

**A Further Investigation into the Allegations of Abuse by Jimmy
Savile at Leeds General Infirmary**

A Report by Leeds Teaching Hospitals NHS Trust

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1. Acknowledgements

The investigation team would like to thank the people who came forward for this internal investigation and also those people from the previous independent investigation to share their experiences of Jimmy Savile at Leeds Teaching Hospitals NHS Trust (“the Trust”). The Trust is sincerely sorry for the distress their experience of Jimmy Savile caused them and their families. The Trust welcomes the opportunity to understand what happened to our patients and staff so that we can learn from their experience to ensure this does not happen again. We appreciate that one victim found it difficult to share their experience with us but we are grateful that they have agreed for us to remain in contact should they feel more comfortable about meeting with us in the future.

The investigation team would like to thank the previous independent investigation team for its thorough and comprehensive investigation which produced a detailed report into the matters relating to Jimmy Savile at Leeds Teaching Hospitals NHS Trust. Their investigation and report has been an invaluable source of information for this subsequent investigation. This, together with the 31 recommendations made in the independent report, has enabled the internal investigation team to take stock on the Trust’s progress with regards to actions required to meet their recommendations.

The investigation team would like to thank the NHS Savile Legacy Unit and Leeds Teaching Hospitals NHS Trust Quality Committee for their support and guidance throughout the investigation. In addition we would like to thank colleagues at the Trust for helping the investigation team with checking any evidence on past and current practice in relation to the accounts of people who came forward to tell us about their encounter with Jimmy Savile at the Leeds General Infirmary. We would also like to thank colleagues at West Yorkshire Police for their assistance in communicating with the victims and witnesses who came forward.

2. Executive Summary

In December 2012, the Trust Board commissioned an external independent investigation team to thoroughly and comprehensively investigate matters relating to Savile. We refer to this as “the independent report”. The independent investigation was led by Professor Sue Proctor.

Immediately following publication of the independent report in June 2014, the Trust established a helpline for anyone who had concerns arising from the investigation or publication of the report.

The Trust safeguarding team was commissioned by the Quality Committee to co-ordinate and lead on any actions arising out of any new concerns raised.

On the 28th August 2014, the NHS Savile Legacy Unit provided the investigation team at the Trust with a list of eight names comprising of six victims and two witnesses. Of the eight names provided, we were initially given consent to contact three of the victims and one witness. Due to on-going police investigations, consent to contact the remaining victims and a witness was delayed.

During the week commencing 3rd November 2014, the investigation team was given permission to contact two more of the victims and the remaining witness.

In December 2014, we were also contacted by the internal investigation team from Yorkshire Ambulance Service NHS Trust (YAS), who are currently carrying out their own investigation into historic matters relating to Savile within its predecessor organisation, West Yorkshire Metropolitan Ambulance Service (WYMAS). This information has also been included in this investigation report.

In total we have interviewed three of the six victims and both witnesses and the accounts of three victims and one witness are included in this report. We have excluded one witness account because they did not witness any abuse by Savile, two victims have not agreed to be interviewed and we do not have permission to

contact the final victim. We have also included a summary of the witness evidence provided by the YAS investigation team.

Within the report, where we set out in sections 11 to 25 the details of each witness or victim account, we have also followed this with a review of relevant current practice, policy and procedures, measuring actions taken by the Trust in working towards fulfilling the 31 recommendations made by the independent investigation team.

This report includes a section on the effectiveness of the Trust's current safeguarding arrangements and makes the following additional recommendations.

The additional recommendations are:

- The Trust should afford any other victims of Savile, the opportunity to share their experience with the Trust to enable the Trust to establish if there are any other lessons to be learned.
- To have an appropriate safeguarding policy in place for the admission of children and young people who are admitted to adult wards. Such admissions are exceptional events, but in some cases necessary.
- To ensure that safeguarding is included in the work of the Transitions Strategy Board looking at the needs of 16/17 year old patients.
- The Trust should review its policies and procedures related to the care and welfare of its employees to ensure there is explicit reference to safeguarding staff from abuse.
- The Trust should review its complaints procedure to ensure that there is accessible information available for children that is child friendly using language that children are able to understand.

- The Trust should review its process for informing children of their right to be safe from abuse.

3. Introduction

Concerns regarding Savile were initially highlighted in an ITV documentary shown in October 2012. Following this broadcast the Trust received a number of calls from staff, former patients and others reporting accounts of verbal, physical and sexual abuse at the hands of Savile. Through subsequent investigations including Operation Yewtree led by the Metropolitan Police, we now know that Savile was a prolific sexual predator, paedophile and rapist.

In December 2012, the Trust Board commissioned an external independent investigation team to thoroughly and comprehensively investigate matters relating to Savile. The independent investigation team, led by Professor Sue Proctor, commenced their work in January 2013. During the investigation 60 victims gave evidence of abusive or inappropriate behaviour perpetrated by Savile during his time at the Leeds General Infirmary, and of these 33 were patients at the time they reported they were abused.

The independent Report¹ was published on 26th June 2014 alongside the reports of investigations at twenty eight other hospitals including Broadmoor. The report paints a truly shocking picture of the extent of the activities of Savile within the Trust's hospitals from the 1960's to 2009.

In October 2012 the Secretary of State for Health invited Kate Lampard to oversee the independent investigations in the NHS organisations with which Savile had been most closely associated to provide independent assurance on behalf of the Department of Health. It is expected that Kate Lampard will publish her final lessons report in early 2015.

Immediately following publication of the independent report in June 2014² the Trust established a helpline for anyone who was affected by the findings of the

¹ The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust, June 2014

² *Ib id*

independent investigation or publication of the independent investigation report. The Terms of Reference for the helpline are contained at Appendix A.

The Quality Committee on behalf of the Trust Board commissioned the safeguarding team to investigate further allegations in relation to Savile. The Trust Executive Lead for the investigation is Professor Suzanne Hinchliffe, CBE, Chief Nurse. The Terms of Reference are contained in the body of this report and included at Appendix B. The Biographies for the internal investigation team and Executive Lead for the investigation is at Appendix C of this report.

4. Terms of Reference

The purpose of the investigation is outlined below.

- i. Enable any new victims or witnesses to come forward and give them the opportunity to have their story heard.
- ii. To provide a managed and coordinated process for patients, members of the public and Trust staff (including ex-employees) who contact the Trust direct, via the NHS Savile Legacy Unit, or other bodies to identify themselves as a new victim or witness.
- iii. In meeting any new victims or witnesses if any unmet needs are identified to signpost the victims or witnesses to the national helplines and/or other support networks.
- iv. To ascertain if there any new concerns that relate to any currently employed staff in order for the appropriate action to be taken.
- v. To assess and, if deemed appropriate, refer any new concerns to the police.
- vi. To assess and, if deemed appropriate, refer any new concerns to any other investigating bodies for example Human Resource Department or

safeguarding investigation in line with local safeguarding policy and procedures³.

- vii. To investigate any new allegations, provide apologies and learn from their experience in order to initiate any further action required by the Trust by way of recommendations to ensure people are protected from abuse.

Scope of the Investigation

- i. To give new victims and witnesses the opportunity to come forward and be heard concerning any allegations of abuse made that might have links to Jimmy Savile and how these allegations came to light.
- ii. The extent to which others in Leeds Teaching Hospitals NHS Trust knew of the allegations against Savile and/or his associates and did/did not report or act on them.
- iii. To investigate allegations raised by new victims and witnesses who have come forward who are outside of the timeframe of the independent investigation commissioned by the Leeds Teaching Hospitals NHS Trust Board and subsequent independent report published in June 2014.
- iv. To look at the present practice and procedures of Leeds Teaching Hospitals NHS Trust and steps taken to minimise the risk of recurrence of abuse, through lessons learned and responses to those lessons learned.
- v. This investigation and any future investigations into the matters relating to Savile will be mindful of the extensive investigation undertaken by the independent investigation team and the resulting report published by the Trust on the 26th June 2014.

³ <http://www.leedssafeguardingadults.org.uk/> <http://www.leedslscb.org.uk/>

- vi. It is not within the scope of this investigation to re-investigate or re-interview any victims or witnesses who have previously been subject to interview by the independent investigation team, unless any new enquiry leads the investigation team to any matters related to a previous allegation or link to a previously identified witness or victim.
- vii. Leeds Teaching Hospitals NHS Trust commissioned a very detailed and thorough investigation into matters related to Jimmy Savile as published in the independent report in June 2014. It is not within the scope of this investigation to provide a detailed report on the policy and practice throughout the time of Jimmy Savile's association with Leeds Teaching Hospitals NHS Trust, or its predecessor organisations. This report will however make reference to the previously published report regarding the following areas:
- volunteer staff, their role(s), their access to patients;
 - vetting and other safeguarding in place in relation to volunteers;
 - staff vetting;
 - child and adult protection and safeguarding;
 - whistleblowing;
 - complaints handling and investigation;
 - Savile's fund raising activities at Leeds Teaching Hospitals NHS Trust;
 - Savile's association with Leeds Teaching Hospitals NHS Trust.

5. The Report of the Investigations into Matters Relating to Jimmy Savile at Leeds - The Independent Report published 26th June 2014

The independent report and its findings have been shared widely with staff within the Trust. The Chief Executive, Julian Hartley addressed the report and its findings as part of his 'Start the Week' message to staff on the 30th June 2014 when he said:

“I’m sure everyone of you will have been as shocked and appalled as I was at details of the activities of Savile at our hospitals, outlined in the independent report published last week, and reported widely in the media.

We commissioned the report so we could fully understand what happened, and learn from it and I’d like to thank everyone who spoke to the investigation team about their experiences. My email to you last week, outlined the greater safeguards, security and procedures we now have in place to protect our patients, visitors and staff.

I want to reiterate today the importance of us having an open culture where everyone feels comfortable and confident to speak out and raise concerns. It’s extremely important that you are familiar with the policies and procedures that support this. We must all play our part in protecting patients from harm to ensure nothing like this ever happens in Leeds again.”

The full public address is contained at Appendix D.

The executive summary of the independent investigation together with the full report is accessible on the [Leeds Teaching Hospitals NHS Trust](#) web pages⁴. This has also been published on the [Department of Health](#) website along with 28 other NHS reports⁵.

The independent investigation report and its 31 recommendations were accepted by the Trust Board.

Following publication of the independent investigation report, an action plan was formulated by the Chief Nurse and presented to the Trust Board. It identified each of the 31 recommendations and an Executive Director was allocated to each recommendation. Each of the named Executive Directors is responsible for taking ownership of their relevant recommendations and reporting on progress made, future

⁴ <http://www.leedsth.nhs.uk/savile-report>

⁵ <https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile>

action plans and time scales in which to address each of the recommendations. The action plan is contained within Appendix E to this report.

Significant progress and improvements have already been achieved in addressing each of the 31 recommendations.

6. NHS Savile Legacy Unit

Following the June 2014 publication of the NHS reports into the activities of Savile and the significant media coverage which followed, the Department of Health anticipated the publicity might encourage further individuals to come forward to report information or allegations of abuse involving Savile. On the 26th June 2014 the Secretary of State for Health Jeremy Hunt, made a statement to the House of Commons in which he emphasised the need for further reports of abuse to be properly investigated. He accepted that such investigations can pose a significant challenge to NHS Trusts therefore it is vital that they are conducted to a professional and ethical standard that can withstand scrutiny.

The NHS Savile Legacy Unit (the NHS SLU) was established to provide general assurance relating to all new NHS investigations. The unit is independent of the Department of Health and its primary functions are as follows:

- to co-ordinate all NHS related allegations with regard to the activities of Savile;
- to quality assure and support the investigation by NHS Trusts of such allegations;
- to act as a conduit between NHS Trusts, the police and partner organisations, as necessary and appropriate;
- to review and quality assure Trust reports and recommendations.

7. Information Received from the NHS Savile Legacy Unit

On 28th August 2014, the NHS SLU provided the Trust's internal investigation team with a list of eight names comprising of six victims and two witnesses (Appendix F). Of the eight names provided, four had given consent to be contacted by the Trust's internal investigation team, and we contacted them in September 2014.

During week commencing 3rd November 2014, we were given permission to contact three more of those included in the list of eight names.

On the 8th December 2014 information was passed to us by the NHS SLU, which said that a new witness had spoken to investigators from the Yorkshire Ambulance Service NHS Trust ("YAS"); YAS is also investigating matters relating to Savile within its predecessor organisation West Yorkshire Metropolitan Ambulance Service (WYMAS). We were told that the witness had disclosed information which was relevant to our investigation. The information received from the YAS investigation has been included in this report.

Of the seven individuals (who we had consent to contact), six had given prior evidence to West Yorkshire Police, of experiencing or witnessing abuse related to Savile. The other one was a former member of staff who had trained and worked at the Leeds General Infirmary (LGI) in the 1950s. She did not complain of abuse, but said that she saw a man, who she believes to have been Savile, in and around the LGI during her employment there. This evidence had the potential to place Savile within the LGI earlier than had previously been established by the independent report.

We have not been given permission to contact the final victim from the original list of eight names. We interviewed one witness who told us that she had seen Savile in the LGI in 1971, when she was 10 years of age. She saw him in the emergency department and again later, when she was admitted to a children's ward. She said she had seen Savile come on to the children's ward late one evening, but she did not witness any abuse or untoward behaviour by Savile. Given the terms of reference for

this investigation, this witness's account has not been included in this report and we have spoken with the witness to explain why this is.

Total number of contacts received from NHS SLU (victims and witnesses)	8	
	Analysis	
	Victims	Witnesses
Interviewed and included in the report	3	1
Interviewed but not included in the report (outside terms of reference)	0	1
Not yet interviewed	3	0
Totals	6	2

The main source of referral to the NHS SLU was West Yorkshire Police, with the exception of one witness who was sourced from the National Society for the Prevention of Cruelty to Children (NSPCC).

On receiving permission to contact the victims and witnesses from the NHS SLU, Professor Suzanne Hinchliffe personally wrote to each of the victims and the witnesses who had provided consent to be contacted, to apologise on behalf of the Trust for their experience and to explain the process of the investigation. (Appendix H). Jeff Barlow, Head of Safeguarding and Sharon Scott, Resilience Manager (The Trust's Internal Investigation Team) contacted each person to make arrangements to meet with them to hear of their experiences. Three victims and two witnesses agreed to speak with us. However, one victim was contacted but wanted time to consider whether they wanted to take the opportunity to tell us of their experience.

We kept in regular contact with this victim to support their decision and encourage them to meet with the team. The victim continued to decline the opportunity to meet

with the investigation team. The victim also told us that they found it difficult to have contact with NHS hospital services. The victim did agree that the team could continue to contact them and assess whether they may wish to meet with us at any point in the future. We have assured this victim that if she does feel able to speak with us, the Trust will learn from her experience and embed any lessons learned.

We have been unable to interview another victim from the original eight names, after permission was given to contact them by the NHS SLU on the 3rd November 2014. The victim has not spoken to us to date, despite numerous attempts to contact them. We were able to speak to a close family member on the 17th November 2014, who confirmed that the victim had received the letter inviting them to be included in the investigation. The family member agreed to speak with the victim and encourage them to speak to us to ensure that they are given the opportunity to share their experience with us so we can learn from their experience. To date we have not been contacted by the victim.

8. Methodology

Status of the Investigation

The terms of reference for this investigation were approved by the Quality Committee on behalf of the Trust Board. The Quality Committee is a sub-committee of the Trust Board and is chaired by a Non-Executive Director with other Trust Executive representation.

The Chairs of the Leeds Children's Safeguarding Board (LSCB) and Leeds Safeguarding Adults Board (LSAB) formed part of the local oversight committee within Leeds for the Savile independent investigation. The chairs of the local safeguarding boards formed part of the panel providing an assurance and oversight role in addition to providing expert advice to the independent investigation team. The Leeds LSCB Manager and Head of Safeguarding Adults (on behalf of the LSAB) were given a verbal update on the terms of reference for this internal investigation in October 2014. The local safeguarding boards were advised that the internal

investigation would build upon the previous independent investigation rather than repeat an investigation into areas already covered by the independent investigation report.

A draft copy of the investigation report was presented to the Trust Quality Committee in November 2014 and the NHS Savile Legacy Unit in December 2014. In November 2014 a verbal investigation status update was provided to Trust Board. Chairs action was taken for the approval of this report on behalf of Trust Board in December 2014. The final draft was submitted to the NHS Savile Legacy Unit on 18th December 2014. The final report will go to the January 2015 Trust Board meeting and the Trust will share the findings of this report with the local safeguarding boards.

The Investigation

Health records of victims were accessed and reviewed from the following hospital data sources.

- Patient Access System (PAS) - this is the Trust's electronic data base which records patient's clinical details, such as hospital appointments, clinic details, attendance to emergency department and hospital admissions. The system details admissions and appointment details including dates, times and clinic details.
- The patient's medical records which detail all the hospital records and clinical details for patient's receiving and accessing care at the Trust.

We requested and examined employee records in order to attempt to verify any dates of employment for any individuals named by the witnesses. Two individuals were named by a witness and both of these individuals were employed by the Trust in the 1950s through to the late 1970s. We were able to confirm the employment of one of the individuals, but also learned that they are now deceased.

One victim identified a Trust employee by name but we were unable to verify the employment record of the individual. We appealed to long standing Trust employees

through selected internal email to come forward to verify any historical victim and witness accounts. A small number of long standing employees did come forward but we were unable to corroborate any victim or witness accounts through our discussions with them.

Historic Policies and Practice

We were mindful of the thorough and comprehensive investigation previously undertaken by the independent investigation team and the independent report⁶ published in June 2014. We used the original investigation report to corroborate any dates, contemporaneous policy documents and other records for this investigation. We made reference to the extensive evidence collated for the production of/and contained within the independent report published in June 2014.

The independent report provides a very detailed and comprehensive review of the policies, procedures and accepted practice at the time of the reported incidents. In relation to this report, we heard evidence of incidents which took place in 1954, 1970s, 1988 and 1994. We reviewed the existing evidence as contained in the independent report to avoid any unnecessary duplication.

Policy Critique

We undertook a review of the Trust's current policies, procedures and practice in place at the time of this report. It should be noted that there has been significant changes to the Trust structure and practice both prior to and since the publication of the independent investigation report in June 2014. We consulted with senior leaders within the Trust to review any records and understand historical and current practice in order to establish the likelihood of the reported incidents taking place or whether they could occur in the future.

⁶ The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust, June 2014

Witnesses and Victims

The Trust wrote to three victims and one witness at the beginning of September 2014. Two more of the victims and the remaining witness were written to at the beginning of November 2014. Each of them was invited to be interviewed. They were advised of the investigation and the reason for the Trust looking into further allegations about matters relating to Savile. The witnesses and victims were advised that the interviews would be recorded and a typed transcript would be provided for them to verify for accuracy. The witnesses and victims who agreed to be interviewed gave permission for their account of the incident(s) to be included in the internal investigation report. They were advised that their identities would not be included in the report and the Trust would store the typed transcripts on a secure server with restricted access. The witness and victims are identified by a reference of nominal letters which bear no resemblance to their actual names.

All those we spoke to, who had been abused by or had an encounter with Savile, have been advised of the support available to them, such as victim support services and other local crisis services. Jeff Barlow, Head of Safeguarding has provided his contact details to the victims should they need any further assistance with accessing support or help coming into and feeling safe in the hospital. To date none of the interviewees have taken up any offer of support.

The witnesses and victims were interviewed by the internal investigation team using the PEACE Investigative Interviewing Technique:

PEACE stands for:

- Preparation and Planning
- Engage and Explain
- Account, Clarify and Challenge
- Closure
- Evaluation

The PEACE model is a non-accusatory, information gathering approach to investigative interviewing. It is considered to be best practice and suitable for any type of interviewee, victim, witness or suspect.

9. Details of Parallel Reviews/Processes

Following publication of the independent report in June 2014, the Trust received ten enquiries via the public and staff advice helpline, which the Trust established specifically to deal with enquiries and/or further allegations of abuse. Eight of those enquiries related to Savile. Four of these enquiries were received from family members of patients or patients who were themselves in hospital at the time that Savile was associated with the hospital.

The family members and former patients were not raising new allegations against Savile but were seeking assurance that they, or their children or deceased relatives had not been abused by Savile. Whilst these callers were understandably concerned about matters, the terms of reference for this investigation refer to any allegations of abuse by Savile and therefore the enquiries made by these callers were outside the terms of reference. The details were however passed to the Trust's safeguarding team, so that further enquiries could be made, based upon the information given by the callers, to establish whether or not it was likely that Savile was present on Trust premises on the dates and times given by the callers. We are told that, in each instance, the safeguarding team could not find any evidence to link Savile to the dates, times and locations given. Each of the four callers were assured by the safeguarding team, that following internal investigations no evidence had been found to establish Savile's presence in the Trust on the dates they referred to.

One enquiry concerned Savile's link to an event taking place at High Royds Hospital and the caller was referred to Leeds and York Partnership NHS Foundation Trust (LYPFT). This incident relating to High Royds Hospital has been investigated and we understand that it will be included in the LYPFT report.

One caller wished to provide further information on Savile that did not directly relate to any allegations of abuse on Trust premises or at any other NHS premises.

Another caller made an allegation about abuse that did not occur on NHS premises; nor was it linked to the Trust's hospitals and the caller was advised to contact West Yorkshire Police.

Two of the calls concerned allegations of abuse by Savile at the Trust and these cases were referred to West Yorkshire Police for further investigation, and to the NHS SLU for information. One of the cases was subsequently referred back to us following a police investigation into the allegation and this case is included within this report.

Investigation by Yorkshire Ambulance Service (YAS) NHS Trust into matters relating to Jimmy Savile within West Yorkshire Metropolitan Ambulance Service (WYMAS)

We were informed by the NHS SLU on the 10th December 2014, that a witness interviewed as part of the YAS investigation had disclosed that he had heard rumours about Savile at the LGI. We have spoken with the YAS investigation team who informed us that the witness told them that the rumours he had heard were just "hearsay"; however he did recall one incident with a porter. The witness informed the YAS investigation team that he was happy to be interviewed by us but he was currently absent from work. The WYMAS investigation team shared the transcript of the witness account with us and have kindly liaised with the witness on our behalf. We have included a summary of the evidence given by the YAS witness at paragraph 23 of this report.

10. Witness and Victims Accounts

We were originally provided with a list of eight names by the NHS SLU. Of these eight, we were given consent to contact seven; five were victims, who alleged they had been abused by Savile and two were witnesses.

One witness said they had seen Savile in and around the LGI in the 1950s; the other witness had seen Savile within the Accident & Emergency Department and on one of the Children's wards at the LGI.

After making contact with these seven individuals, three of the victims and the two witnesses agreed to be interviewed. One victim declined to be interviewed and we are yet to hear from one of the victims. We were also provided with details of a witness account as part of the YAS investigation stating that a porter at the LGI had informed him that he had witnessed what he thought was an abusive encounter perpetrated by Savile in the 1970s.

This section of the report is presented in distinct sections. In relation to each individual, we provide an account of their encounters with Savile, followed by our findings. We have then included a section on current practice, policy and procedure, where they are relevant to individual accounts. All victims and witnesses have been anonymised.

11. Victim KM - Account of the Incident

KM was 14 years of age when he was admitted to a mixed sex adult ward at the LGI in 1994. Whilst he was an in-patient he was required to have an x-ray. KM said that he was taken from the adult ward to the x-ray department by a hospital porter and was left in the x-ray department unaccompanied. KM recalled he was waiting in the x-ray department and there was no one else present. He was sitting in a wheelchair wearing a dressing gown.

KM recalled that he was required to drink fluids for the x-ray and at the time he was in a great deal of pain and discomfort. Whilst KM was in the x-ray department waiting area he noticed a camera crew walk past carrying filming equipment and shortly after they had passed through, Savile appeared. KM recalled Savile was wearing a light blue track suit with a “*SID the Kids logo*” and on reflection thought Savile may have been in the hospital to promote the “*SID the Kids charity*”. KM said he was not aware of the charity at the time when Savile approached him and engaged him in conversation⁷.

KM said, *“He came up to me because I was literally just sat in the wheelchair at the front in the waiting area there, and he came and lent over me and told me to cheer up and said things can’t be that bad.”*

“He put his hand on my leg, as he said it and then all of a sudden just moved his hand under my gown because I had a hospital gown on, I just had me dressing gown draped over me, put his hand on my genitals and squeezed them. How long it lasted, I don’t know I can’t say. It was 5 seconds, 10 seconds. It wasn’t a long time and then looked at me and said now then I bet that’s cheered you up.”

⁷ Hans Peters who was President of the Trewins Branch Council and John Lewis Watford Branch Council for many years tell us that the first Ad Hoc Charities committee at Trewins was established by David Carter when he was President. David had a kidney transplant and created *Sid the Kid* as a fund raiser for the Renal Unit at the Royal Free Hospital Hampstead.

“And I just as far as I remember I just froze and didn’t say anything, and then he just sort of just smiled and walked off. That’s suppose what I remember about it quite prominently was that he didn’t sort of, he didn’t look around or anything.”

We understand from witness and victim accounts set out in other reports relating to Savile that he was brazen to be openly inappropriate with his victims with a lack of regard as to whether anyone saw him or not. KM’s account was plausible and his account of abuse is similar in nature with accounts of other male victims.

KM told us that he had *“a lot going on at the time”* due to his social circumstances therefore he did not tell anyone at the time of the incident about what Savile had done to him. He did tell his sister that he had seen and spoken to Savile when she visited him that evening, but did not tell her about the incident. He said that his sister was a little dismissive of his celebrity encounter and thought he was making it up.

12. Victim KM - Investigation

KM told us that the reason why he came forward was because at the time of the publication of the 28 NHS reports, the media attention seemed to be focussed on the female victims. KM wanted to tell his story in order to make it clear that Savile also abused male victims. KM felt people should be made aware that male victims of Savile have also experienced considerable distress and lasting effects from their experience of abuse. We asked KM how this experience had affected him and KM disclosed that he has experienced a number of problems in his life and more specifically within his childhood years.

13. Victim KM - Findings

KM felt that the lessons to be learned by the Trust are that children should not be placed on adult wards and if they are required to leave the ward for any investigations they should be chaperoned by a nurse or other appropriate person. KM asked if we could check whether we could establish why Savile was in the hospital on that day, and if we could establish if Savile was connected with the *“Sid*

the Kid” charity. KM was also interested in whether we could verify if a copy of his consent form was contained in his medical records.

In response to KM’s requests, we have not been able to establish why Savile was in the hospital at the time of the incident or if there was a link to the film crew that KM recalled was present just before his encounter with Savile. We have searched for any registered charities and not found any registered charities of that name. We have conducted an internet search and found reference to a local fund raiser called “*Sid the Kid*”⁸ which was established by a David Carter when he was President. David had a kidney transplant and created “*Sid the Kid*” as a fund raiser for the Renal Unit at the Royal Free Hospital Hampstead. We have enquired with the Leeds Teaching Hospitals NHS Trust Charity Foundation but have not been able to establish a link with either the Trust or Savile for this fund raiser. It is however possible that Savile may have been wearing a track suit with the logo “*Sid the Kid*” by way of promoting the fund raiser.

The independent investigation undertook a thorough investigation into Savile’s fund raising activity for the hospital and there is no reference to “*Sid the Kid*” in the independent report.⁹ Savile did have some connection with renal services and fundraising for a dialysis machine at the LGI. We have contacted the communications department of the Royal Free Hospital Hampstead and advised them that one of the victims has disclosed that Savile was wearing a track suit bearing a “*Sid the Kid*” logo and advised them to check to see if there is any association between Savile and this fundraising campaign.

The investigation team reviewed KM’s medical notes and found an entry made in the clinical records, made by KM’s consultant at the time, which confirmed that the X-ray and related procedure had been carried out in February 1994.

⁸ http://trewins.memorystore.org.uk/page_id__209_path__0p2p17p42p.aspx

⁹ Op cit

14. Victim WL - Account of the Incident

WL said he had attended the Accident and Emergency Department at the LGI in 1988 when he was 29 years old with stomach pains. He described how he was waiting for an x-ray when he encountered Savile.

WL said that Savile approached him whilst he rested on a trolley in a corridor within the department. WL was wearing a hospital gown without any under garments and in addition to the gown he had a hospital blanket over his lower body, positioned just over his legs. WL did not recall anyone else being around him, other than Savile.

WL recalled that Savile was wearing a uniform which resembled that of a medical/nursing uniform. He recalled the uniform was a white V-neck tunic type garment like those worn by medical staff. WL told us that Savile approached him and engaged him in friendly conversation about the mining community in South Yorkshire. WL said that whilst Savile was talking to him he placed his hand on WL's thigh and when Savile removed his hand he brushed WL's penis before walking away. WL recalls that he was in a state of shock and could not believe what had just happened. WL said that he did not inform any of the hospital staff at the time of the incident and has never mentioned the incident to anyone due to feeling embarrassed.

15. Victim WL - Investigation

When asked what had prompted him to come forward to give evidence now, WL referred to media reports and said he felt the need to come forward to disclose the incident to West Yorkshire Police. WL said that the incident with Savile has had a detrimental effect on his mental state.

WL was complimentary of the NHS and wished to make clear to the Trust investigators that he did not blame the NHS for what had happened to him but in the same vein could not understand how someone who was not a medical person could be allowed to wear a uniform and be allowed to walk around a hospital.

16. Victim WL - Findings

WL presented as a credible witness who gave an account which is in keeping with some of the findings of the previous independent investigation (we found two similar accounts in the independent report). It has been publicised that Savile was a tactile person who would openly touch staff and patients at the hospital and some of those people report that they felt uncomfortable with the way that he would touch them. WL's experience is in keeping with those accounts.

WL questioned why the hospital would allow Jimmy Savile to dress like a hospital employee and have free access to the hospital. The independent investigation team previously found that, *“Many people that the investigation team spoke to described Savile wearing the distinctive white coat that porters wore during the early part of his association with the Infirmary. He mainly connected himself with the porters in the Accident and Emergency Department and x-ray departments, areas that would have given him wide access to many wards and departments.”*¹⁰

The independent investigation team heard accounts relating to custom and practice from portering staff which indicated there was a lack of internal controls relating to recruitment, training and induction and day to day line management within portering services. The independent report also found that there had been a process of modernisation of portering services since the 2000s, which made significant progress in addressing the lack of internal controls.

¹⁰ Op cit p.81

17. Victim LV - Account of the Incident

LV informed us that she described herself as a “survivor of abuse” rather than being a victim. LV advised us that she was sexually assaulted by Savile when she was a student nurse “*in or around 1981*”. LV recalls that she would have been 21 years of age at the time and a student on placement on a male urological ward at the LGI. At the time of the incident, it appeared to LV that Savile was in a relationship with a staff nurse on the ward and Savile had visited the ward to arrange a date with the nurse.

LV recalls witnessing Savile speaking to the staff nurse when LV was heading to the linen cupboard on the ward. Whilst in the linen cupboard LV had her back to the door and was reaching up with both arms in order to get some linen from the shelf. LV said “*he grabbed me from behind, grabbing both breasts and then he started pushing his groin into my back and bottom.*” In a state of shock she turned around and on immediately doing so another student nurse came into the linen cupboard at which point he laughed and said goodbye. LV said that the student nurse did not witness the assault.

18. Victim LV - Investigation

LV told us that she did not report the incident to anyone because she was a student nurse and was fearful that her disclosure would jeopardise her career as a nurse. She identified that she was finding the nurse training difficult and felt that it would have a negative impact on her overall performance as a student. LV said she has never disclosed the incident to anyone until now.

LV was unable to identify the nurse with whom she thought Savile was having a relationship. LV was able to identify the ward sister on the ward where she was on placement at the time of the incident. LV said that she did not believe that the ward sister or any of the other staff or students were aware of Savile’s abusive behaviour. The decision not to tell anyone about abusive encounters with Savile is consistent with the majority of the accounts of victims coming forward to both the independent and internal investigation teams (Proctor et al 2014).

LV chose not to speak out at the time of the abuse, due to a fear of not being believed, the hierarchal culture in nursing at the LGI at the time and Savile's celebrity status and influence.

19. Victim LV - Findings

We have been able to verify a summary of an employment record which confirms that LV undertook her nurse training in Leeds. LV gave a credible account of the incident, which is consistent with other victim accounts from hospital employees who were victims of Savile. On the balance of probability we feel that LV did experience an abusive encounter with Savile.

20. Witness TB - Account of the Incident

TB told us that she commenced her nurse training in February of 1954 at the Leeds General Infirmary (LGI). She described an incident which happened in 1954, when she was working on ward six, which was a female medical ward at the LGI. TB recalled that a female patient had died and had been taken to the mortuary.

The ward sister informed TB that she had forgotten to remove the wedding rings from the deceased and TB was requested to go down to the mortuary in the late evening to retrieve the rings and bring them back to the ward. TB recalled that the ward sister told her *“to be careful and come back if the pink haired man is there.”*

TB recalls that when she went to the mortuary *“he was there so I turned round and went back to the ward.”* TB stated that this was the first time she had been made aware of the pink haired man, but *“I wasn’t aware that there was anything to be worried about because I had seen him cleaning windows around the hospital for some time.”* When we asked who TB thought the *“pink haired man”* was, TB was convinced that he was Savile.

This would have placed Savile in the LGI and in particular the hospital mortuary in 1954. There is a particular significance to this witness testimony because the evidence identified by the previous independent investigation did not place Savile in the LGI until the early 1960s (Proctor et al, 2014).

Due to the significance of this issue we explored this further with TB to establish who she thought the *“pink haired man”* was and what his role was in the hospital. TB stated that as far as she was aware, *“he was, the night porter but also the day odd job man, he used to be there at all sorts of times day and night, wandering round the hospital doing jobs as needed, but his favourite job was when he was doing the portering.”* TB went on to say *“But I mean I had seen him, out up ladders cleaning windows. I mean he needed to do, I think.”*

TB believed this man to be Savile but did not refer to him by name unless directly asked but she stated that she was able to identify the man as Savile when she saw him on the television some years later. TB said *“everybody knew him, he was part of the staff and you just did. But mostly, he was referred to as pink hair.”*

We studied the information in the reports of all the Savile NHS investigations but could find no reference to *“pink hair”*. There is reference online to Savile dying his hair different colours:

“Savile's first television role was as a presenter of Tyne Tees Television's music programme Young at Heart, which aired from May 1960. Although the show was broadcast in black and white, Savile dyed his hair a different colour every week”¹¹

It is not beyond the realms of possibility that Savile was colloquially known as “pink hair” but we could find no reference to Savile being known as *“pink hair”*.

TB was clear that the man she described as *“pink hair”* was Savile as she recalled:

“...there was one occasion when I saw him on a children's TV programme and his hair do was exactly the same as it had been at the LGI, and that's when I thought gosh that's either a look-a-like or the same man.”

TB recalls seeing the man she knew as *“pink hair”* in the mortuary and described him as just standing there and he did not appear to be actually doing anything in the mortuary. TB recalled that he saw her but did not speak to her and she had ample opportunity to turn around and leave without needing to speak to him. TB said this was the only time that she had a near encounter with the man she believed to be Savile, but she would see him around the hospital on occasions. At the time, TB did not know the man known as *“pink hair”* to be Savile, until she saw him later on television.

¹¹ http://en.wikipedia.org/wiki/Jimmy_Savile

21. Witness TB - Investigation

We explored further the notion that Savile was in the mortuary and the fact that the ward sister also implied that *“pink hair”* was likely to be in the mortuary. TB thought that Savile might have been present in the mortuary because *“he was known as wanting, to be the porter, for the body. I think it was just, that was his day or something like that for doing a particular job that day.”* TB went on to tell us that she believed that *“he was a porter while I was there, he’d been a porter there as I say and a decorator and a window cleaner. He was found all over the hospital in other words.”*

The independent report explored whether Savile had access to the mortuary. They found that there were always two people to transfer a deceased body to the mortuary.¹² They explored whether Savile may have had access to the mortuary at the LGI outside of his role as a volunteer porter. They established that the perception amongst mortuary staff was that he was friendly with the Chief Mortician at the hospital from the late 1970s to the mid-1990s, and that Savile would visit the mortuary to see him socially.¹³

22. Witness TB - Findings

The independent investigation team identified that Savile was known to be friends with the former Chief Mortician (in post 1970s-1990s) and now deceased. We have sought to check employment records, to confirm the dates of employment of the former Chief Mortician, in order to ascertain if he may have been employed in the 1950s. There is no employment record for the former Chief Mortician and there is no legal requirement to keep employees records for an indefinite period. Any employment records pre-dating 1990 are not routinely stored therefore we are not able to verify the dates of employment for the former Chief Mortician. Furthermore we are unable to establish if Savile had an association with the hospital prior to the 1960s.

¹² Op cit p. 93

¹³ Ib id p. 93

We understand that in the 1950s Savile was working in the night clubs in Manchester and Leeds and it was 1958 before he joined radio Luxembourg before later broadcasting on Radio One in the 1960s. Savile first appeared on television in 1964, which is the point in his career when we might presume he began to be recognised as a known celebrity. Savile may have been well known locally to people frequenting the club in Leeds that he managed. It is possible that Savile may have been known locally and by staff working at the LGI because of his association with the club scene in Leeds.

TB told us that she thought nothing much of the incident until one or two years later when she saw a Giles cartoon featured in the Daily Express newspaper which she believed made reference to Savile arranging a visitors room in the nurses home at the hospital in order for them to have male visitors such as their boyfriends. TB described the cartoon as being a nurse's sitting room for friends that had some sort of caption related to Savile. TB said that she had kept a copy of the cartoon but could not find it nor could she recall what the caption stated. We undertook a search of the archive for Giles cartoons¹⁴ but we could only find one Giles cartoon that referenced Savile as "*Jim'll Fix it*" which was published in 1982.

TB recalls that she felt "*perturbed*" at the time of the incident and became more perturbed when she saw the Giles cartoon and again more recently with the media attention on the activities of Savile. We asked TB what messages she wanted to give us in order for us to learn from her experience. TB told us that she felt angry that there were people in a position of authority who she felt knew about Savile and she was cross that nobody said or did anything about it. TB was specifically referring to the ward sister, who warned her about "*pink hair*", but also named the Matron. TB felt that as they were in positions of authority, they would have known about Savile's activities but TB did not specify any abusive behaviour. TB was convinced that the Matron also knew about the concerns related to Savile. TB named the ward sister and Matron during her interview and she felt it is highly likely that they are both deceased as TB said that they were both middle aged in 1954.

¹⁴ <http://www.cartoons.ac.uk/giles-archive><http://www.cartoons.ac.uk/giles-archive>

We feel that TB gave us what she feels is a genuine account of events and that she does believe that the man she encountered and knew as “*pink hair*” was Savile. However we were unable to find any other corroborative evidence to place Savile in the hospital before the 1960s. The internal investigation team could not be absolutely certain that Savile was not associated with the hospital before the 1960s and it is clear that TB was certain that she had encountered Savile. We were unable to find any evidence to corroborate Savile's presence in the LGI in 1954.

There is still a clear lesson to be learned from TB’s account. Staff should be able to raise concerns and be supported and enabled in the process of raising concerns without any fear of reprisal. In addition, the encounter once again highlights the need for robust systems to restrict and monitor access to the mortuary; both these issues were identified in the independent report and have been addressed by the Trust.

We identified a recurring theme between TB’s account and LV’s account even though they span almost 30 years. TB felt that senior staff and others knew about Savile’s abusive encounters and did not say anything and LV was abused by Savile but was fearful of saying anything. The culture in hospital settings through the 1950s, 60s, 70s and 80s is very different to the culture which exists today. Before the 1990s, nursing was organised in a very rigid hierarchical manner with Matron taking the lead in all aspects of the day to day running of the ward. For nursing students it would be rare that they would be able to directly speak to a ward sister or medical practitioner unless they were spoken to first. The ward sisters were a powerful influence on the ward culture by setting and monitoring the ward rules and expectations of staff behaviour. (Proctor et al 2014).

In addition to this there were fewer systems in place to safeguard adult patients and virtually no systems to safeguard staff. It is understandable that LV would have found it difficult to speak out about her encounter with Savile. Taking into account policy and practice and culture at the time, LV may have been fearful of ridicule and reprisal at making an allegation.

23. Witness XL - Account of the Incident

We were advised by the NHS SLU on the 10th December 2014, that a witness had spoken to the investigation team at YAS and told them that he had heard rumours about Savile from a porter in the mid to late 1970s. The witness was working as a patient transport driver with WYMAS from October 1973.

XL recalled hearing a number of rumours in the mid-1970s about Savile at the LGI and was able to recall a specific incident in the mid-to late 1970's. XL recalled chatting to a porter at the LGI when Savile walked past them.

XL said that the porter called Savile a "prat" after Savile had walked past them without acknowledging them. XL asked the porter why he had called Savile a "prat". XL told the YAS investigation team that the porter told him:

"I was going down to x-ray to pick a patient up, he [Savile] was there with this young girl on a trolley with a blanket over her, and he was the only one in x-ray, and she was waiting to be x-rayed for...whatever...I don't know...and as I walked in his hand came from under the blanket very quickly, [and he said] I would swear blind he was touching her up."

24. Witness XL - Investigation

We have spoken to the YAS investigation team who told us that the witness is willing to be seen by us for the purpose of our investigation. Unfortunately at the time of writing this report the witness was absent from work due to illness but he was prepared to be interviewed by us once he was fit and had returned to work. In the meantime the YAS investigation has been kind enough to liaise with us and XL to verify any further details.

The YAS investigation team have confirmed that XL does not know the name of the porter he spoke to and he reports that the conversation took place sometime in the mid to late 1970s.

We understand from the independent investigation team that they were unable to identify or interview any Trust employees from the 1970s. Due to the absence of historical personnel records we have found it very difficult to locate individuals employed in the 1970s unless they are currently employed by the Trust.

25. Witness XL - Findings

The YAS investigation team have confirmed that XL is not able to identify the porter with whom he had the conversation. The YAS investigation team were clear that XL said that the rumours he had heard about Savile at the LGI were all “*hearsay*” and he did not witness Savile abuse any patients or staff at the LGI.

26. Assurance on Relevant Current Practice, Policy and Procedures

Whistle Blowing Procedures

The Trust has revised the Whistle-Blowing Policy in January 2014 and the revised policy covers arrangements for staff to express concerns both within the organisation and to external agencies. The Trust commissioned an independent organisation to review the Trust's Whistle Blowing Policy in consultation with Trust staff. The policy has been reviewed with considerable revisions and explicit reference to safeguarding policies. The Trust launched the revised policy in March 2014 with a dedicated communications campaign, called "*if in doubt, speak out*".

The campaign and supporting information on the Trust intranet site provides staff with an overview of the recent review, the process to follow and also key contact points. The policy introduces the designated role of Whistleblowing Leads; the Trust Executive Team has agreed that this will be undertaken by senior managers from both the Clinical Service Units and corporate functions. A quality matters briefing including the reporting structure for safeguarding was disseminated to all staff in January 2014 to be prominently displayed in clinical areas. Any member of staff can raise a safeguarding concern to either the Trust safeguarding team or to the Local Safeguarding Boards. (Reference LV, TB).

Safeguarding Activity

In the past twelve months the Trust's safeguarding team has received safeguarding alerts from Trust staff raising concerns about other Trust employees, Clinical Service areas and other people that have an association with the Trust. We have seen an increase in alerting activity and the Trust has undertaken a number of safeguarding, conduct and disciplinary investigations with outcomes that protect patients. The Trust Safeguarding Steering Group receives quarterly reports on safeguarding activity which includes any allegations of abuse. The Trust Board receives an annual report on safeguarding which includes a summary of all safeguarding activity, including where allegations have been substantiated. (Reference LV)

Procedures Related to the Care and Welfare of Staff

The Trust has a conduct and disciplinary policy. The policy references the Conduct and Disciplinary Supporting Guide which should be read in conjunction with the policy document. The guidance clearly references safeguarding and the requirements to safeguarding children and vulnerable adults, with a link to the Trust safeguarding policies.

If allegations involve issues relating to the risk of maltreatment of children or vulnerable adults, a referral to the safeguarding team should be made by the Investigating Officer at the earliest opportunity in accordance with the referral procedure. This is the case regardless of whether the allegation relates to alleged misconduct in or out of work. The Trust has a policy in place for dealing with allegations of abuse against children concerning Trust staff. This policy sets out a procedure to follow if an allegation has been made about a member of staff who may have harmed or be a risk of harming children.

We have reviewed the Trust safeguarding policies and other staff welfare related policies and procedures. We found that the Trust safeguarding policies do not make reference to safeguarding Trust employees, volunteers and students. We reviewed the Trust policies which relate to the care and welfare of staff. The conduct and disciplinary procedural document makes clear reference to the safeguarding of patients but does not include the safeguarding of Trust employees, volunteers and students. The Trust attendance management policy, dignity at work policy, grievance policy and managing work related stress does not reference safeguarding. (Reference LV).

Access to the Mortuary

Access to the mortuary today is restricted to authorised staff only. Any entry into the LGI mortuary is restricted by swipe card access with a speak and view entry system; entry to St James's Hospital mortuary is restricted by numeric keypad and speak and view system. Only designated and authorised staff have an access card and a key

code number therefore only people with the required authority are able to access the hospital mortuaries.

There are designated areas for staff authorised to enter for viewings of the deceased. There is a designated access route to both sites for Chapels of Rest. The Trust is currently developing processes and guidance to put in place for the deceased. The Trust has a procedure in place for the movement of bodies. A number of Standard Operating Procedures are in place for all mortuary procedures and activity, including for the release of bodies. The Trust mortuaries are subject to accreditation and inspection and mortuaries with post mortem suites (both the LGI and St James's mortuaries have post mortem suites) are subject to Clinical Pathology Accreditation and Human Tissue Act (HTA) License. (Reference TB).

Patient Safety

Patient Safety is at the heart of the “*Quality Ambition*” work being developed by the Chief Medical Officer and Chief Nurse which includes the following:

Empowerment and accountability are crucial in relation to safety of patients, staff, and visitors. The #Hellomynameis campaign has been launched and over half of all staff have signed up. The #Hellomynameis campaign promotes nurses and other frontline NHS staff to introduce themselves politely and tell their patients their name, this is part of a campaign launched by a terminally ill doctor on the popular social media website Twitter.

The Quality Improvement Strategy is complete and was presented to the Trust Board in September. Work with Haelo¹⁵ has commenced on two Trust wide patient safety initiatives – “*Reducing Harm from Falls*” and “*Preventing Cardiac Arrests - care of the Deteriorating patient*”. 30 wards across the Trust are involved. Staff health and well-being is also the cornerstone of all workforce policies. Leadership from the Trust Board has been refreshed and strengthened with quality being the dominant theme.

¹⁵ <http://www.haelo.org.uk/about-us/>

The Chief Executive has led an inclusive process to develop new values for the Trust. The five values which have been agreed are patient-centred, fair, accountable, collaborative and empowered.¹⁶

Safeguarding key performance indicators for portering and other facilities staff have been provided by the Head of Safeguarding to the facilities directorate for local implementation. In terms of introducing more qualitative measures about performance these are currently being further explored by the estates and facilities department. Patient questionnaires are already undertaken with patients that have had contact with and been provided a service by the hospital porters. Patient experience of the portering service is about timeliness, privacy and dignity, all of which are included in the Trust's current performance reporting.

The Trust has invested in developing monitoring systems to measure and improve portering and security services. A Computer Aided Radio Personnel System (CARPS) monitors and records the time each porter takes to undertake specific tasks. The data enables estates and facilities senior management team to monitor key performance indicators which can identify any porters who are not meeting their targets. The Trust has a better understanding of the work undertaken by portering staff on duty and a tighter control on the whereabouts of porters whilst they are undertaking portering duties. (Reference KM, WL, TB).

Volunteers Policy

The Trust has reviewed and refreshed its Volunteer Policy. The revised policy (approved in November 2013 and updated in March 2014) includes employment checks, induction, training, access to the Trust, and clarity regarding role boundaries. All volunteers are subject to Disclosure and Barring Service checks.

¹⁶ <http://www.leedsth.nhs.uk/about-us/vision-consultation-and-strategy/>

The Sanctioned Visitors Policy

The Sanctioned Visitor's Policy includes a section relating to Very Important Person (VIP) visitors which is relevant to all Trust staff.

The purpose of the VIP policy is to ensure the risk is managed for the safety and security of patients and staff arising from visits to the hospital by approved or invited visitors such as VIPs and celebrities, or media representatives. The policy requires that one-off or very short-term approved official visitors are always accompanied throughout their visit to the Trust where there is a possibility of contact with lone staff or vulnerable patients/visitors. Where approved official visitors are in the Trust frequently or for extended periods of time they must be appropriately checked and authorised by an Executive Director and communicated to the relevant teams. This includes, for example, media film crews, charity patrons or celebrities linked with a particular service. (Reference KM, WL, TB).

27. Summary Analysis of the Effectiveness of the Current Safeguarding Arrangements at Leeds Teaching Hospitals NHS Trust

The Trust is one of the largest Trusts in the United Kingdom and serves a population of approximately 752, 000 in Leeds and surrounding areas treating around 1.5 million patients a year. In total, the Trust employs more than 15,000 staff and has around 2000 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital. Day surgery and outpatients' services are provided at Wharfedale Hospital and outpatients' services at Seacroft Hospital.

Safeguarding adults, children and young people is a core responsibility in delivering acute hospital health care. Leeds Teaching Hospitals NHS Trust puts patients and the quality of their care as a high priority and as such commits to patient choice, control and accountability which includes support and protection for people when they are at their most vulnerable. All Trust staff (including voluntary, and other unpaid staff) have responsibilities for the safety and well-being of patients.

Safeguarding encompasses:

- prevention of harm and abuse through provision of high quality care;
- effective responses to allegations of harm and abuse, responses that are in line with local multi - agency procedures;
- using learning to improve service to patients.

In 2013/14 the Trust reviewed and strengthened its governance arrangements for safeguarding. The safeguarding steering groups now report directly into the Quality Committee which is a sub-committee of the Trust Board. The Quality Committee is chaired by a Non-Executive Director and has Executive representation. The minutes of both the adult and child safeguarding steering groups accompany an assurance report to the Trust Risk and Patient Safety Sub-committee on a quarterly basis.

The Trust has realigned its safeguarding adults and children's teams under the direct leadership of the Chief Nurse and Deputy Chief Nurse therefore enabling the promotion of enquiring leadership at all levels. The Trust appointed a Head of Safeguarding in October 2013 and safeguarding has clear and concise leadership from the Chief Nurse. The Chief Nurse is the Executive Member of the Trust Board, Leeds Safeguarding Children's Board and Leeds Safeguarding Adults Board.

The Trust revised the safeguarding adults and safeguarding children policies in December 2013 and January 2014 and produced a number of supporting policy and procedures including a policy on Responding to an Allegation of Abuse Against an Employee. The Conduct and Disciplinary Policy has a reference to safeguarding which includes guidance on coordinating a conduct and disciplinary process with safeguarding when there are allegations of abuse against an employee.

The Trust has raised awareness on safeguarding through a number of quality matters briefings to all staff and the distribution of the safeguarding adults and children newsletters through e-bulletins. The Trust external website includes information on safeguarding within the information for patients and visitors pages. In

August 2014, the Trust has participated in the preventing abuse of adult's campaign in partnership with the Leeds Safeguarding Adults Board through the use of social media, patient information leaflets and posters to be displayed in clinical areas. The Trust safeguarding intranet pages have been revised to include information on safeguarding and enable clinical staff to raise concerns about safeguarding to either the safeguarding team or safeguarding teams within social care.

28. Conclusion

This investigation has given people who came forward following the publication of the independent report, the opportunity to tell us of their experience of Savile. This has enabled us to not only advise them of the actions the Trust has taken in relation to the 31 recommendations made by the independent investigation team, but to establish if there are any further lessons for the Trust. The independent report concluded that *the “considerable majority of victims who came forward, telling their stories to the investigation team was the first time they had ever disclosed what happened to them at the hands of Savile.”*¹⁷

This is certainly a true reflection of what we were told by those we interviewed about their encounters with Savile. It was evident that, for those we spoke to, the abusive encounters with Savile had a lasting, and in some cases, detrimental effect on their lives.

During the course of this investigation, we found no evidence to identify any third parties who may have been involved in any of the incidents of abuse. However there are valuable lessons to be learned by the Trust, to prevent harm to patients and protect others from abuse.

Many of the recommendations made by the independent investigation have been addressed and the Trust is continuing to progress further actions required to address all of the 31 recommendations set out in the independent report.

This investigation into matters relating to Savile at the LGI has enabled us to relate the relevant actions to meet the recommendations to the victim and witness accounts contained in this report and we hope that this provides some assurance to all those who came forward to speak to each investigation team.

The 31 recommendations cover the majority of the lessons learned from not only the independent investigation into matters relating to Jimmy Savile but our investigation

¹⁷ Op cit p.140

to enable the Trust from preventing harm to our patients. In addition to those 31 recommendations we are making the following recommendations which are represented at section 29.

29. Recommendations (Action Plan at Appendix I)

The Trust should afford any other victims of Savile, the opportunity to share their experience with the Trust to enable the Trust to establish if there are any other lessons to be learned.

We were not able to interview all of the victims of Savile who have come forward since June 2014 due to either parallel investigations or because the victim did not feel able to talk to the investigation team. This means there may have been a missed opportunity to identify any further lessons which could be learned to be included in this report.

It is also envisaged that on the publication of this and other organisations investigation reports, that there is the potential for further adverse media attention in relation to Savile's abusive behaviour. It is clear from this report that other victims came forward following the publication of the 28 NHS investigation reports and for some, the process of the investigation has helped by enabling them to share their experience. As a health organisation we are keen to learn from people's experience to ensure that we have the right systems in place to protect patients from harm.

The Trust should have a process in place to enable other victims to come forward to enable them to share their experience and where applicable access support. If required the Trust should have a process in place to enable any further investigation in line with the Trust internal safeguarding investigation into any allegations of abuse.

To have an appropriate safeguarding policy in place for the admission of children and young people who are admitted to adult wards. Such admissions are exceptional events, but in some cases necessary.

The investigation team has established that 16/17 year olds may be admitted onto an adult ward and in exceptional circumstances a child could be admitted to adult ward. The Trust should develop a Standard Operating Procedure to provide a robust system for risk assessment and reasonable adjustments required to enable a safe therapeutic environment for children and young people who are admitted to an adult ward. This should include a process for any child or young person requiring any investigatory procedure such as an x-ray, away from the ward, to be safely supervised whilst off the ward by an appropriate person.

To ensure that safeguarding is included in the work of the Transitions Strategy Board looking at the needs of 16/17 year old patients.

The Trust Transitions Strategy Board Group for 16/17 year olds should have representation from the Trust safeguarding team to ensure that safeguarding is embedded into any development plans for meeting the clinical needs of 16/17 year olds at Leeds Teaching Hospitals NHS Trust.

The Trust should review its policies and procedures related to the care and welfare of its employees to ensure there is explicit reference to safeguarding staff from abuse.

Many of Savile's victims were staff and Trust employees have a right to be safe from abuse. Any staff who report that they are experiencing abuse should be supported and protected from abuse.

The Trust should review its complaints procedure to ensure that there is accessible information available for children that is child friendly using language that children are able to understand.

A complaints process for children should be clear and easy to understand from a child's perspective. The information should be accessible and presented in a child friendly manner which should be less wordy and easy to understand.

The Trust should review its process for informing children of their right to be safe from abuse.

The information should be presented in a number of ways to ensure children are made aware of their right to be safe from abuse. The information should be accessible and presented in a child friendly manner. Staff should be made aware of their duty to inform children of their right to be safe from abuse.

30. References

McShane J (2013). Savile The Beast. The Inside Story Of the Greatest Scandal in TV History. Blake: London.

Proctor S, Galloway R, Chaloner R, Jones C and Thompson T (2014). The Report of the Investigation into Matters Relating to Savile at Leeds. Leeds Teaching Hospitals NHS Trust.

Web References

<http://www.leedsth.nhs.uk/savile-report>

<http://www.leedsth.nhs.uk/about-us/vision-consultation-and-strategy/>

<https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile>

<http://www.theguardian.com/media/2014/jun/26/jimmy-savile-sexual-abuse-timeline>

http://trewins.memorystore.org.uk/page_id_209_path_0p2p17p42p.aspx

http://en.wikipedia.org/wiki/Jimmy_Savile

<http://www.cartoons.ac.uk/giles-archive><http://www.cartoons.ac.uk/giles-archive>

<http://www.leedslscb.org.uk/>

<http://www.leedssafeguardingadults.org.uk/>

Trust Policy and Procedures

Attendance Management Policy

Being Open Procedure

Child Protection Manual- Safeguarding Children

Complaints Policy

Conduct and Discipline Policy

Conduct and Disciplinary Supporting Guidance

Consent to Examination or Treatment Policy

Dignity at Work Policy

Grievance Policy

Learning from Experience Procedure

Managing Work Related Stress

Responding to External Agency Visits, Inspections and Accreditations Procedure

Safeguarding - Responding to Allegations of Abuse of a Child against an Employee

Safeguarding Children Policy

Safeguarding Child Protection Supervision Policy

Safeguarding Children Criminal and Legal Proceedings Policy for Staff Assisting
Police with Enquiries

Safeguarding Adults at Risk Policy

Whistleblowing Policy

Visitors Access Policy

Appendix A

Local public and staff advice line - Following publication of the report into matters relating to Jimmy Savile at LTHT Terms of Reference

Updated at 14:00 on 27 June following closure of command and control room

Aims:

- Signpost to national helplines and support networks
- Provide general information to staff and public (ie how to access the report, FOI requests process, etc)
- Ascertain if any new concerns relate to current staff employed
- Assess where any new concerns require referral to police
- Assess where any new concerns require referral to internal investigatory bodies (ie HR, Safeguarding)
- Acknowledgement (letter/phone call) thank you for coming forward

Purpose:

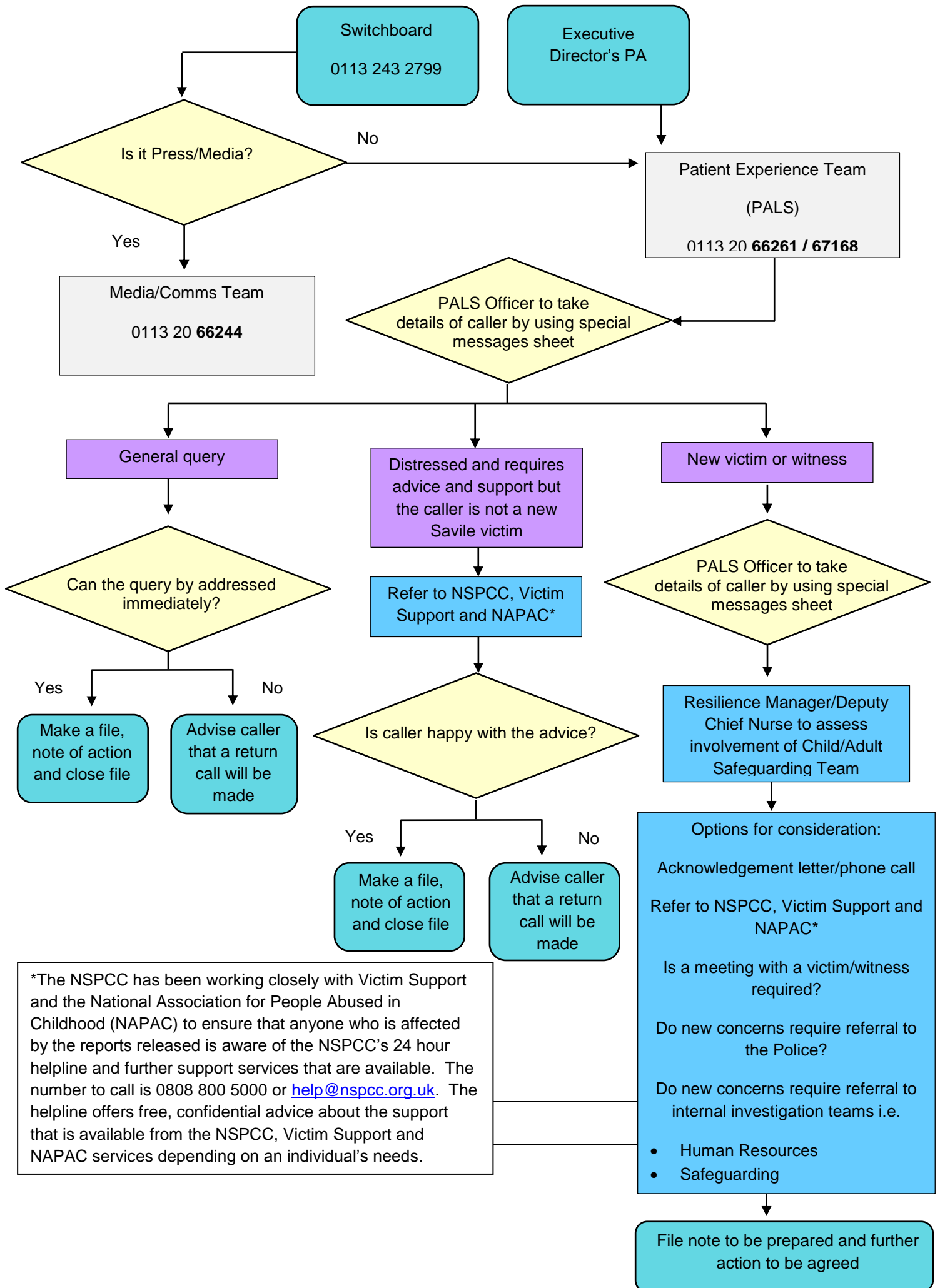
- To provide a managed and coordinated process for public and Trust staff who contact the Trust direct to request information or to identify themselves as a new victim following the publication of the independent investigation report.
- Allow new victims and witnesses the opportunity to come forward to share their concerns and anxiety.

Scope:

- To give new victims the opportunity to come forward and be heard.
- Any new victims and witnesses coming forward are out with the independent investigation report.
- The command and control room closed at 2pm on 27 June. From 2pm on 27 June until further notice switchboard will divert all calls (from staff or public) to the existing PALS service **01132067168** or **01132066261**, e-mail patient.relations@leedsth.nhs.uk. All calls coming in to the Trust following closure of the command and control advice line will continue to be logged (using the special message sheet and not within Datix) and forwarded to the Head of Safeguarding and Resilience Manager for further action.

Process:

- Switchboard (0113 24 32799) will divert callers to existing PALS service **01132067168** or **01132066261 until further notice. Answer phone facility is available out of hours.**
- All calls will be recorded on a "special message sheet" and routed appropriately ie:
 - General Savile information requests (ie where can I find the report) will be handled immediately / as soon as possible.
 - New victims / witnesses coming forward. Contact information will be taken, call back times determined and where possible agreed. Any new victims / witnesses will be triaged to ensure (a) they have immediate access to national helpline and support networks (b) their case is assessed to determine next steps, ie referral to internal investigatory body, referral to police (with consent) (c) their case is referred to the safeguarding team for further review, meeting and if appropriate, investigation.



*The NSPCC has been working closely with Victim Support and the National Association for People Abused in Childhood (NAPAC) to ensure that anyone who is affected by the reports released is aware of the NSPCC's 24 hour helpline and further support services that are available. The number to call is 0808 800 5000 or help@nspcc.org.uk. The helpline offers free, confidential advice about the support that is available from the NSPCC, Victim Support and NAPAC services depending on an individual's needs.

Caller:		Staff	Ex Staff
		Patient	
		3rd party	
Contact Telephone Numbers:	Call back time agreed		
E-mail address:	Date:		
	Time:		
How would you prefer to be contacted and when:			
Mobile, e-mail, letter			
Date of Birth..... NHS No.....			
Address:			
Reason for call / brief summary / details of incident:			
Has this been previously reported to anyone and what action was taken?			
Hospital:			
Area/Ward:			
Relevant dates:			
Actions:			
Call taken by:			

Appendix B

Terms of Reference (V2)

Post publication investigation into matters relating to Jimmy Savile

Following publication of the independent investigation report into matters relating to Jimmy Savile the Board of the Leeds Teaching Hospitals NHS Trust (LTHT), under its general responsibilities for oversight of the organisation, has commissioned the Adult Safeguarding team to investigate all additional allegations of sexual abuse, committed by the late Jimmy Savile, referred to the Trust via the NHS Savile Legacy Unit or other bodies. The Adult Safeguarding team will provide a report to Quality Committee on the findings of the investigation in December 2014.

Aims:

To allow new victims and witnesses the opportunity to come forward.

Purpose of the investigation is outlined below.

- i. Enable any new victims or witnesses to come forward and give them the opportunity to have their story heard.
- ii. To provide a managed and coordinated process for patients, members of the public and Trust staff (including ex-employees) who contact the Trust direct, via the NHS Savile Legacy Unit, or other bodies to identify themselves as a new victim or witness.
- iii. In meeting any new victims or witnesses if any unmet needs are identified to signpost the victims or witnesses to the national helplines and/or other support networks.
- iv. To ascertain if there any new concerns that relate to any currently employed staff in order for the appropriate action to be taken.
- v. To assess and, if deemed appropriate, refer any new concerns to the police.

- vi. To assess and, if deemed appropriate, refer any new concerns to any other investigating bodies for example Human Resource Department or safeguarding investigation in line with local safeguarding policy and procedures.
- vii. To investigate any new allegations, provide apologies and learn from their experience in order to initiate any further action required by the Trust by way of recommendations to ensure people are protected from abuse.

Scope of the investigation:

- viii. To give new victims and witnesses the opportunity to come forward and be heard concerning any allegations of abuse made that might have links to Jimmy Savile and how these allegations came to light.
- ix. The extent to which others in Leeds Teaching Hospitals NHS Trust knew of the allegations against Savile and/or his associates and did/did not report or act on them.
- x. To investigate allegations raised by new victims and witnesses who have come forward who are outside of the timeframe of the independent investigation commissioned by the Leeds Teaching Hospitals NHS Trust Board and subsequent independent report published in June 2014.
- xi. To look at the present practice and procedures of Leeds Teaching Hospitals NHS Trust and steps taken to minimise the risk of recurrence of abuse, through lessons learned and responses to those lessons learned.
- xii. This investigation and any future investigations into the matters relating to Savile will be mindful of the extensive investigation undertaken by the independent investigation team and the resulting report published by the Trust on the 26th June 2014.

- xiii. It is not within the scope of this investigation to re-investigate or re-interview any victims or witnesses who have previously been subject to interview by the independent investigation team, unless any new enquiry leads the investigation team to any matters related to a previous allegation or link to a previously identified witness or victim.
- xiv. Leeds Teaching Hospitals NHS Trust has undertaken a very detailed and thorough investigation into matters related to Jimmy Savile as published in the independent report in June 2014. It is not within the scope of this investigation to provide a detailed report on the policy and practice throughout the time of Jimmy Savile's association with Leeds Teaching Hospitals NHS Trust, or its predecessor organisations. This report will however make reference to the previously published report regarding the following areas:
- volunteer staff, their role(s), their access to patients;
 - vetting and other safeguarding in place in relation to volunteers;
 - staff vetting;
 - child and adult protection and safeguarding;
 - whistleblowing;
 - complaints handling and investigation;
 - Savile's fund raising activities at Leeds Teaching Hospitals NHS Trust.
 - Savile's association with Leeds Teaching Hospitals NHS Trust.

Process:

All future investigations into matters relating to Savile will be mindful of the extensive investigation and report previously delivered by the independent investigation team in Leeds.

The Chief Nurse will provide Executive Leadership. The LTHT Safeguarding team will lead the post publication investigation and work collaboratively with the Trust's Resilience Manager with oversight from the NHS Savile Legacy Unit to:

- Interview new witnesses and victims who have come forward following finalisation or since publication of the independent investigation report.
- Benefit from and refer to the contextual material that was gathered and published in June 2014.

- Produce a written report with recommendations that will set out new 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.

Identify recommendations for further action.

- Engage with and work within the remits of revised guidance to be issued by the NHS Savile Legacy Unit to ensure a robust investigative strategy is in place which enables a thorough investigation of each new allegation but does not duplicate those matters and/or lines of enquiry that have previously been investigated and reported upon.

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 offence(s), the police will be informed. Where such evidence indicates the potential commission of disciplinary offence(s), the relevant employers will be informed.

September 2014

Appendix C

Biographies of the Internal Investigation Team

Professor Suzanne Hinchliffe CBE, Chief Nurse/Interim Chief Operating Officer, Leeds Teaching Hospitals. Professor Hinchliffe is the Executive Lead for safeguarding and the Executive Lead for this internal investigation.

Chief Nurse: Suzanne Hinchliffe CBE: Suzanne joined the trust as the Chief Nurse in May 2013 moving from the University Hospitals of Leicester NHS Trust, where she worked as the Chief Nurse, Chief Operating Officer and Deputy Chief Executive since 2009.

Joining the NHS in 1979, Suzanne trained as a Registered Nurse and Registered Midwife building a portfolio of nursing and operational experience across the UK alongside further qualifications at masters level in business, finance and law.

Suzanne has extensive experience in acute NHS services and has been a member of a number of national advisory committees, involved in regulatory inspection, a Fellow of the Institute for Health Improvement and was a board member of the National Governance team leading reviews across acute, primary care and ambulance service organisations.

With a portfolio of Chief Executive, Chief Operating officer and Chief Nurse positions over the past 17 years, Suzanne maintains a quality brief with national publications regarding care indicators and quality improvement together with a quality networks in Europe and the United States. Suzanne was awarded the CBE in 2003 for services to health.

Head of Safeguarding, Jeff M Barlow, Leeds Teaching Hospitals NHS Trust: Jeff Barlow is the lead investigator for this internal investigation. Jeff Barlow has over 20 years' experience of working within the NHS. His professional background is a Registered Nurse in Learning Disabilities and Diploma in Social Work, with

additional qualifications as an Approved Mental Health Professional, Best Interest Assessor and a Master of Laws (LLM). The safeguarding department at Leeds Teaching Hospitals NHS Trust sits within the Corporate Nursing structure of the organisation. The safeguarding department is independent of clinical operations and ensures that any and all allegations of abuse of vulnerable children and adults are investigated. Both the author and safeguarding department is independent of the clinical operations within Leeds Teaching Hospitals NHS Trust clinical services and therefore the author is impartial in completing this report.

Sharon Scott, Resilience Manager, Dip HEP, MA: Having worked consistently within the NHS, in a number of disciplines, in both acute and primary care for over 21 years, joining Leeds Teaching Hospitals NHS Trust in 2008, Sharon leads, on behalf of the Chief Executive, the Trust's Emergency Preparedness, Resilience and Response (EPRR) and business continuity portfolio. Sharon manages a number of strategic and high profile projects, strategies, and initiatives, embedding learning and system wide resilience to sustain a cycle of improvement.

A trained SUI investigator with experience of complaints and claims management, Sharon studied Law and Medical Ethics and obtained a Masters degree in Health Care Law from the University of Huddersfield. Within her current field of resilience she obtained a Diploma in Health Emergency Planning from the Royal Society for Public Health.

Appendix D

Chief Executive's Statement

Speaking today, Thursday 26 June 2014, after the publication of the report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust, Julian Hartley, Chief Executive of the Trust said:

“This is a profoundly shocking report in which for the first time we are able to gain a clear picture of the abuse perpetrated by Jimmy Savile during his involvement with our hospitals in Leeds, in particular the Leeds General Infirmary, which started in 1962 and continued through to the late 2000s.

“As Chief Executive of the Leeds Teaching Hospitals NHS Trust I firstly want to offer a sincere apology to each and every one of Savile's victims, and thank them for being courageous enough to tell their stories. I recognise how difficult this must have been and I respect and thank them for coming forward.

“My first reaction when reading this report is one of tremendous sadness that this was allowed to happen, huge sympathy for the victims, as well as anger that this individual used the NHS and his celebrity status to exploit and abuse our patients, staff and public.

“I want to take this opportunity to emphasise to our patients, their families and members of the public that the way hospitals in Leeds operate today is very different from the accounts included in the report, with a much greater focus now on security, safeguarding and raising concerns. The Board at Leeds Teaching Hospitals is committed to learning from the findings of this report and ensuring we have the highest standards of safeguarding and security in place.

“The Trust commissioned this report so that we could fully understand the actions of Savile and identify the areas where we can improve and learn from these dreadful events. I would like to thank Dr Sue Proctor and the investigation team for their diligence, single-mindedness and commitment to paint as full a picture as possible of what went on in our hospitals during those years. This is a report we need to study in greater detail and ensure we and others learn from its findings.

“As a Leeds citizen and a well-known celebrity for more than six decades it is perhaps understandable that Savile would have had some involvement with hospitals in the city. This report, however, paints a grim picture of an individual with a very dark side who used his role as volunteer and fundraiser, combined with his national fame, to mask a range of dreadful acts he perpetrated on children and adults alike over a prolonged period of time.

“As an individual, Savile's activities, as we know, were not confined to the hospitals in Leeds, and it is fair to say that we were by no means the only institution he deceived.

“Although I was not in post here in Leeds during Savile’s lifetime, I grew up in West Yorkshire in the 1970s and share the collective reaction among our staff of shock, revulsion and horror. Many of my colleagues have been bewildered by what happened and feel personally betrayed by him - a famous man they took too much on trust.

“Of course, hindsight is a gift we are now blessed with, and looking through this report it is clear to see that through the years there were individuals very discomfited by Savile’s behaviour. What was lacking at the time was the escalation of these concerns to senior figures in the Trust to act upon.

“The report is clear that there is no one person at the hospital who is to blame for what happened, other than Jimmy Savile.

“However, it is also absolutely clear that there should have been far more scrutiny of him and what he was doing at our hospitals over the years and more robust safeguards and internal controls in place to protect our staff and patients in our care. The lack of visibility of senior managers across the Trust during this time and the lack of questioning and curiosity about Savile’s role and presence in our hospitals over the years is certainly a lesson for all NHS Boards and one that we are addressing in Leeds.

“We are deeply upset by the findings of the report and our first thoughts must be with the victims who suffered in silence over so many years, and continue to do so. The important thing for us now is to learn from this report, and ensure arrangements are in place for any patient, member of staff or the public to report any issues of concern without embarrassment or fear.

“The Leeds report makes 31 important recommendations, all of which we are dealing with. Since the revelations first came to light we have been taking a long and hard look at how we manage our organisation to ensure there are no weaknesses which a determined and resourceful criminal like Savile could exploit. The Board is committed to ensuring each and every recommendation made in today’s report is delivered in full.

“Hospitals in Leeds are very different places today.

- We have much improved security in and around our patient areas including locks on wards, card access systems and a large network of CCTV cameras in place and we encourage staff to actively challenge unusual activity and visits.
- We promote a culture of openness and patient safety and have strengthened our arrangements to encourage staff at all levels of the organisation to speak out and raise concerns, however small they may seem at the time. Myself and the senior team spend much of our time on wards and in departments across all our hospitals including the Leeds General Infirmary, speaking to patients, staff and visitors.

- VIPs and celebrities do not have open access in and around the hospitals and instead are registered at every visit and accompanied at all times.
- We have significantly strengthened our internal controls to minimise risks to patient safety including much improved arrangements to protect adults and children in our care, enhanced employment checks for frontline staff and volunteers and a more robust approach to how we manage risk.

“In short, over the years we were badly taken in by a clever and manipulative individual, we let our guard down, and people came to harm as a result of this. For this we are truly sorry.

“This report would not have been possible without the courage of the victims to come forward and share their experiences. I would encourage anyone with further information that they would like to share with us about this investigation to contact the Trust confidentially and I can assure you, you will be treated with the utmost respect and sympathy.

“I think I speak for the whole of Leeds Teaching Hospitals in saying that we are determined to ensure we protect our patients, staff and public from harm and that we will derive every ounce of learning from this report. In doing so we will honour Savile’s victims who were brave enough to expose the truth”.

Julian Hartley

Chief Executive

June 2014, Press release

Agenda Item 14.1

Savile Action Plan Public Board Thursday 27 November 2014

Presented for:	Information and assurance
Presented by:	Professor Suzanne Hinchliffe CBE, Chief Nurse / Interim Chief Operating Officer
Author	Professor Suzanne Hinchliffe CBE, Chief Nurse / Interim Chief Operating Officer
Previous Committees	Executive Directors Meeting.

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	
A centre for excellence for research, education and innovation	
Seamless integrated care across organisational boundaries	
Financial sustainability	

Key points	
1. Actions against all Savile recommendations have been progressed or are complete.	Information
2. Updates regarding progress have been provided to the Safeguarding Boards, Trust Board Sub Committees and Overview and Scrutiny Committee.	Information
3. Measures are in place to support new victims or witnesses who have come forward since publication of the independent investigation report or who may come forward in the future.	Information

Summary:

In December 2012, Trust Board commissioned an external independent investigation team to thoroughly and comprehensively investigate matters relating to Jimmy Savile during his relationship with Trust hospitals from the 1960's to 2009.

The independent report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust was published on 26 June 2014 alongside the reports of investigations at 28 other hospitals including Broadmoor.

Following publication of the independent report the Trust established a help line for anyone who had concerns arising from the independent investigation or publication of the report. In response to new victims coming forward the Trust commissioned the safeguarding team to investigate further allegations in relation to Savile to enable any new victims or witness to come forward and give them the opportunity to be heard. A separate draft report following the further investigation is to be discussed at Quality Committee on 13 November 2014.

The independent report published in June 2014 details 31 recommendations which were accepted by Trust Board. This report aims to update Trust Board on the status of all recommendations to date and to provide assurance to Trust Board that procedures are in place to enable new victims and witnesses to come forward.

1. Background

The independent investigation report details 31 recommendations grouped into six themes of:

- Leadership, organisational values and executive accountability.
- Patient centred drivers and safeguarding.
- Board and ward coherence.
- Security and controls on the physical access to hospital premises.
- Policy development and implementation.
- Fundraising.

An Executive Director is taking the lead for each of the 31 recommendations. Significant progress and improvement has already been achieved since the commencement of the independent investigation in changing the Trust's practice which are identified in the six themes and 31 recommendations.

Following publication of the independent investigation report an action plan was formulated by the Chief Nurse and presented to Trust Board. It identified each of the recommendations together with a named Executive Director responsible for taking ownership of their relevant recommendation(s), and reporting on progress made, future action plans and times scales in which to address each of the recommendations.

The updated draft action plan is available at Appendix A.

The draft action plan has been overseen by the Chief Nurse and verbal progress reports have been provided to Safeguarding Committees and the Health and Social Care Overview and Scrutiny Committee attended by the Chief Nurse and Director of Quality.

Governance arrangements for assurance have also been agreed, including the Sub-Committees of Trust Board that will receive reports on progress to ensure that actions are implemented.

2. Publication Under Freedom of Information Act

- This paper has been made available under the Freedom of Information Act 2000.

3. Recommendation

Trust Board is asked to:

- Receive the draft Savile action plan and note that actions against all recommendations have been progressed or are complete.
- Note that progress reports have been provided to Safeguarding Boards, Trust Board Sub Committees and Overview and Scrutiny Committee.
- Note that procedures are in place to enable new victims or witnesses to come forward.

4. Supporting Information

The draft Savile action plan is included as an Appendix within this cover paper.

Sharon Scott
Resilience Manager
3 November 2014

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
1. Learning; Organisational Values; Executive Accountability									
The organisational development programme should incorporate the following:									
1.1 The safety of patients, staff, volunteers and visitors as a central priority (source chapters six, seven and eight);	✓			Chief Nurse Chief Medical Officer		<p>Patient Safety is at the heart of the Quality Ambition work being developed by the CMO and CN. Staff health and well-being is also at the cornerstone of all workforce policies. Leadership from the Trust Board has been refreshed and strengthened with Quality being the dominant theme.</p> <p>The Chief Executive has led an inclusive process to develop new values for the Trust. The 5 values which have been agreed are patient centred, fair, accountable, collaborative and empowered.</p> <p>The Trust has reviewed and refreshed its volunteering policy ensuring revised recruitment processes.</p> <p>The Trust has developed and approved an access policy for sanctioned visitors to safeguard patients and staff.</p> <p>(Y0) Further work has taken place to embed the 5 values - workshop at Leeds Town Hall, 15th July 2014, to reinforce the behaviours needed if the values are to be real. Empowerment and Accountability are crucial in relation to safety of patients, staff, and visitors. The Hellomynameis campaign has been launched and over half of all staff have signed up. The Quality Improvement Strategy is complete and has been presented to the Board in September. Work with Haelo has commenced on 2 Trust wide patient safety collaborative - Reducing Harm from Falls and Preventing Cardiac Arrests - care of the Deteriorating patient - 30 wards involved.</p>	✓		Rolling programme

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
1.2 The promotion of enquiring leadership at all levels in the organisation. It should value a culture of curiosity and questioning, and behaviours that enable all staff and volunteers to have the courage to challenge any inappropriate behaviour witnessed in the Trust (source chapters four, six, seven, eight and nine);		✓		Director of HR	Karen Vella	<p>In 2013 The Trust embarked on an ambitious programme of OD and leadership development. This continuing programme is a vehicle to embed our new value set and behaviours, and is designed to positively encourage a culture of personal responsibility. Led by the CEO as a key element of the wider staff engagement programme leaders at every level in the organisation are being developed to enable and increase leadership confidence capacity and capability to support the cultural transformation we are striving for, and sustain the delivery of high quality, safe and effective healthcare.</p> <p>In addition to the existing programme of leadership development, a programme of targeted packages has been launched, designed to support a new culture of leadership at all levels in the Trust. This programme is packaged under the name of Leading in Leeds.</p> <p>Please see update in section 1.3 re Development and Implementation of new arrangements for Whistleblowing.</p>	✓		Rolling programme

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
1.3 A review of existing policies, knowledge and understanding about how staff and volunteers can effectively raise concerns, and a new approach that empowers them to speak out (source chapters seven, eight and nine)	✓			Director of HR	Suzanne Barker	A comprehensive review of the Trusts Whistleblowing arrangements was undertaken in Q3 of 2013/2014. This review was led by the Policy Director from Public Concern at Work to provide specialist and independent advice and guidance in line with legal and best practice requirements. The review involved a series of interviews with key stakeholders and a staff survey available to all staff (completed by approximately 630 staff). The review also included a review of the trusts existing arrangements to support staff in raising concerns. This work has been reported to the Trust Board, Workforce Committee and Executive team at regular intervals. The outputs of this review have informed a new Whistle blowing policy document, process and infrastructure to handle concerns in the Trust. Implementation of the new policy has involved a bespoke training package for designated Whistleblowing Leads and awareness campaign across the Trust.			Review Completed Rolling programme of awareness & training
1.4 A review of the effectiveness of current approaches to the management of and responses to complaints from patients and visitors (source chapters six, seven and eight);				CN	Scott Van-Steen	A comprehensive review of the management and effectiveness of complaints from patients and visitors has been undertaken and an action plan to deliver improvements developed. The Trust complaints policy has been reviewed and refreshed to include the recommendations of the Clywd & Hart review. Both developments have been reviewed the TDA. Patient feedback on the complaints processes has also commenced. Complaints reports are submitted to the Trust Board and feedback of learning shared with CSUs.	✓		Complete
2.1 That the Trust safeguarding policies extend explicitly to the care and transportation of deceased patients (source, chapter six and nine);	✓			CN	Jeff Barlow	The Trust safeguarding policies for adults and children have been reviewed and amended to ensure they extend explicitly to the care of deceased patients.	✓		Complete

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.2 That there are policies and controls in place covering security at the mortuary, and that these are regularly audited (source, chapter six and nine);				Director of E&F	Deputy Director of E&F	<p>Restricted access to mortuary</p> <ul style="list-style-type: none"> Entry to LGI mortuary is restricted by swipe card access with speak and view Entry to SJH mortuary is restricted by numeric keypad and speak and view. <p>Designated areas for entry staff and viewings</p> <ul style="list-style-type: none"> Designated access route to both sites for Chapels of Rest <p>Processes and guidance in place for RIP patients to be developed</p> <ul style="list-style-type: none"> A Trust procedure is in place for the Movement of Bodies <p>Standard Operating Procedures</p> <ul style="list-style-type: none"> A number of SOPs are in place for all mortuary procedures and activity, including for the release of bodies. Documents stored on the EQMS pathology document management system. <p>Mortuaries subject to accreditation and inspection Mortuaries with PM suites at LGI and SJH are both subject to:</p> <ul style="list-style-type: none"> Clinical Pathology Accreditation (CPA) approved (Latest inspection 2013) Human Tissue Act (HTA) Licensed (Latest inspection 2012) <p>A number of inspections have been made, and funding approved to enhance the current security infrastructure (working group in place and works to be completed by quarter 4)</p> <p>Peer review has also taken place. Deputy Director of E&F and Chief pathology technician have visited the Bradford city mortuary facilities (recent build). Minor actions will be included into the above works.</p>	✓		Complete Periodic Audit to take place

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.3 On the quality of its safeguarding compliance in respect of adult and child patients, and its duty to protect staff. Working with the Safeguarding Boards for Children and Adults in the city, an audit programme should include a review of the safeguarding of adults and children in in-patient areas; staff training and employment checks (source chapters four, six, seven, eight and nine);	✓			CN	Jeff Barlow	<ul style="list-style-type: none"> Assurance on the quality of safeguarding compliance in respect of adult and child patients is provided to the Quality Committee sub-committee of the Trust Board. The Chief Nurse is a full member of the City Wide Safeguarding Boards for Children and Adults. The current programme of assurance reporting and audit programme includes staff training and safeguarding in in-patient areas. Areas for further development have been identified ie L2 Peer review visits have been progressed for children’s safeguarding. Self-Assessment in respect of Section 11 has been undertaken. 	✓		Complete On-going training programme in place

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.4 That current DBS checks are in place for all relevant employees, volunteers and where appropriate contractors as a matter of urgency, and that this position is reviewed to inform each Board meeting (source, chapter eight and nine);		✓		Director of HR	Carol Robinson	<p>The Trust pre-employment and pre-works check procedure (2013) details the requirements for disclosure checking, the monitoring arrangements that are in place and the assurance mechanisms for new employees, volunteers, agency workers, secondees, honorary employees, individuals employed on a contract for service. Checks for external contractors are the responsibility of their employers and the Trust undertakes regular audits to assure itself of compliance.</p> <p>Since 2002 the Trust has had processes in place requiring disclosure checks for employees joining the organisation. In addition, prior to 2002, police checks were undertaken across the Trust.</p> <p>In September 2013, the Trust, in line with NHS Employers' recommendations (July 2103) that these checks should be considered for the existing workforce, embarked on a major exercise to complete enhanced DBS checks for 4535 existing members of front-line staff.</p> <p>Since then all job roles have been reviewed and where there is any potential for the job role to have substantial patient contact involving regulated activity now or in the future an enhanced check is mandated. This means that all front-line staff are now covered by the requirement for an enhanced check.</p> <p>The current position is that all 4325 checks for staff in work have now been undertaken. A further exercise will commence from October 2014 to check all remaining job roles in the Trust and undertake standard checks where this is indicated for any existing employee where such a check cannot be evidenced.</p> <p>This work has been reported to the Trust Board, Workforce Committee and Executive team at regular intervals.</p> <p>The Trust has also determined its approach to the re-checking of staff at appropriate intervals. This is a risk based approach based on the following factors:</p> <ol style="list-style-type: none"> 1. All professionally registered staff who have been convicted of a criminal offence or about whom there are concerns are notified to the Trust by the relevant professional body. 2. There is a large cohort of staff (4534) who have been subject to a recent check. 3. The Trust has a turnover of circa 10%, and new starters are checked as part of pre-employment checks. <p>On this basis it is proposed to undertake an annual rolling programme to check one third of existing non-professionally registered staff with a DBS check in excess of 3 years as at the 1st of April each year.</p>	✓		Phase 1 completed for all staff in work Phase 2 commencing in Oct 14

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.5 On the quality of the complaints system, and the Board should monitor full adherence to the recommendations of the Clywd & Hart Review 2013 (source chapter six, seven, eight and nine); and	✓			CN	Scott Van-Steen	<ul style="list-style-type: none"> A Complaint Policy review has been completed in line with national recommendations, including the Clywd & Hart review. The Trust Board receives assurance through a bi-monthly complaints report. Complaints Improvement Plan update has been provided to the TDA. Internal targets for complaints identified. Feedback from complainants commenced in Jan 14. The Trust's complaints process has been reviewed by Patient Opinion. 	✓		Complete
2.6 On the robustness of its processes for staff and others to raise concerns, and on how such matters are responded to and addressed. Particular attention should be given to allegations of sexual impropriety (source, chapter six, seven and eight);		✓		Director of HR	James Tracey	<p>Allegations of sexual impropriety would be handled under the Trust's Dignity at Work policy.</p> <p>The Dignity at Work policy was updated in February 2014 and as part of the Definitions section "inappropriate behaviour of a sexual nature" has been included in the types of harassment list to address the recommendation received from the Savile enquiry team. The Guidance document supporting the Dignity at Work policy is available to managers and employees via the HR pages of the intranet. This provides further clarity on the definitions of inappropriate behaviour and harassment.</p> <p>The Dignity at Work Policy and Guidance is currently under review as part of the regular HR policy review cycle and consideration of the findings of the Savile Report will be incorporated as appropriate.</p> <p>Please see update in section 1.3 re Development and Implementation of new arrangements for Whistleblowing.</p>	✓		Specific action complete Policy under review as part of policy review schedule
2.7 There should be a trust-wide campaign to raise awareness of the safeguarding duty to patients across all patient contact staff and volunteer groups (source chapters six, seven and eight);	✓			CN	Jeff Barlow	Awareness of safeguarding and how to raise concerns is an integral part of staff induction and mandatory and priority training for staff and volunteers. A campaign to further raise awareness has been developed and supported by a new training officer for the Trust with immediate effect.	✓		Complete Process will be on-going

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.8 Review of Safeguarding promotional material, educational material and information used in the Trust will be completed July 2014 to ensure that it is inclusive of all patient contact and support services.	✓			CN	Jeff Barlow	<p>All safeguarding promotional material, educational material or information used in the Trust should be explicit in the inclusion of all patient contact and support services (source, chapter six and eight)</p> <p>Quality Matters Briefing issued to CSUs Jan 2014.</p> <p>Quality Matters briefing update on Safeguarding due Jan 2015</p> <p>Safeguarding adults campaign - leaflets and posters to be displayed in clinical areas - August 2014.</p> <p>Safeguarding Intranet pages have been revised to include educational and promotional materials.</p> <p>LSCB and LSAB safeguarding newsletter/bulletins are disseminated to all staff through in-touch bulletin</p> <p>Safeguarding training delivered at corporate induction has been reviewed and amended - June 2014</p>	✓		Complete
2.9 The quality of work carried out by porters should include measures of patient experience and safeguarding, in addition to the measurement of time to complete tasks (source chapter six)				Director of E&F	Craige Richardson	<p>Safeguarding KPI's for portering and other facilities staff have been provided by the Head of Safeguarding to the facilities directorate for local implementation (see above). In terms of introducing more Qualitative measures around performance. These are being further explored. Patient questionnaires are already undertaken. Much of Portering's effect on the Patient experience is around (1) Timeliness and Privacy/ dignity. Both of these form part of our current performance reporting.</p>	✓		

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.10 Porters should receive training and support about the transportation and handling of deceased patients. Debriefing and counselling should be available for porters who are adversely affected by carrying out this duty (source, chapter six and nine);				Director of E&F	Craige Richardson	Porters currently receive training on how to transport patients, both; on induction, refresher and on the job. A package of training measures has been developed specific to transportation and handling of deceased patients and implemented in August 2014. Future model being considered for post-handover to mortuary	✓		
2.11 The Trust Quality Committee should commission a specific project on the care, transportation and storage of deceased patients to give wider assurance that the matters raised by Savile's association with the hospital mortuary could not happen again (source, chapter six);	✓			CEO	Director of E&F	Discussions in progress	✓		
2.12 Guidance and active support on interacting with VIP patients should be developed and issued to consultants and senior clinicians, and its use monitored through the appraisal process (source, chapter four, five and six).	✓			CMO		The sanctioned visitor policy includes a section relating to VIPs - this is relevant to all staff. A sanctioned visitor's policy was approved on 28th November 2013. A 'lookback' exercise has been undertaken re application. Communicated to all triumvirate leads to outline and highlight their responsibilities in the policy and raised profile of the policy more widely with wider staff through internal communication mechanisms.	✓		Complete

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.13 A sanctioned visitor policy should be established and implemented across all sites of the Trust with some urgency It should set clear boundaries regarding the role of celebrities, VIP and media contractors in the Trust, including their access to hospital premises. This policy should include robust processes for Board assurance and information about the rules of engagement with media, celebrity visitors or other VIP or non-essential visitors to the hospital (chapter four, six, seven, eight and nine)				Head of Comms		The sanctioned visitor policy includes a section relating to VIPs - this is relevant to all staff. A sanctioned visitor's policy was approved on 28th November 2013. A 'lookback' exercise has been undertaken re application.	✓		Complete

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.14 The Trust should conduct a review to ensure the support, advice and care it provides to victims of sexual assault and statutory rape is consistent with current best practice (source chapter six and seven);				CN	Jeff Barlow	For patients attending A&E or GUM there are posters and information available regarding support services for people who are victims of domestic violence and sexual assault. If a person reports an assault or rape this would be reported to the police (with consent). If required we would take specimens would be taken in either A&E or GUM and these are treated as 'evidence' samples. The police have support services that they offer to the individual. Children are taken to the specialist unit in Manchester and adults are dealt with locally. For anyone who is concerned about HIV infection the attached guidelines. http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=2274 are followed. The safeguarding adults policies refer to external partnerships and links with West Yorkshire police http://nww.lhp.leedsth.nhs.uk/common/guidelines/other_versions/1206.doc The Leeds Safeguarding Adults Partnership works together with the attached agencies to support individuals: http://www.leedssafeguardingadults.org.uk/useful_contacts.html	✓		
2.15 The Trust should conduct an audit of placements of children and young people on adult in-patients areas to ensure this no longer happens (source, chapter six, seven and eight);	✓			COO	Head of Nursing Children's Services	With the creation of the children's hospital the under 16 year olds are admitted to children's wards in almost all cases. However it is not without exception - teenage terminations/maternity care take place within the women's service at St James's. 16 - 19 year olds - this is variable and individual discussions take place based on whether the child is having a continuation of treatment that started prior to the age of 16, maturity , special needs etc. The TYA ward accept oncology young adults up to the age of 19 . PICU - patients over the age of 16 will be referred to adult PICU but again there is always an individual discussion about appropriate placement and there is flexibility. A new Transition Board has been developed and Chaired by the CMO.	✓		Complete and rolling audit programme

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
2.16 The Trust should put in place a safe confidential counselling service for all staff, patients, visitors and volunteers affected by the content of this report (source, chapter seven)				CN		A confidential counselling service has been arranged for staff or volunteers affected by the report. Support for patients and visitors are also available via the National Support line.	✓		Complete
2.17 The Trust should establish a confidential helpline and referral service for victims of Savile, including those who have not yet come forward (source, chapter seven).				CN	Jeff Barlow	Arrangements have been made for any new victims of Savile to discuss their concerns with members of the Adult or Children's Safeguarding staff together with referral to a National support line. Local counselling facilities have been arranged for any new staff or volunteer victims.	✓		In place
3.1 Development of strategies and actions should continue to improve the visibility of executive and non-executive directors across the organisation. (source chapters four, six, eight and nine);				CEO		<ul style="list-style-type: none"> Refreshed Ward to Board / Exec / Non Exec visits schedule for 2014/15 in place. Rolling programme of Friday clinical visits by CMO/CN. Venue changes for Executive meetings. NED representation for key Trust Committees Trust Board attendance at staff / service awards Programme of attendance at Lead Clinician & new Consultants groups in place. Protected Friday for Executive visibility agreed 	✓		Rolling programme
3.2 As part of their Board responsibility, directors should foster a culture of curiosity, internal scrutiny and constructive challenge, particularly on matters which have a major impact on public confidence in Trust services (source, chapter eight and nine).				CEO		<ul style="list-style-type: none"> Hotspots weekly report at Executive Team Meeting. Weekly Quality meeting chaired by CMO/CN to highlight potential serious incidents, complaints, untoward events. NED engagement on Trust projects ie: policy review. Informal Executive commenced weekly Increased time with Clinical Directors in place in safety, risk and governance Introduction of Executive Management Group 	✓		Rolling programme

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
3.3 The Board should develop an understanding of how it feels to be a patient in the Trust and identify methods of communication to share good practice and celebrate success in addition to ensuring concerns are addressed promptly (source, chapter six, seven and eight).				CEO		Understanding of the patient experience in the Trust is currently gathered from a variety of formal and informal sources with areas for improvement and action being identified. These include local surveys, friends & family, 'IWantGreatCare', peer reviews. A variety of methods to share and celebrate good practice are already established including quality and safety matters briefings, Chief Executive start the week briefings, Lessons learned forums, local newsletters, media briefings. The Board receives regular information and assurance through the Patient Experience Sub-Committee (PESC) of the Quality Committee regarding the experience of patients and actions in place to improve. This includes assurance through formal means (e.g. national and local patient surveys) and friends & family. In addition the Trust Board receives assurance through a bi-monthly complaints report which includes informal feedback from patients and their families together with a Friends and Family report, Serious Untoward Incidents report, Safety Thermometer updates, Members meetings, 'IWantGreatCare' feedback and Patient Involvement Improvement Plan progress. Work is also progressive with 3rd sector partners	✓		
4.1 The Trust should review security across all sites, including on call residences and decommissioned areas in its estate to develop a comprehensive strategic security plan. The Board should seek regular assurance that all restricted areas are secure including high risk areas (source chapter six and eight).				Director of E&F		A full review of all sites undertaken including functional and non-functional areas. Risk assessed and categorised and security profile developed for each category, protocol developed and issued for decommissioned areas and incorporated into the Strategic Security Plan which is now in place. Board assurance by annual governance statement and quarterly reports to the Board on non- functional areas.	✓		Completed

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
5.1 A unified HR system should be established across the Trust which fulfils the recruitment and employment requirements for all employees, volunteers and contractors in a consistent manner (source, chapter eight, nine and ten);		✓		Director of HR	Chris Carvey	The Trust utilises the national NHS Jobs system for recruitment of all employees and holds employment data for all employees on the national ESR system. All Volunteer records have been transferred to ESR. The system is not designed to hold contractor information. The Trust is also developing arrangements with partner organisations to improve the management information in relation to agency workers, however, it is not be feasible to hold this data on ESR.	✓		Completed
5.2 The Trust should review its policy on gifts and hospitality and seek assurance that all staff (including volunteers and non-executive directors) are aware of their responsibilities and comply with the policy. Compliance should be reviewed at least annually by Internal Audit (source, chapter five and ten);				Jo Bray Trust Board Secretary		The revised policy Standards of Business Conduct was approved at the May Board meeting, which addressed the issues raised. To be included in internal Audit annual work plans. Internal Audit will review compliance with this policy during 2014-15 and this will be included in the Internal Audit Plan for future years.'	✓		Completed
5.3 The Trust should develop with some urgency a volunteer policy. This should cover their employment checks, induction, training, access to the Trust, and clarity about the boundaries of their roles (source chapter four, six, eight and nine);				CN	Krystina Koslowska	The Trust has reviewed and refreshed its Volunteer policy. The revised policy (approved in November 2013 and updated in March 2014) includes employment checks, induction, training, access to the Trust, and clarity regarding role boundaries. All volunteers have been subject to DBS checks.	✓		Completed

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
5.4 The Trust should develop a major strategic plan for the management of potentially catastrophic issues where the public confidence in the organisation may be at stake in the light of unprecedented events. This will enable greater clarity and consistency in matters of communication, accountability and action (source, chapter eight and nine);			✓	CN	Sharon Scott	Strategic plan has been developed to respond to immediate or catastrophic issue aligned to Trust MAJAX plan approved October 2014. This includes: <ul style="list-style-type: none"> • Help-lines for staff and public • Support for staff and public • Accountability and coordination arrangement, ie Director level responsibility, Single point of contact, etc • Staffing arrangements 24/7 (significant number of media requests, FOI, telephone calls from public over a sustained period of time) • Board updates • Stakeholder engagement and communication 	✓		Completed
5.5 The Trust should work with the Leeds Teaching Hospitals Charitable Trust to develop and implement a policy for the management of large financial donors, specifically setting out how to deal with requests for favours from them (source, chapter five)				Jo Bray Trust Board Secretary		At the May Board meeting; <ul style="list-style-type: none"> - The Board approved the revisions to the Standards of Business Conduct - Fund Advisors Information Manual – produced by the (Charitable Foundation) was formally adopted by the Trust and therefore becomes a document that all staff must adhere to. - A new policy has been approved, LTHT Policy for Responding to Charitable Donations. 	✓		Completed

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
5.6 The Trust Dignity at Work policy has been in place since 2011, but does not explicitly mention sexual harassment in its definition of what constitutes harassment or unwanted behaviour. This should be reviewed and sexual harassment clearly defined, with examples given. Following review, this policy should be audited. In particular to gain assurance that staff who have line management responsibility for others are fully conversant with the required actions to take when faced with allegations of sexual harassment or unwanted behaviour (source, chapter six, seven, eight, nine and 10);		✓		Director of HR	James Tracey	<p>The Dignity at Work policy was updated in February 2014 and as part of the Definitions section “inappropriate behaviour of a sexual nature” has been included in the types of harassment list to address the recommendation received from the Savile enquiry team. The Guidance document supporting the Dignity at Work policy is available to managers and employees via the HR pages of the intranet. This provides further clarity on the definitions of inappropriate behaviour and harassment. . This includes, under the definition of inappropriate behaviour, “Physical contact ranging from touching to serious assault”.</p> <p>The Dignity at Work Policy and Guidance is currently under review as part of the regular HR policy review cycle and consideration of the findings of the Savile Report will be incorporated as appropriate.</p>	✓		<p>Specific action complete</p> <p>Policy under review as part of policy review schedule</p>
5.7 All policies should be reviewed to ensure they comply with statutory obligations about the retention of records (source, chapter nine and 10);				Director of Informatics	Balbir Bhogal	<p>These matters were discussed at the IGSC in February 2014. Subsequently a paragraph has been added to the Policy for the Development and Management of Trust-Wide Policies and Procedures, and also the standard template. Policy Leads have been reminded to take this into account when their documents are next reviewed.</p>	✓		Completed

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
5.8 All Trust policies should extend in their scope to the broader community including volunteers, non-executive directors and where appropriate contractors, and in time, governors (source, chapter eight, nine and 10);				Chief Nurse	Craig Brigg/ Julia Roper	<p>This is not possible for external contractors, but will include staff on secondment.</p> <p>The Board induction programme for new members has been reviewed within the last year complying with the FTN recommended induction check list (ie the key policies to be supplied).</p> <p>The Trust is at least two years away from becoming an FT and amendments to policies will be reviewed in light of the Trust having a Council of Governors and at this stage would not add this into current policies, as there is a wider communication/ promotion and understanding of the role and statutory duties of Governors that needs to be understood throughout the organisation.</p> <p>Current policies and procedures have been reviewed to assess their relevance to volunteers.</p>	✓		Completed
5.9 The Trust should review how it seeks the views of a wider range of stakeholders in developing policies, and should ensure that all policies are patient centred. In doing so, it should draw best practice from other organisations within and outwith the NHS (source, chapter 10);				Chief Nurse	Craig Brigg/ Julia Roper	<p>A list had been identified for stakeholder engagement and reviewed by Policy Task and Finish Group in July.</p> <p>The T&F group agreed that rather than have a list, the policy leads and Executive Directors be prompted to take this into consideration when each policy/procedure is due for review. This has now been put in place.</p>	✓		Completed
5.10 All policies should be succinct, clearly set out in plain language, and identify the points that people need to know in order to implement them safely (source, chapter 10);				Chief Nurse	Craig Brigg/ Julia Roper	<p>The Board established a Policy Task and Finish Group in June 2013. The work has now been mainstreamed and includes routine review of all policies and procedures with formal approval processes to include the style and user friendly reading.</p>	✓		Initial work completed Review On-going

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
5.11 There should be mandatory compliance with policies designed to protect patients and staff. The role of the Trust's internal Audit should be reviewed as part of this (source, chapter nine and10).				Chief Nurse	David Gregory	Process in place to review Trust Policies and procedures. Internal Audit engaged in review of policies compliance.	✓		Partial work completed
6.1 A baseline review of the range of projects supported by Leeds Teaching Hospitals Charitable Trustees should be undertaken to assess consistency with the current priorities of the Trust (source, chapter five);				TW		Consistency check against current projects has been completed. New arrangements and procedures are being established to ensure focussed utilisation of available charitable funds and future fundraising consistent with clinical and Trust policies. Director Attendance at meetings has been updated.	✓		Complete
6.2 The Charitable Trustees should work closely with the Leeds Teaching Hospitals NHS Trust Executive Team to establish priority - setting and decision-making processes that reflect the needs of the patients of the hospital and the services provided to them (source; chapter five).				TW		Regular meetings now take place between members of the Exec Team at the Trust and Charitable Trustees	✓		Complete

ACTION PLAN - SAVILE REPORT (27 11 14) v1

Recommendation	Trust Board Sub-Committee *			Lead Director	Management Lead	Current Position and Action Agreed	In progress		Date for completion
	QC	WC	RC				Y	N	
Actions that MUST be taken to improve quality and safety									
6.3 Assurance that charitable funds are channelled appropriately should be gathered on a systematic and on-going basis and reported to both the Charitable Trustees and trust Board Audit Committee to ensure that the mechanisms in place to do this continue to be effective (source, chapter five).				TW		Bi-annual report to Audit Committee of proposals, submissions and outcomes to be introduced. A report will be submitted to the February Audit Committee containing above information.	✓		February 2015

Appendix F

LTHT cases as of August 22nd 2014

Date To NHS SLU	Source	Identifier	Patient/Staff	Age at time	Gender	Location	Date Of Incident	ALB	Status	Comments
9.6.14	WYP	KM	Patient	14 years	Male	LGI	1993	TDA	Referral to LTHT	CONSENT TO CONTACT SECURED
16.6.14	WYP	N/A	Patient	7-9 years	Female	LGI	1971-3	TDA	Referral to LTHT	CONSENT TO MAKE CONTACT SECURED
9.5.14	WYP	WL	Patient	30s	Male	LGI	1990-95	TDA	Referral to LTHT	CONSENT TO MAKE CONTACT SECURED
20.5.14	WYP	N/A	Patient	16 years	Female	LGI	1968	TDA	Referral to LTHT	DO NOT MAKE CONTACT
8.7.14	WYP 260396	LV	Staff Member	20s	Female	LGI	Early 1980s	TDA	Referral to LTHT	CONSENT TO MAKE CONTACT SECURED
10.7.14	WYP	N/A	Patient	6 years	Female	Seacroft	1966	TDA	Under investigation WYP	CONSENT TO MAKE CONTACT SECURED
24.7.14	NSPCC	TB	Staff Member	Poss 20s	Female	LGI	1952/3-56	TDA	Referral to LTHT	CONSENT TO MAKE CONTACT SECURED
12.8.14	WYP	N/A	Patient	10-12 Years	Male	St James's Hospital	1973 - 75	TDA	Referral to LTHT	CONSENT TO MAKE CONTACT SECURED

Appendix G

Chronology of Significant Events

2011

29th October: Jimmy Savile died.

2012

22 October: The documentary 'The other side of Jimmy Savile' is broadcast on ITV

2013

11 January: Scotland Yard labels Savile a "prolific, predatory" sex offender after its investigation reveals 214 criminal offences across 28 police forces, between 1955 and 2009. Its report, Giving Victims a Voice, found that 73% of his victims were children, and the allegations of abuse include 14 health care organisations.

2014

2 June: NSPCC research for BBC Panorama confirms there have been at least 500 reports of abuse by Savile.

26 June: Department of Health publishes the results of investigations into matters relating to Savile in 28 NHS organisations, including major investigations in Leeds General Infirmary and Broadmoor hospitals. In Leeds, Savile abused 60 people including at least 33 patients aged from five to 75. At high-security Broadmoor hospital, he abused at least five individuals, including two patients who were subjected to repeated assaults.

June/July: Leeds Teaching Hospitals NHS Trust set up a Savile help line to support any victims and witnesses coming forward post publication of the Leeds Teaching Hospitals NHS Trust investigation report.

7th July: NHS Savile Legacy Unit established.

22nd August: The NHS Savile Legacy Unit met with the Leeds Teaching Hospitals NHS Trust investigation team to discuss lines of enquiry received by the NHS Savile Legacy Unit.

28th August: The NHS Savile Legacy Unit provided the contact details of victims and witness to the Leeds Teaching Hospitals NHS Trust investigation team to investigate.

Appendix H

Date:

Our Ref:

Professor Suzanne Hinchliffe CBE
Chief Nurse
Leeds Teaching Hospitals
St James's University Hospital
Trust Headquarters
Beckett Street
Leeds
LS9 7TF

www.leedsth.nhs.uk

Dear

Re: NHS Investigations into matters relating to Jimmy Savile

As Chief Nurse/Interim Chief Operating Officer for Leeds Teaching Hospitals NHS Trust (LTHT) I am very sorry to hear of your experience in relation to Jimmy Savile. I appreciate that this must have been a very distressful experience and I would like to assure you that the Trust takes these allegations very seriously.

The NHS Savile Legacy Unit, responsible for NHS Investigations into matters relating to Jimmy Savile has passed on your details to the Safeguarding Team at the hospital who are now responsible for undertaking an investigation into any further allegations made in relation to Jimmy Savile.

Ray Galloway (Investigation Oversight and Support) of the NHS Savile Legacy Unit met with Sharon Scott, the Trust Resilience Manager, Caroline Ablett, Lead Professional for Safeguarding Adults and Jeff Barlow, Head of Safeguarding on the 22nd August 2014 in order to hand over the investigation.

Ray Galloway has kindly provided the Trust safeguarding team your contact details and I am informing you that we will be making contact with you in due course in order to discuss and learn from your experience. It is important for us to understand what happened to you so we can learn from the experiences of people who were abused by Savile to ensure that this does not happen again. The safeguarding team will provide further details of the investigation when they contact you.

In the meantime if you have any questions then please do not hesitate to contact Jeff Barlow, Head of Safeguarding on 0113 2066698.

Yours sincerely

Professor Suzanne Hinchliffe CBE
Chief Nurse

Appendix I Recommendations Action Plan

Recommendation	Action	Lead	Current Position and agreed action	Target date	Date completion of and outcome
The Trust should afford any other victims of Savile, the opportunity to share their experience with the Trust to enable the Trust to establish if there are any other lessons to be learned	The Trust should have a process in place to enable victims to come forward with any safeguarding concerns related to Savile or other persons employed by or connected with the Trust.	Head of Safeguarding		February 2015	
To have an appropriate safeguarding policy in place for the admission of children and young people who are admitted to adult wards. Such admissions are exceptional events, but in some cases necessary.	The Trust should have an approved and ratified policy document or Standard Operating procedure in place to cover the admissions for children and young people.	Head of Nursing for Children's Services		March 2015	
To ensure that safeguarding is included in the work of the Transitions Strategy Board looking at the needs of 16/17 year old patients.	The Trust should review the Terms of Reference for the membership of the Board to have the Executive Lead for safeguarding or nominated deputy represented on the Board	Chair of the Transitions Strategy Board		February 2015	
The Trust should review its policies and procedures related to the care and welfare of its employees to ensure there is explicit reference to safeguarding staff from abuse.	All relevant policies related to the care and welfare of staff are to be revised with specific reference to safeguarding staff.	Head of Safeguarding		March 2015	

Recommendation	Action	Lead	Current Position and agreed action	Target date	Date completion of and outcome
The Trust should review its complaints procedure to ensure that there is accessible information available for children that is child friendly using language that children are able to understand.	The Trust should develop easy read leaflets and posters on complaints for children and young people. The accessible information should be visible within children's services and available on the Trust website.	Head of Patient Experience		March 2015	
The Trust should review its process for informing children of their right to be safe from abuse.	The Trust should have accessible easy read information within children's services and ensure that the safeguarding training includes staff awareness on their duty to inform children of their right to be safe and how to support children in raising concerns.	Head of Safeguarding		March 2015	