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

Executive Summary

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Executive summary

Leeds General Infirmary is part of the Leeds Teaching Hospitals NHS Trust. Originally the city's teaching hospital, it dates back to the 1700s. The Trust now administers seven hospitals in Leeds and the surrounding area. It is one of the largest teaching hospitals in Europe, with an annual turnover of £1 billion. It employs over 15,000 staff and each year treats almost 1.5 million patients in its wards and departments. Many departments are regional or supra-regional centres of clinical excellence, and many also excel in teaching, research and clinical innovation.

James Wilson Savile was born in Leeds in 1926. He died in Leeds aged 84 in 2011. During his lifetime he was a radio disc jockey, television presenter, media personality and charity fundraiser. For over 50 years he had a close association with the Infirmary and its associated hospitals. Over the years, the nature of this association evolved through his roles as a volunteer, celebrity advisor to the hospital radio service, volunteer porter and significant fundraiser.

He was awarded an OBE in 1972, an Honorary Doctorate in Law from Leeds University in 1986, a Knighthood in 1990 and a Papal Knighthood in the same year.

Initially highlighted in an ITV *Exposure* documentary first shown in October 2012, and then through subsequent investigations including Operation Yewtree led by the Metropolitan Police, it is now known that Savile was also a prolific sexual predator, paedophile and rapist. He operated across the country through his work at the BBC, and in a number of NHS hospitals, including the Infirmary in Leeds.

Following the broadcast of the ITV documentary, Leeds Teaching Hospitals NHS Trust received a number of calls from former patients, staff and others. These callers reported accounts of verbal, physical and sexual abuse at the hands of Savile. The incidents took place throughout his association with the hospital, with greater frequency during the 1960s and 1970s. Over subsequent weeks, many more victims alleging abuse by Savile, including at the Infirmary, came forward to inform the police and health authorities.

The Trust's immediate response was to conduct an urgent internal review of key areas of risk pertinent to Savile's alleged offences. Its Internal Audit department assessed a range of relevant current policies and practices and recommended a series of actions to address deficiencies.

In October 2012, Kate Lampard was invited by the Secretary of State for Health to oversee independent investigations in the NHS organisations with which Savile was closely associated. These are: Leeds Teaching Hospitals NHS Trust; Buckinghamshire Healthcare NHS Trust, which runs Stoke Mandeville Hospital; and West London Mental Health NHS Trust, which runs Broadmoor Hospital. The Department of Health is also conducting a joint investigation with West London Mental Health NHS Trust as part of this process.

In December 2012, the Board of Leeds Teaching Hospitals NHS Trust commissioned an external team to investigate matters relating to Jimmy Savile and the Trust (and its predecessor bodies). Led by Dr Susan Proctor, the investigation team started its work in January 2013 and has continued over the last 18 months to fulfil the terms of reference of the investigation.

The terms of reference for the investigation are as follows:

1 Thoroughly examine and account for Jimmy Savile's association with Leeds Teaching Hospitals NHS Trust (LTHT) and its predecessor bodies, including approval for any roles and the decision-making process relating to these.

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

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

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

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

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

- where the incident(s) occurred;
- who was involved;
- what occurred; and
- whether these incidents were reported at the time and whether they were investigated and appropriate action taken.

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

7 Where complaints or incidents were not previously reported or investigated, or where no appropriate action was taken, consider the reasons for this, including the part played, if any, by Jimmy Savile's celebrity or fundraising role within the organisation.

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

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

10 Identify recommendations for further action.

Summary of findings

Based on the analysis of over 200 witness interviews, and the analysis of over 1,300 documents, the evidence we have obtained (quoted in the main body of the report) supports the following summary conclusions:

- Savile's relationship with Leeds General Infirmary started in 1960. During the 1960s he would regularly visit the hospital as a celebrity, on occasion as a voluntary porter and also in connection with fundraising activities. He also supported the development of the hospital radio service. In 1968, he formally offered his services as a voluntary porter to the Board of Governors and this was considered and approved by the Chairman of the Board of Governors, enabling Savile to commence his sanctioned role as a volunteer porter.
- Savile was most active in his role as porter from the late 1960s to the mid-1970s. He continued in this role, albeit on a more sporadic basis, well into the 1990s. He was a regular presence at the hospital and worked largely with the porters serving the X-ray and Accident and Emergency departments.
- Throughout his association with the Infirmary, Savile successfully sought publicity using the local press and national media to promote various fundraising and other campaigns about services in Leeds or on behalf of other hospitals.

Fundraising and publicity

- Over the years Savile was associated with raising £3.5 million for services at the Infirmary. He successfully maintained an almost continual presence in the local press associated with his charitable fundraising.
- During the 1980s, he would use the Infirmary as a base for fundraising activity for the Stoke Mandeville Spinal Injuries Unit. With the press in attendance, he would host publicity meetings in the Infirmary boardroom, where he would receive donations for this campaign from hospital and community organisations and members of the public in Leeds.
- He continued to be associated with fundraising activities on behalf of services at Leeds Teaching Hospitals NHS Trust and its predecessor bodies throughout his years of association with the Infirmary. In later years, this activity was less frequent, but continued to successfully attract publicity through local media.

Access and influence

- Savile regularly visited wards and departments, both as a porter and as a celebrity. These visits occurred throughout his association with the Infirmary, but particularly from the 1960s to the 1980s. Generally, these would be unannounced visits, at any time of the day or night, and he would chat to patients and staff alike. He was considered to be very popular with patients, and his visits were seen by many as a boost to morale.
- During the late 1960s and 1970s, Savile had wide-ranging access across the Infirmary. There was little evidence of challenge to or controls on his whereabouts during this period, or in later years when he spent comparatively less time at the hospital. In addition to duties as a porter, and his ward visits, he sometimes attended consultant ward rounds, assisted in the delivery of intimate care such as giving bed baths to patients, and regularly visited the mortuary.
- He had access to offices, to on-site residences and to other restricted areas via his relationships with the Head Porter and other senior managers in the late 1960s. This access remained unchallenged for the entirety of his association with the Infirmary. This included a regular allocation of car parking spaces for his vehicles, including the overnight parking of his campervan.

- Savile had three offices allocated to him in succession from 1992 to 2011. Prior to this, he used the Head Porter's office as an informal base. Up to the early 1980s, he used the Infirmary as his postal base for personal mail and media correspondence, which was dealt with by a member of staff on his behalf. This arrangement was then reinstated in the 1990s when he was first allocated a dedicated office.

The abusive encounters

- We are aware that many who read this report will want to discover what happened to the victims. There is no substitute for reading this section of the report (chapter seven), and therefore we include only brief summary information here.
- As part of this investigation 64 people came forward to share accounts of abuse or inappropriate encounters at the hands of Savile. Sixty of these accounts concerned abuse in premises run by the Trust or its predecessors, and four related to other healthcare organisations in either Leeds or other parts of West Yorkshire. Of the victims from the Leeds Teaching Hospitals NHS Trust or its predecessor bodies, ages ranged from five years to 75 years. Nineteen children and 14 adults were patients at the time of their abuse. In addition, 19 members of staff reported abusive or inappropriate encounters with Savile. We heard eight further accounts from victims who were external to the Infirmary, but whose abusive encounters had a connection with it.
- The majority of Savile's victims were in their late teens or early twenties at the time of the encounter. The earliest case was in 1962, when Savile was 36 years old; the most recent in 2009, when he was 82. In terms of patient victims specifically, the earliest case was in 1962 and the most recent in 1999.
- Mostly, his assaults were opportunistic, and many took place in public areas such as wards and corridors. However, eight cases suggest an element of premeditation: in some instances, this included the grooming of victims and their families over a period of months. Mostly Savile worked alone, but on occasion he was assisted in his abusive behaviour by others.
- Encounters ranged from lewd remarks and inappropriate touching to sexual assault and rape. These encounters took place on wards, in lifts, in corridors, in offices and off site in a local café, in his mother's house and in his campervan.
- Only four children and five adults reported their experiences at the time to staff or a colleague. The subsequent individual responses are examined.

Corporate responses

- Consideration is also given to the response of the organisation as a whole, and in particular to that of the senior management during Savile's association with the Infirmary.
- Different levels of the organisation held disparate views of Savile and his value to them. Among staff in the wards and departments he was tolerated because of his celebrity and popularity with patients. He was, however, seen by many as a nuisance, a disruptive presence in the clinical areas and, towards female staff, a sex pest.
- Among the Board of Governors before 1974 and in the opinion of some senior managers in post during the 1960s to 1980s, he was mostly regarded as a force for good, a great and positive publicist for the Infirmary, a morale booster and a welcome fundraiser. Later on, the senior managers in the 1990s and 2000s paid him little attention and were largely indifferent to his (albeit relatively less frequent) presence in the organisation. Occasionally he would attend the launch of a new service, or help to publicise a new initiative, but was rarely courted or in receipt of attention from the contemporary senior managers.

- Recognising the extensive changes in healthcare delivery, NHS governance and other legislative changes that impact on corporate policies and practices today, we assess and critique the current pertinent corporate policies in the Trust.

Governance and internal assurance

A local oversight panel chaired by a Trust Non-Executive Director was set up in January 2013. Its role was to oversee the development, scope, pace and progress of the investigation and to report to the Trust Board. Membership comprised the Chairs of the Leeds Adult and Child Safeguarding Boards; senior representation from the NSPCC, Leeds Local Involvement Network (LINk, now Healthwatch), Victim Support and the University of Leeds; and the Trust Executive Director Lead for Safeguarding. The local oversight panel received legal advice from the Trust's legal advisors.

Co-ordination with the other two principal NHS investigations has been consistent and regular liaison has been maintained. Productive relationships were also established with both the Metropolitan Police Service and West Yorkshire Police.

Recommendations

We have made 31 recommendations for the Trust Board, which are grouped into six themes:

- 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; and
- fundraising.

These aim to build on current good practice in the Trust and to ensure that the Trust Board strengthens its systems of assurance and internal control to minimise the risk of anything similar happening in the future.

Recommendations

Recommendations

As part of this investigation we have reviewed numerous reports of inquiries and studies considering failings in healthcare services, the safeguarding of children and young people, and the safeguarding of adult patients (Francis, 2013; Keogh, 2013; Erooga et al, 2012; Laming, 2003; Laming, 2009). When we consider these reports alongside our investigation concerning Savile's abusive behaviour in Leeds, there is a resonance in our mutual findings on the factors associated with organisational weaknesses and safeguarding standards. From this process of review and the learning from our own investigation, we have found that the following characteristics are invariably associated with healthcare organisations striving to be safer:

- strong, visible, credible and accessible Board leadership;
- clearly defined and commonly agreed organisational values and behaviours;
- executive accountability for the safeguarding of children, young people and adults;
- leadership that fosters a culture of curiosity, scrutiny and constructive challenge, with processes to underpin these behaviours;
- clearly defined, patient-centred drivers for all internal policies and practices;
- a commitment to lead and safeguard patients on a 24 hours, seven days a week basis;
- coherence and connection between the Board and wards/departments;
- a secure environment with regulated access to care settings;
- effective and well-understood policies for staff and patients to raise concerns;
- robust systems of employment checks for staff, volunteers and contractors;
- effective processes of induction, training, review and management of performance; and
- zero tolerance of the abuse, harassment or victimisation of staff or patients.

Our recommendations are therefore derived from the evidence, our consideration of these characteristics, and a prescription of actions necessary to strengthen the relevant corporate systems and processes that, when optimal, will contribute significantly to making the organisation safer. We do recognise that in recent years there has been considerable improvement in many of the corporate systems and processes, but there is still much to do. We have also made some specific recommendations on the Trust's fundraising governance processes and its relationship with the Charitable Trustees, and some specific points about corporate policies.

Our recommendations are presented below in a way that links them to the characteristics of a safer organisation set out above, and to our findings. They should be taken forward by the Chief Executive and their progress monitored by the Board.

Leadership; organisational values; executive accountability

Under the leadership of the new Chief Executive and Board, the Trust has recently embarked on a major organisational development programme to refresh and strengthen its core values and behaviours. We welcome this, and recommend that the following matters are addressed as part of this programme during 2014.

11 The organisational development programme should incorporate the following:

- the safety of patients, staff, volunteers and visitors as a central priority (source: chapters six, seven and eight);
- 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);
- 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); and
- 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).

Patient-centred drivers; safeguarding patients

We believe that the quality of patient services is a central priority for the Trust's new leadership team, and for the Board. These recommendations are therefore intended to strengthen current approaches, and in particular to improve the inclusivity of all patient contact services in their continual quest for improvement in quality. Because of the central importance of safeguarding patients, these recommendations should be addressed by September 2014.

12 The Executive Director with responsibility for safeguarding patients, and the Executive Director with responsibility for facilities and estates, should jointly assure the Board on how support services (including porters, security and mortuary services) contribute to safeguarding patients, particularly in the following areas:

- that the Trust's safeguarding policies extend explicitly to the care and transportation of deceased patients (source: chapters six and nine);
- that there are policies and controls in place covering security at the mortuary, and that these are regularly audited (source: chapters six and nine);
- on the quality of the Trust's 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);
- that current Disclosure and Barring Service (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: chapters eight and nine);

- on the quality of the complaints system; the Board should monitor full adherence to the recommendations of the 2013 Clwyd/Hart Review (source: chapters six, seven, eight and nine); and
- on the robustness of the Trust's 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: chapters six, seven and eight).

13 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).

14 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: chapters six and eight).

15 The quality of work carried out by porters should include reference to patient experience and safeguarding, in addition to the measurement of time to complete tasks (source: chapter six).

16 Porters should receive training and support about the transportation and handling of deceased patients. De-briefing and counselling should be available for porters who are adversely affected by carrying out this duty (source: chapters six and nine).

17 The Trust Quality Committee should commission a specific project on the care, transportation and storage of the bodies 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).

18 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: chapters four, five and six).

More broadly, the following recommendations look to the role of the Board in corporate and system-wide assurance regarding the safety of patients. We believe that these actions should be in place as a matter of urgency by July 2014.

19 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, VIPs 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 and other VIP or non-essential visitors to the hospital (source: chapters four, six, seven, eight and nine).

20 The Trust should conduct a review to ensure that the support, advice and care it provides to victims of sexual assault and statutory rape are consistent with current best practice (source: chapters six and seven).

21 The Trust should conduct an audit of placements of children and young people on adult in-patient areas to ensure that this no longer happens (source: chapters six, seven and eight).

22 The Trust should put in place a safe and confidential counselling service for all staff, patients, visitors and volunteers affected by the content of this report (source: chapter seven).

23 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).

Board/ward coherence

Strengthening the connection between the Board and the rest of the organisation across its multiple sites is an important, but challenging, matter to address. Current approaches we endorse include a weekly electronic newsletter from the Chief Executive, dedicated time for visits to wards and departments, and the work connected to the organisational development programme. The momentum created by these initiatives should be maintained, and by October 2014 the following should be in place.

24 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).

25 As part of their Board responsibility, directors should foster a culture of curiosity, internal scrutiny and constructive challenge, particularly on matters that have a major impact on public confidence in Trust services (source: chapters eight and nine).

26 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 that concerns are addressed promptly (source: chapters six, seven and eight).

Security and controls on the physical access to hospital premises

Keeping its premises accessible and yet safe is an important challenge for the Trust. Providing services on multiple sites and from premises that range from Victorian to modern is a further logistical challenge, and we are aware of the Trust's commitment to minimising the risk to patients and staff by its investments in effective security systems. The following recommendation should be addressed by October 2014.

27 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: chapters six and eight).

Policy development and implementation

We reviewed a number of policies directly connected to issues arising from Savile's impact on the Trust. We note and welcome the Trust Board's initiation of a review of all corporate policies through the creation of a Corporate Policy Review Group. The following recommendations should be implemented by December 2014.

28 A unified HR system should be established across the Trust that fulfils the recruitment and employment requirements for all employees, volunteers and contractors in a consistent manner (source: chapters eight, nine and ten).

29 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: chapters five and ten).

30 The Trust should develop with some urgency a volunteer policy. This should cover volunteers' employment checks, induction, training, access to the Trust and clarity about the boundaries of their roles (source: chapters four, six, eight and nine).

31 The Trust should develop a major strategic plan for the management of potentially catastrophic issues where 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: chapters eight and nine).

32 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).

33 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: chapters six, seven, eight, nine and ten).

34 All policies should be reviewed to ensure that they comply with statutory obligations about the retention of records (source: chapters nine and ten).

35 All Trust policies should extend in their scope to the broader community, including volunteers, non-executive directors and, where appropriate, contractors; and, in time, to governors (source: chapters eight, nine and ten).

36 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 outside the NHS (source: chapter ten).

37 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 ten).

38 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: chapters nine and ten).

Fundraising

Owing to the nature of Savile's activities as a fundraiser for numerous charities, we considered historical and current practice with regard to the priority-setting, governance and leadership of charitable funds connected with the Infirmary. The following recommendations should be addressed by December 2014.

39 A baseline review of the range of projects supported by the Leeds Teaching Hospitals Charitable Trust should be undertaken to assess consistency with the current priorities of the Trust (source: chapter five).

40 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).

41 Assurance that charitable funds are channelled appropriately should be gathered on a systematic and ongoing basis and reported to both the Charitable Trustees and the Trust Board Audit Committee to ensure that the mechanisms in place to do this continue to be effective (source: chapter five).