway at [ray.galloway@dh.gsi.gov.uk]. Plans for coordinating publication will be discussed at a meeting with the SLU and the NHS investigations leads in October [date tbc]; **it is crucial that your lead investigator and Trust solicitor attend this meeting.**

The SLU will produce a factual summary report of all new NHS investigations undertaken by NHS Trusts by January 2015.

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 NHS Trusts will be made available to the public unless exceptional circumstances apply. Once assured by the SLU, it is expected that your report will be made available to the public on your Trust's website.

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 1);**

- 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 and Board and Committee papers, as well as any finance papers and correspondence with the Charity Commission, if relevant to your investigation.

- 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 relevant staff, former staff, board members and former board members, volunteers, known complainants and all other relevant witnesses should be invited to interview. The SLU 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 2);**

- Interviews should be recorded and typed transcripts made. Audio recordings should be stored securely and confidentially and kept for the duration of the investigation and as advised by your legal advisers.

- Interviewees should have the opportunity to review the transcript and confirm they are an accurate reflection of the interview.

- 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 the SLU and a view reached about how to proceed;

- Draft reports should be subject to legal review by Trust lawyers. The SLU 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 the SLU 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 conducting 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 the SLU 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 information or reports of abuse, including where there was a risk that abuse had occurred 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. 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 (including employment checks etc)
- 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 or other partner organisations (i.e. NSPCC/NAPAC etc) 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 3)**
- Develop as comprehensive a chronology as possible of events leading up to the incident or the time of the allegation

- Keep a record of the investigation methodology, any decisions made in relation to the methodology and the reasons behind them
- Develop a list of people who need to be interviewed and regularly review the list to ensure the relevance and need for further interviews
- 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 and accurate 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 sought or 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 7 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, ensuring confidentiality is maintained **(see Appendix 4 for example check list).**
- Ensure that the report is legally reviewed before sending to the SLU
- Send the draft report to the SLU 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 such as your Local Victim Support, victims and witnesses may wish to contact one of the following:

NAPAC Association for people abused in childhood	**NSPCC**	**SAMARITANS**
0800 085 3330	0800 800 5000	08457 909 090
www.napac.org.uk	www.nspcc.org.uk	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 7 above for further details about how this should work).

Legal assurance

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

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 7 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 1

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 behavior 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 2

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 3

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 4

Check list

☐ You should have completed the SLU assurance proforma *before* submitting your final report to the SLU (see Appendix E).

☐ Your legal advisers should have cleared the report and the SLU 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 5

Contact log

NHS Savile Legacy Unit

Independent oversight and report assurance

Sue Proctor	sue.proctor@dh.gsi.gov.uk	0113 25 45481
Ray Galloway	ray.galloway@dh.gsi.gov.uk	0113 25 45153
Claire Jones	claire.jones@dh.gsi.gov.uk	0113 25 45502

NHS SAVILE LEGACY UNIT ASSURANCE PROFORMA

Independent oversight of NHS investigations into matters relating to Jimmy Savile

Final report proforma

Please could the investigation lead and trust chief executive complete this proforma and return to the SLU so that the report can be signed off for publication.

Please attach this form to the absolute final version of your report before sending it to the SLU.

If the answer to any of these questions is 'no', please provide an explanation.

	Yes	No
Please confirm that a hard copy of your final report has been shared, in controlled circumstances, with the local police and they have signed it off for publication.		
Please confirm that any allegations relating to other hospitals and/or trusts have been referred on to the appropriate investigation team. Please write N/A if you have not found any.		
Please confirm that the final report has been reviewed and signed off by the trust's legal advisors.		

Please confirm that legal advice was sought about whether Scott[3] letters needed to be issued.		
If Scott letters were needed: • Were letters issued? • Were responses received? • Was the report amended in light of the responses?		
Please confirm that you have offered, or plan to offer, to share the report with: • The victim • The informant (if not the victim) • Any other relevant party.		
Please confirm that you have the appropriate consent to quote from statements and interviews (this includes if you have used direct quotes from MPS information).		
Please confirm that appropriate support was offered to victims and witnesses and will continue to be offered at time of publication and afterwards.		
Please confirm your report has been signed off by the trust board. If so, on what date did this happen?		

[3] Warning letters setting out potential criticisms of individuals

Lead investigator, signature:	
Trust chief executive, signature:	