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

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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.

Acknowledgements

We would like to thank:

The patients, former patients, family members and others who came forward to share their experiences of Savile. Those members of staff (current or former) who were also victims, and who shared their experiences with us. We would also like to thank those who came forward initially to either West Yorkshire Police or the Metropolitan Police Service as part of their investigations and then gave permission for us to contact them, to view their witness statements and, on occasion, to hear their accounts. For many it was the first time they had spoken about painful experiences from childhood, or from many decades ago, and we recognise that this process will have brought back difficult memories. We are very grateful for their contributions, both on our behalf and on behalf of all those who will read and use this report.

The members of the local oversight panel, our legal advisors, the investigation teams in other NHS organisations and the National Oversight Team for their guidance throughout the investigations. We have also benefited from the insights of advisors from other investigations.

Current and former members of staff from Leeds Teaching Hospitals NHS Trust. It has been a difficult and demanding time for the organisation to have this investigation ongoing since the beginning of 2013. We are grateful to all staff and former staff who have come forward to be interviewed as witnesses – and to those who shared their accounts of the organisation – to enable us to build a contextual narrative for the period covered by the investigation. Their co-operation has been a major strength in fulfilling the terms of reference and completing the investigation.

Staff at Leeds Teaching Hospitals NHS Trust who have helped us with the practicalities of completing our work, including the information governance, patient records, communications and IT teams for their professional advice and the facilities support staff for the service they have provided to us.

The Board of Leeds Teaching Hospitals NHS Trust for commissioning the investigation and providing support throughout its duration to enable the smooth running of our work.

West Yorkshire Police and the Metropolitan Police Service, who were helpful in answering our questions and sharing their records with us. We are particularly grateful for the work they did in seeking permission to access witness statements and consent to contact many of the victims who had come forward as part of the Operation Yewtree investigation.

All staff at the West Yorkshire Public Service Archive office for their attention to detail, patience and diligence in identifying and retrieving documents for the investigation.

The Digital Services Team at the *Yorkshire Post* for going above and beyond what we could have expected in helping us retrieve cuttings from their archive. These have helped enrich our understanding of Jimmy Savile's relationship with the city and people of Leeds.

The team at Victim Support, the Leeds Teaching Hospitals NHS Trust psychology team, chaplaincy team and all others who gave so generously and so professionally of their time and skills in offering support and counselling to the participants in the investigation.

1 Introduction

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Introduction

This report presents the context, methods, findings and recommendations of an investigation conducted between January 2013 and April 2014 into matters relating to Jimmy Savile and Leeds Teaching Hospitals NHS Trust (and its predecessor bodies). A full description of our methodology is presented in chapter two.

This investigation covered the years of Savile's relationship with the Leeds General Infirmary from 1960 until his death in 2011. During this time, significant changes took place in society in terms of culture, behaviours and values, and legislation. Major changes in the policies, structure, organisation and delivery of healthcare also impacted on the experience of staff and patients over the years. To do justice to the breadth and diversity of the experiences covered by witnesses and victims in this investigation, we have shaped this report in a particular way.

Nature of the investigation: We describe our approach to the design and conduct of the investigation to fulfil the terms of reference (appendix one).

Setting the context: We present a brief overview of relevant cultural and policy changes between 1960 and 2011 and how they have affected attitudes and behaviours towards women and children. We also briefly consider the role of celebrity in society. A description of key structural and professional changes in the NHS over the years is also presented and consideration is given to the impact of these on hospital services in Leeds.

Findings: The next six chapters present our findings. Each one starts with a short summary of the pertinent findings for ease of reference. We begin with an overview of the relationship between Savile and the Infirmary (chapter four). We then summarise his fundraising behaviour and look in some detail at the various projects he particularly sponsored (chapter five). A detailed examination of his access and influence across the hospital in his roles as celebrity, volunteer porter and fundraiser is then presented (chapter six).

The next chapter presents the summaries of accounts from each of Savile's victims interviewed as part of this investigation. This is followed by an analysis of key themes from these descriptions of abusive encounters (chapter seven). There is no substitute for reading this chapter in its entirety to understand the scale and extent of the abuse and its impact on the victims.

Next we consider individual responses to Savile from the perspective of those victims who reported what happened, staff who observed inappropriate behaviour, and others (chapter eight). The final chapter on our findings considers the corporate responsibilities and responses to Savile's offences (chapter nine).

Policy critique: We present a review and critique of all current pertinent Trust policies.

Recommendations and conclusion: Our recommendations for the Trust, many of which will have implications for other NHS organisations, are presented in full, before some brief concluding remarks.

We begin with a brief introduction to Savile, and to the Leeds Teaching Hospitals NHS Trust.

Jimmy Savile

James Wilson Savile was born in Leeds in 1926, the youngest of seven children. During the Second World War, he was conscripted as a 'Bevin Boy' to work in the coal mines of West Yorkshire. Later he was a wrestler and then ran dance halls in Leeds and Manchester before becoming a very successful radio disc jockey on Radio Luxembourg from 1958 and then BBC Radio 1 from 1968. In 1960 he began working as a television presenter for Tyne Tees Television and in 1964 became the first host of *Top of the Pops* on the BBC. He continued to be a regular presenter of this programme until its final edition in 2006. Between 1975 and 1994 he presented *Jim'll Fix It*, a hugely popular family programme designed to make dreams come true. Savile died at home in October 2011, aged 84.

Throughout his lifetime he was an active supporter of many charities and hospitals, in particular Leeds General Infirmary, Stoke Mandeville Hospital and Broadmoor Hospital.

Savile was awarded an OBE in 1972 and a Knighthood in 1990. Witnesses to this investigation told us that he was a friend and confidant of senior politicians, royalty and many other influential people (source: witness statements N204; N111; N265; and N86). In 1990 he was awarded a Papal Knighthood by Pope John Paul II.

During his lifetime there were some unsubstantiated rumours about his sexuality and some connecting him with child abuse. Since his death, analysis of police records has indicated that five allegations of sexual assault were made to the police between 1955 and 2009 (HM Inspectorate of Constabulary, 2013).

In October 2012, ITV broadcast a documentary in which five women gave detailed accounts of abuse at the hands of Savile. Subsequently, an investigation led by the Metropolitan Police took place, known as Operation Yewtree. This suggested approximately 450 specific allegations against Savile, including when he worked at the BBC from 1965 to 2006 and in a number of NHS organisations, including the three mentioned above (Gray and Watt, 2013).

In 1960, Savile started a relationship with Leeds General Infirmary that was to last for the next 50 years. Initially, he became involved in the hospital radio service. He also volunteered and raised funds for the hospital. In 1968 he started as a volunteer porter, and continued in this role – and as a celebrity visitor and fundraiser – throughout his years of association with the Infirmary. From the 1990s, his portering work became more sporadic as he became elderly and had more health problems. His celebrity status and familiarity with many staff in the Infirmary contributed to him having unchallenged access throughout the hospital.

Because of his celebrity profile and strong identification with Leeds, his presence in the hospital was perceived positively by many: a morale booster, bringing encouragement and raising the spirits of concerned and vulnerable patients and their families. However, he was also regarded by a considerable number of staff as a disruptive nuisance, a self-publicist and 'a creep'. Overall, a majority who expressed a view to us held a more neutral or negative opinion of Savile.

Savile's eccentric style and his media profile in general, particularly from the 1960s to the 1980s, ensured that he was known, or at least recognised, by children, young people, their parents and grandparents. The paradox of the man was reflected in public responses to his attention. On the surface it was, in many cases, welcomed and seen as exciting, glamorous and flattering; but others disliked him and felt uncomfortable in his presence.

Leeds Teaching Hospitals NHS Trust

In 1998 St James's and Seacroft Hospitals and the United Teaching Hospital of Leeds (which included the Infirmary premises) merged to form one large trust, the Leeds Teaching Hospitals NHS Trust. The Trust now includes seven hospitals across the city. It is one of the largest teaching hospitals in Europe, with an annual turnover of £1 billion. Over 15,000 staff are employed and each year hundreds of medical, nursing and therapy students learn their professional skills in its wards and departments. Each year 225,000 patients are treated as in-patients, with over 1.2m seen as out-patients. Many departments are regional or supra-regional centres of clinical excellence, and many also excel in teaching, research and clinical innovation.

Over the years of Savile's association with the hospital there were a number of structural changes in terms of the scope of the organisation, the Board and governance structures, and the number of individual hospitals they had responsibility for. Chapter three presents a synopsis of these factors in describing the history, context and personalities of influence in the Infirmary from 1960 to current times.

The hospitals within Leeds Teaching Hospitals NHS Trust

Leeds General Infirmary is based in the city centre. It is a vast and complex array of old and contemporary buildings. The oldest, on Great George Street, dates back to 1868 (although the original General Infirmary was first established in 1767) and the most recent, the Jubilee Wing, was built in 1998. It was the original teaching hospital for the city (see site plan).

St James's Hospital was originally built on the site of the city workhouse in the 1840s. It is located about a mile to the east of the city centre. The Poor Law Infirmary was renamed St James's Hospital in 1925. During the 1970s, there was vast expansion as three large wings were built. For a time, this site alone was renowned as the largest teaching hospital in Europe. The Trust's headquarters is based on this site. In 2008 the new Bexley Wing was completed, housing a world-class cancer treatment centre.

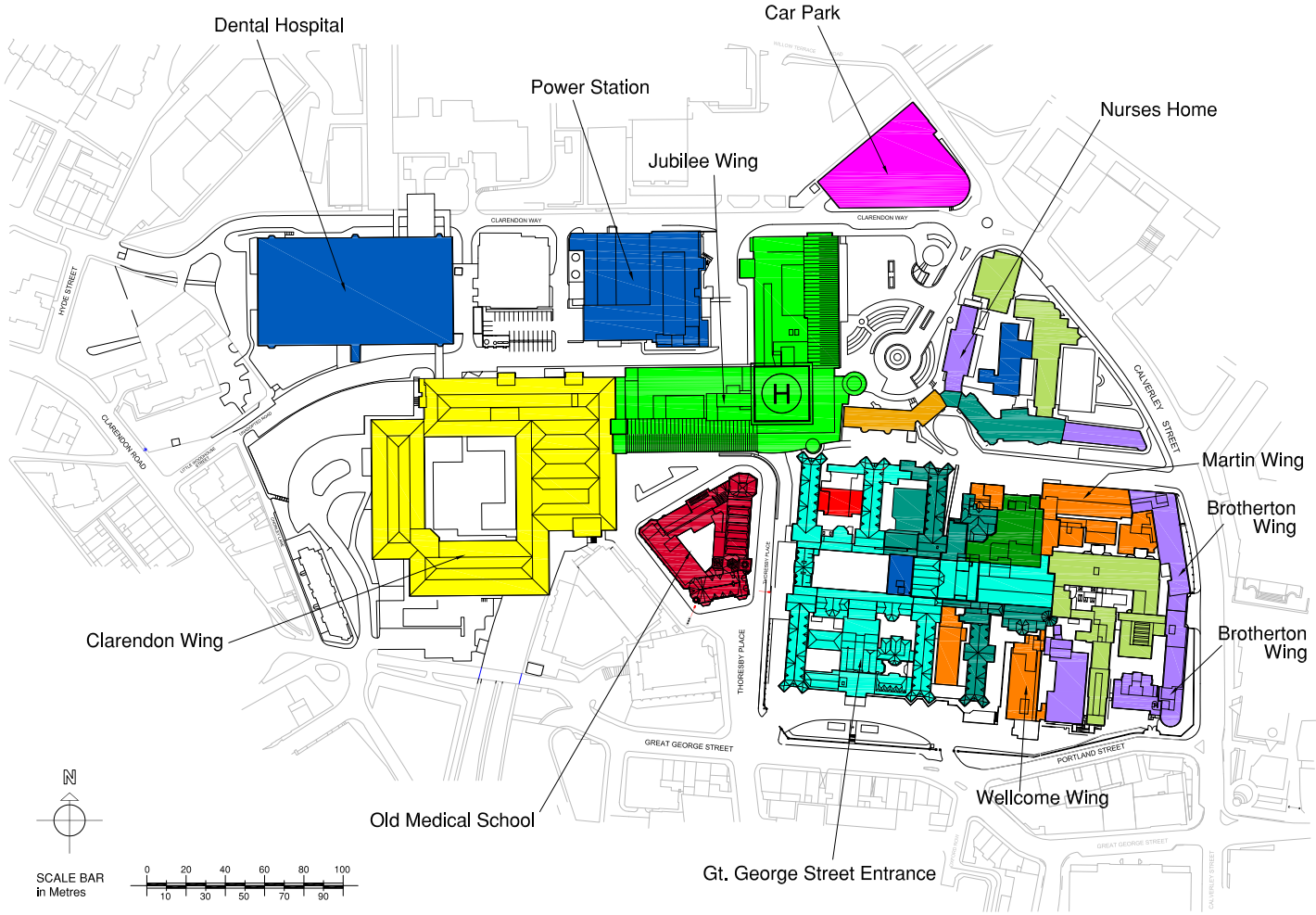
Chapel Allerton Hospital was established to care for ex-servicemen returning from the First World War. It is located about five miles to the east of the city centre, and provides mainly orthopaedic and musculoskeletal care services.

The Children's Hospital in Leeds is located near the General Infirmary and was formally opened in 2012. All acute and specialist services for children are now located on the same site. Many regional specialist services are provided there.

Leeds Dental Institute originates from early in the last century, and became part of the United Teaching Hospitals in 1948. The current building, which houses the Dental School and Hospital, is located near the General Infirmary and was opened in 1979.

Seacroft Hospital is located two miles from the city centre and was originally a hospital for patients with infectious diseases. It dates back to 1904. Currently, services such as reproductive medicine, diagnostics and out-patient services are provided on this site.

Wharfedale Hospital was originally the site of the workhouse in Otley, about 12 miles from the centre of Leeds. In 2005 a new hospital was built on the site, which provides a range of services including diagnostics, out-patient services, minor injuries and elective day case surgery.



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Notes:
Do not scale this drawing, figured dimensions to be worked to in all cases
All dimensions to be checked on site prior to work commencing on site.

Revisions:

Title:
LEEDS GENERAL INFIRMARY
AGE PROFILE

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Date: SEPT 2013 | Revision

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The Leeds Teaching Hospitals NHS Trust

ESTATES & FACILITIES
St James's Hospital, Beckett Street, Leeds, LS9 7TF
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Leeds General Infirmary - Age Profile

2 Origin and nature of the investigation

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In December 2012, the Board of Leeds Teaching Hospitals NHS Trust commissioned an independent team, led by Dr Susan Proctor, to investigate matters relating to Jimmy Savile and the Trust (and its predecessor bodies). The team was established during January 2013 and was fully in place by mid-February 2013. The investigation team was drawn from a range of backgrounds, including the police, the NHS and the civil service. Individual team members possess knowledge and expertise in working on complex and sensitive matters; in investigative procedures; and in matters relating to the safeguarding and protection of patients. Brief biographies of team members are included in appendix two.

We began with an awareness-raising campaign within the Trust, informed by our terms of reference (appendix one). Within a robust governance framework we have conducted over 200 interviews with witnesses, victims and others. We also reviewed over 1,300 documents from hospital boards and committees, numerous articles from the archives of the *Yorkshire Post* and other press, and hospital archive material and correspondence (appendices three and four – where press articles are cited, they are referred to by the corresponding number in these appendices).

The Speaking Out campaign

The awareness-raising Speaking Out campaign was launched in February 2013 to encourage victims and witnesses to come forward and contribute to the investigation.

Speaking Out campaign activities included:

- a dedicated website, with links to the Trust corporate website;
- a Facebook page;
- a letter from the Trust Chief Executive and Chair to all employees, describing the investigation;
- posters and flyers distributed across Trust premises between February and May 2013;
- flyers attached to the payslips of 15,000 Trust employees in March 2013;
- the campaign logo featuring as a screensaver across all Trust computers in February 2013; and
- a letter from the Chair to 22,000 members on the Trust database, describing the investigation.

Presentations about the investigation were given during February and March 2013 to the Trust executive team and medical management team, and also to partner organisations such as the three Clinical Commissioning Groups in Leeds and the former Strategic Health Authority. Articles on the investigation were included in Leeds University's staff newsletter, which is distributed to 6,000 people, and its medical alumni magazine, which has a circulation of 10,000.

The campaign attracted local media interest and was featured on the websites of the *Yorkshire Evening Post* and local radio stations.

Dedicated telephone lines and e-mail addresses to contact the investigation team were set up. Between February 2013 and December 2013, we received 161 telephone calls and 61 e-mails as a result of the Speaking Out campaign. There were 2,456 individual visits to the Speaking Out website over the same period.

Status of the investigation

In commissioning this investigation, the Trust Board acted within its powers to appoint an external team, none of whom is a current employee of the Trust. The Trust has provided information and documents for scrutiny. It also supported the Speaking Out campaign by promoting awareness of it, and contributions to it, in the ways described above. However, the Trust had no influence over the structure, conduct, design, delivery, outcome or recommendations of this investigation or report.

In recent years, a number of high-profile UK public inquiries have taken place, in some cases involving large numbers of witnesses giving evidence in public. This investigation was not such an inquiry, nor was it an internal serious incident investigation; it was an independent investigation and it is important to make this distinction.

The investigation has not been conducted in public and the investigation team had no power to compel witnesses to come forward to give evidence or to disclose documents. We have relied upon the goodwill of those who did come forward to participate. Through the course of the investigation we invited former and current staff, former associates of Savile and all those who came forward with accounts as victims or as witnesses to speak to us. Seven people refused or were unable to participate in the investigation on terms acceptable to all parties. Four of these were former staff who we were keen to talk to in order to gain insight into the hospital context in the 1960s and 1970s. The other three were external to the hospital. We are confident, however, that the accounts of those who did come forward, along with the corroborating documentary evidence, provide a more than sufficient basis for our subsequent analysis.

Our task has been to review and hear all relevant evidence; to consider the questions and issues raised in the terms of reference; to remain impartial and objective; to identify lessons to be learnt; and to make recommendations based upon the evidence. We are confident that our approach to this investigation enabled us to conduct a thorough and robust investigation and to fulfil our terms of reference.

The investigation

Contact with the investigation team was recorded and stored in indexed electronic and paper files. We initially identified and interviewed key witnesses from the Trust who had corporate and historical knowledge that we felt would help to define and inform the scope of the investigation.

Individuals who came forward to give personal accounts of abuse involving Savile were told that they would not be identified in the report unless they requested otherwise, and that their details would remain confidential. Subsequent discussions with these individuals during the course of the investigation have continued to give this assurance. No victims have requested to be identified in the report. All other witnesses were able to request anonymity, but they were told confidentiality could not be guaranteed. Witnesses who were current employees were

advised that if disclosures appeared to indicate criminal activity, or conduct potentially meriting disciplinary action, they would be referred to the police or the Trust for appropriate action, in line with its corporate policies.

We have made sure that the anonymity of all victims has been preserved, and that their interview transcripts remain confidential. Other participants and witnesses were informed that their anonymity would be preserved as far as possible. With the exception of current and former executive and non-executive directors, all other witnesses and interviewees have not been named in this report.

Members of the team were trained in interview techniques, and in recognising when interviewees might need further assistance and how to appropriately refer them to support services. Interviews were primarily conducted by two members of the team; interviewees were able to choose the gender of their interviewers if this was important to them.

We acknowledged that some people would be reliving difficult or stressful experiences and might need further support before and after speaking to us. We engaged with the staff side representatives in the Trust (for example, the Chair of the Staff Side Council, which includes representation from trade unions) to ensure that information sent to current staff was clear and appropriate. All witnesses and victims were offered confidential support from both the Trust's in-house psychology service and a range of independent organisations, for example Leeds Victim Support. Twenty-five people took up this offer.

Interviews were digitally recorded. The recordings were transcribed and stored both as audio files and as paper transcriptions in victims' and witnesses' individual secure files. Interviewees were each given a paper copy of their interview transcription to check for accuracy and to keep for their own records. They were also asked to sign a declaration statement to confirm the accuracy of the transcription, and to give permission for the inclusion of references to their accounts, or for quotations from their accounts to be included in this report.

We applied a number of tests to ascertain the validity of the accounts of both victims and witnesses. These relied on both qualitative and quantitative factors and included the following:

- The demeanour of the witness. Their credibility, their ability to recall details and their responses to close questioning of the specifics of their experience with due consideration to the limitations of adult survivors recalling the details of their abuse as children.
- Consistency in accounts. Allegations of abusive encounters were cross-referenced with other accounts to identify evidence of similar fact. This allowed common methods and venues to be established which, in some cases, acted as partial corroboration. None of the victims who had been patients or staff at the time of the abuse had discussed their experience with other victims. We heard that two of the victims had been at school together. Following the broadcast of the ITV *Exposure* documentary, they contacted each other as they were aware of a mutual association with Savile when they were teenagers. They discussed whether they should inform the police about their experiences with Savile. At no time did they discuss the details of what had happened to them. Most victims had not discussed the full extent of their experiences even with close family.
- Documentary evidence. In spite of some of the challenges in sourcing documents, particularly those from the 1960s and 1970s, every opportunity was taken to identify and analyse written records, and use these to corroborate the accounts we heard, including recollections and any records of hospital admissions. This included reviews of historical hospital site plans, to understand the location of encounters, clinical and personnel records, corporate papers and newspaper reports.

- Professional knowledge. The investigation team has a combined expertise of over 100 years in healthcare, in terms of extensive clinical, management, policy and research experience. It also includes a professionally accredited senior investigator with extensive experience of investigating rape and serious sexual offences. We were able to challenge accounts of current and historical practice where appropriate, and scrutinise the likelihood of some of the detailed aspects of allegations being made. Further, we considered contemporaneous practices in light of policies, opinions from those with specialist knowledge in relevant practices (appendix five), professional journal papers, and other historical documents from the relevant period to confirm or refute our assessments.
- Key witnesses. We interviewed a number of people to ascertain contextual features of life in the Infirmary from the 1960s onwards. This was a helpful source of corroboration of descriptions of processes and systems as viewed by patients or staff in the recollections covering a time period from 1960 to 2011.
- Comparison with accounts given to police and legal advisors. Where such accounts had been previously given to police or to individuals' legal advisors, we ensured that thorough comparative review was undertaken to assess consistency (taking into account that a victim's confidence to disclose full details of an incident might increase over time).
- Media records. Local and national media archives were accessed to inform the investigation and to corroborate accounts, especially in terms of locating Savile in Leeds on particular dates.

Factual information given during interviews – for example, dates of admission to hospital, dates of employment at the hospital or details of publicity events – were verified against archived hospital records wherever possible. However, owing to the duration of Savile's relationship with the Infirmary, for many of the early cases (ie in the 1960s, 1970s and 1980s) historical hospital documents such as employment records were unavailable. According to the NHS code of practice on records management (Department of Health, 2006), personnel records should be retained for a minimum of six years after an individual leaves employment, with a summary record retained up to their 70th birthday. Patient hospital records should be retained for eight years after the patient was last in hospital (other than in paediatrics). After this time period, records may be archived or destroyed. As we were looking at cases for patients from 1962 to 1999, sourcing some records was not possible.

For some of these early cases, it was sometimes difficult for witnesses and victims to be confident about factual details such as the ward they attended as a patient, or specific dates for certain events. Many of those who had been victims as patients or children had very strong memories of their encounter with Savile, although the details of the context, such as staff and ward names, for example, were not available or volunteered. Applying the above-mentioned tests in such cases was helpful in providing corroboration between police statements, legal statements and the interviews, and in the consistency of accounts from different witnesses of both Savile's methods and the contextual factors concerning the organisation and running of the hospital during the different decades examined.

Every interview transcript was reviewed by the Director of Investigation and the Lead Investigator to identify further investigative actions, such as related lines of enquiry and corroborative opportunities. The further lines of enquiry informed activity including additional interviews, document research and the recovery of relevant personnel and medical records. This aimed to strengthen the evidence already gathered and to progress the investigation.

The multi-disciplinary investigation team met each week to review and discuss progress with the investigation, and as part of this, we undertook our own regular internal quality assurance process.

Between February 2013 and January 2014, some 200 people were interviewed. They gave evidence as victims, and others were current or former employees or associates (for example, visitors) of the Infirmary or of Savile.

Policy critique

In accordance with the terms of reference, we reviewed the Trust's relevant current policies and practices. Policies pertinent to the issues raised by Savile's activities at the Infirmary had been identified by the Trust's Internal Audit team in October and November 2012. We used this as our starting point, identifying further policies for consideration in response to intelligence that was emerging through witness interviews.

The policies were considered against the following criteria, and where possible were compared with those of other similar NHS organisations:

- the consultation process when a policy is being developed or reviewed;
- benchmarking against best practice;
- communication and dissemination;
- board assurance that policies are fit for purpose and adhered to; and
- the monitoring of compliance.

This process is described in more detail in chapter ten.

Sourcing and analysis of documents

Detailed examination of historical records ran in parallel to the interviews. This included examination of:

- board, committee and sub-committee papers for Leeds Teaching Hospitals NHS Trust and its predecessor bodies (1960 to 2012);
- patient records and hospital admission registers, which were searched to confirm dates of hospital admissions;
- complaints records held by the Trust;
- hospital policies pertinent to issues being investigated (1960 to 2011);
- policy guidance and circulars from the Department of Health and Social Security (to 1988) and then the Department of Health (1988 to 2013);
- press cuttings (1960 to 2011); and
- records of fundraising by the Trust and its associated charities.

Historical records were interrogated for mention of Jimmy Savile in any context, and to establish hospital practice and policy throughout the period of his association with the Trust. After a thorough manual search through archived files, the documents were catalogued and checked by two members of the team before being processed using a digital document management system. This helped us to review them systematically against several search terms, and enabled easy retrieval of documents in light of any new information emerging from interviews. It also provided a single electronic archive of documents considered during the investigation.
A summary of documents examined is presented in appendix three.

Governance and scrutiny

A local oversight panel chaired by a Trust Non-Executive Director was set up at the start of the process to review progress, monitor associated and emerging risks, and provide assurance to the Trust Board on the scope, pace, proportionality and comprehensiveness of the investigation. The panel met monthly and 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 Lead for Safeguarding. In addition to its assurance and oversight role, the panel's external members provided expert advice to the investigation team. Terms of reference for the local oversight panel are included in appendix six.

National oversight was provided by Kate Lampard and her team. The sampling team established by them met with us every four to six weeks throughout the course of the investigation to monitor progress and to gain assurance of the quality of our approach through sampling aspects of the design, method and data. A similar process was in place for the investigations at Broadmoor and Stoke Mandeville hospitals.

Risks

Throughout the course of the investigation, we identified two types of risk – risks to the investigation and risks for the Trust.

Risks to the investigation were identified as, for example, the limited availability of historical records, and mitigating actions were discussed and agreed. Responsibility for individual risks was assigned to members of the investigation team, and the risks were discussed at weekly investigation meetings.

Risks for the Trust, such as its compliance with best practice employment checks, were discussed at the local oversight panel meetings and escalated through its Chair to the Trust Board.

Connections with other Savile investigations

The investigation team had regular contact and dialogue with the investigation teams at Stoke Mandeville and Broadmoor hospitals. Initially this focused on discussion of methodology, areas of collaboration to support the investigation (such as the commissioning of appropriate software to enable document analysis) and approaches to the provision of support for victims. As the investigations proceeded, information disclosed by witnesses and document analysis that was of potential interest or relevance to the other investigations was shared. This also included the joint interviewing of a small number of witnesses who had connections with one or more of the three Trusts.

Through regular meetings with Kate Lampard's sampling team, we were also able to inform them of areas of insight or developments that might be of interest to the other investigations and, in turn, were advised of learning from the other investigations that was of interest or relevance to Leeds.

We were made aware of other individuals who had been victims of Savile in other hospitals in West Yorkshire, either by them contacting us directly or via reports to the police. In each case we advised the organisations concerned, and provided guidance and support in helping them with their own investigations. We also participated in each of the subsequent interviews. The accounts from these victims are included in chapter seven.

We liaised with senior management at ChildLine to identify if any allegations had been made to them relating to Savile and Leeds hospitals since their establishment in 1986. No such allegations were recorded.

In October 2013, Operation Yewtree disclosed that they had received information suggesting Savile had abused people in a further 19 NHS organisations. The Department of Health advised these organisations to conduct investigations into these matters. We were asked by the Department of Health to investigate nine individual cases where people had initially contacted the Metropolitan Police but where no specific NHS or healthcare organisation had been named. We conducted a parallel investigation into those cases and the report of that investigation was provided separately to Kate Lampard (see appendix ten).

During the course of our investigation, we were informed by the BBC review team about potential witnesses who had a connection with Savile through working with him in Leeds. These contacts were subsequently followed up and witnesses interviewed. Late in 2013, we participated in a joint meeting with the team leading the BBC review. The purpose of this was for them to share emerging themes and for a joint high-level discussion about similarities or indeed differences in the matters emerging from our respective investigations.

Relationship with the police

From the outset of the investigation there has been close liaison with both the Metropolitan Police Service and West Yorkshire Police. In February 2013 a meeting took place between the Senior Investigating Officer for Operation Yewtree at New Scotland Yard, the Lead Investigator and the Director of Investigation. That meeting formed the basis for information-sharing between the Metropolitan Police Service and the Leeds Team.

Whilst the relationship has been positive, we have on occasion had concerns that all relevant information known to the Metropolitan Police Service may not have been assessed effectively and disseminated to us as promptly and/or as comprehensively as we might have wished. This concern was subsequently borne out in November 2013, when a significant amount of further information relating to both victims and witnesses was released to the investigation by the Metropolitan Police Service.

Whilst a substantial proportion of this information had been provided to the police by members of the public some 12 months previously, we do not consider that the delay compromised our investigation of the allegations in any way. However, the belated disclosure did result in a deferral of the completion of this report and, we understand, that of the two other principal NHS investigation reports, by several months.

On a more local level, consistent liaison has been maintained with West Yorkshire Police to ensure that all relevant information relating to victims was both identified and then shared effectively. Regular meetings have been held with the local Senior Investigating Officer and officers responsible for criminal investigations and liaison with victims and witnesses. This has resulted in a pooling of expertise and relevant knowledge about NHS systems and structures that has been of mutual benefit to both West Yorkshire Police and this investigation.

Limitations of the investigation

This investigation has been challenging in terms of its scale and complexity, covering numerous cases over 50 years, and relying on documentation and recollections about matters from a long time ago. Whilst the team has worked to ensure that standards of the investigation have been as robust as possible, we acknowledge that, owing to factors beyond our control, this has been challenging in respect of the following:

- Availability of documents going back over decades. Hospital patient records are only required to be retained for eight years after the previous hospital admission; staff records are retained until the employee's 70th birthday, or for six years after they leave the organisation if they work beyond the age of 70 (Department of Health, 2006). Generally, NHS financial data is only required to be retained for eight years (NHS Business Services Authority, 2011).
- Cultural and behavioural differences in governance, reporting and recording. Records have been sourced from 1960 to the present day, but the earlier records are far less detailed than current documentation in terms of content, data and analysis.
- Retention of records. The Trust does not have a master list to facilitate the access of older personnel records, so this process was conducted manually. Where these records could not be traced, we confirmed employment dates through the NHS Pensions Authority.
- Technology and manual recording of documents originating before computerisation. Documents were searched manually and scanned into a document management software package. Most of the documents prior to 1990 were manually typed or handwritten and their presentation was of variable quality when scanned into the software package.
- Finally, the investigation was not a criminal investigation and could not compel witnesses to come forward; persuasion and tenacity were needed. However, the fact that the investigation was not held in public may have encouraged a number of witnesses to come forward voluntarily.

Specific issues for consideration in this investigation

Hindsight

The initial disclosures about Savile's abusive behaviour were made in the ITV *Exposure* documentary broadcast in October 2012. The wider response to the allegations was shock and in some cases disbelief. Gradually, as public knowledge of Savile has increased, and the consistencies in victims' accounts have been disclosed, there has been a much wider acknowledgement of the scale of his abusive behaviour.

In trying to absorb the extent of Savile's abuse of victims in Leeds, many witnesses have commented that, if only they had known then what is known now, they would have acted to stop him.

We can now recognise much more clearly what should have happened in response to the small number of disclosures about Savile's behaviour in order to have put a stop to it, and for him to have faced the proper judicial processes. We have considered the oral and written evidence presented to us by trying to understand what was known at the time about Savile, rather than through the potentially distorting lens of what we know now.

The legislative guidance, internal controls, rigour around reporting and governance that we take for granted today did not exist to the same degree in the 1960s, 1970s or 1980s. Indeed, some routine processes such as employment checks for criminal history were not introduced until 2002. It is unfair and inappropriate to expect the checks and safeguards evident today to have been in place all those years ago. These cultural and contextual factors are examined in chapters three, four and six.

Accountability and blame

In the wake of recent health scandals, such as that involving Mid Staffordshire Hospital, there has often been a quest to identify someone to blame. People holding positions of authority have found themselves being held to account in public. It is a normal and understandable reaction to troubling circumstances, especially when the main perpetrator cannot be brought to justice, but it is not always an appropriate one.

Savile operated mostly alone, although some of those we interviewed indicated that he was on occasion assisted in his conduct by a small number of individuals, some of whom were thought to be employees. He appears to have been most active in his abuse of patients and staff during the 1960s and 1970s. In considering who was responsible for the corporate systems in place at the Infirmary when Savile abused patients, it is important to remember that current senior managers and clinicians should not be held to account for failings and weaknesses that predate them.

Implications for other NHS organisations

Although Savile had a close and enduring relationship with the Infirmary in Leeds, it has since emerged that a number of other NHS organisations are investigating whether or not he abused patients or others on their premises.

This was an investigation commissioned by Leeds Teaching Hospitals NHS Trust Board. We believe, however, that there are many relevant points in our findings and recommendations for any healthcare provider, especially those running organisations with multi-site provision and complex structures of devolved decision-making (see the recommendations in chapter eleven).

Leaders in every NHS Trust should read this report and in particular the accounts from the victims, using these to stimulate discussion and to consider the implications for their own organisations. We further recommend that they consider if such events could happen in their organisation, and what controls they have in place to assure themselves that patients, visitors and staff in their organisation are safeguarded from harm.

3 Contextual narrative

3 Contextual narrative

Introduction

Jimmy Savile's relationship with Leeds General Infirmary lasted over 50 years, from 1960 to 2011. He was active as a volunteer porter from the early 1960s until 2002, during which time the cultural norms and behaviours in wider society changed almost unrecognisably. Significant changes also took place in the NHS which affected the organisation and delivery of services. These are considered in part two of this chapter. The first part presents a brief but important overview of some of the pertinent societal changes.

Because of the extent of the social and cultural changes over the last 50 years, we believe it is important that the contextual circumstances are considered, as they may have had a major influence not only on Savile's behaviour, but also on the responses to it from victims, witnesses and others. Many of the victims' accounts presented later in the report demonstrate clearly that his behaviour was unacceptable in any context, and in a significant number of cases was criminal, then as now. However, the intervening years have seen many differences in how people behave, in what is seen to be appropriate, and in general attitudes towards women, children and celebrities.

We have principally relied on sources of information derived from a discussion event led by a range of social historians on behalf of the three NHS investigations (held at King's College London in May 2013); literature searches on the key themes of societal attitudes to women and children and matters relating to celebrity (assisted by the library of Leeds University); and reviews of key policy and legal documents in relation to issues of gender equality and child protection or safeguarding. This is not intended to be comprehensive by any means, but rather to give an indication of the extent of the changes that have taken place concerning these matters in the UK over the last 50 years.

Part one: Society

Attitudes towards women

With reference to the 1960s in the UK, many popular cultural commentaries describe the 'swinging sixties', with tales of decadence and glamour in London. However, the reality for most of the population in the urban north was very different. Generally, many people remained extremely socially conservative, were concerned about what the neighbours might think, and believed in knowing their place in the social hierarchy. By the end of the 1960s, numerous legislative changes in respect of obscenity laws, homosexuality, abortion and divorce had taken place (Thane, 2010). Despite this, the notion of the 'permissive society' reducing the predominance of traditional moral codes of behaviour took a good few years to work through all levels of society.

In spite of the various legislative changes during the late 1960s, relations between the sexes remained far from equal. There were certainly greater opportunities for women, but alongside these – with the introduction of the contraceptive pill and a wider accessibility to more liberal

information about sexual matters – there were risks. There was great pressure for young women to conform to these new sexually liberated expectations in order to be considered fashionable, popular and attractive (Dixon, 2011).

In terms of employment, most women who worked expected to give up their career when they married, and certainly when they had their first child (Thane, 2010). Legislative changes had an impact on the relations between the sexes, and on expectations of greater equality. In 1975 the Sex Discrimination Act guaranteed equal pay for certain groups of women. This was updated in the 1986 Sex Discrimination Act, which also established sexual harassment as a form of discrimination (Thane, 2010). In 2002, the European Union Council and Parliament amended a former Council Directive to prohibit sexual harassment in the workplace.

Sexual harassment can be defined as unwanted conduct of a sexual nature, or on the grounds of a person's gender. It includes a range of behaviours from lewd remarks to sexual assault, and can occur in a variety of circumstances (Charney and Russell, 1994). Such conduct has the effect of violating a person's dignity, or of creating a hostile, offensive, degrading or humiliating environment for them. There are also gender differences in perceptions of sexual harassment, with women perceiving a wider range of behaviours as harassing (McCabe and Hardman, 2005).

From the 1960s to the 1980s girls and women were often socialised if not to expect, then certainly to tolerate, unwanted sexual advances, especially in the workplace. Inappropriate or unwelcome comments, especially towards younger women, were commonplace. Often, even today, despite a different threshold of acceptability, victims of sexual harassment at work do not speak out owing to fears about adverse consequences for them: not being believed, humiliation, public scrutiny and potential damage to career prospects (Wolf, 2004). Victims who do speak out can be seen as attention-seeking, or trouble-makers, and can become 'the accused', with intensive scrutiny of their private life as a consequence of raising the alarm (Dittman, 2003). And so, even today, many victims remain silent.

Greater sexual freedoms during the 1970s meant that contraceptive advice was more widely available. Access to pornography increased considerably, with the introduction of new magazines and the relaxation of censorship rules in mainstream cinema with regard to nudity and sexual behaviour (Dixon, 2011). These new-found freedoms are thought to have had a significant effect on how men viewed young women. There was an increased tendency to expect unmarried and young women and girls to be sexually available and even promiscuous, and the images in all these easily accessible forms of media reinforced the idea that women welcomed any male attention (Dixon, 2011).

One matter which had a major impact on how the media portrayed women, and on how women viewed themselves and their own safety, was the reaction to the murders perpetrated by Peter Sutcliffe, the 'Yorkshire Ripper'. From 1975 to 1980, Leeds and other northern cities were the focus of a number of serious and violent sexual assaults and 13 gruesome murders of local women (Burn, 1984). During these years women were often afraid to venture out alone, particularly after dark. Security measures were increased in organisations where large numbers of women were employed, including hospitals. Witnesses in this investigation spoke of how these events created tension and anxiety for those young women in the city working in the hospital at this time. After the largest ever enquiry led by West Yorkshire Police, Sutcliffe was eventually convicted and sentenced in 1981.

Attitudes towards children

In the 1960s and 1970s, the protection of children from abuse was not a matter with anything like the levels of legislative control that exist today. Legislation in the 1960s focused largely on the responsibilities of local authorities towards children 'in care', in enabling them to take over parental rights for such children, and in enabling children convicted of criminal acts to be subject to care orders. Children were largely still expected to be seen and not heard, and were often not taken seriously if they reported accounts of what we would describe today as inappropriate behaviour or abuse from an adult.

During the 1970s and 1980s, a number of significant developments began to alter social attitudes and government policies concerning the protection of children and young people. In 1974, following the death of Maria Colwell at the hands of her stepfather, the serious lack of co-ordination between children's welfare services was exposed. The creation of Area Child Protection Committees was intended to strengthen the co-ordination of services and the safeguarding of children at risk of harm (Gray and Watt, 2013).

In 1986, a national survey was launched by the BBC's *That's Life* (consumer interest) TV programme on the topic of child abuse. Following transmission, a 24-hour helpline was set up, which was swamped by calls mainly from children, but also from adult survivors of abuse. Callers disclosed experiences of cruelty and abuse (Harrison, 2000). Over 3,000 adults completed the survey, and many recounted (often for the first time) experiences of sexual abuse in their childhood. Victims said that they felt they had no one to turn to, and would not have been believed even if they had told someone.

The scale of this unprecedented response led to urgent dialogue with some of the major organisations representing children in the country and, following this, the launch of a new charity for children, ChildLine. ChildLine provided a dedicated 24-hour phone service for children, and on its first night took over 55,000 calls (Harrison, 2000).

In 1987, two paediatricians in Middlesbrough diagnosed over 120 cases of child sexual abuse in 57 families from the area. This controversial case, known as the Cleveland sexual abuse scandal, was the subject not only of a media storm but also of major and extensive legal and professional inquiry. The majority of the 'Cleveland' children were returned to their families with all proceedings dismissed. Nevertheless, the case led to a major reappraisal of the need for greater understanding of child sexual abuse among professionals in child health, social care and education.

In a review of the legacy of Cleveland 20 years on, Valios (2007) asserts that 'for paediatricians, Cleveland was a defining moment in realising that the unthinkable did happen to children'. One of its legacies was the emergence of research into and greater understanding of the factors associated with child sexual abuse, its diagnosis and treatment (Valios, 2007).

Prior to this scandal, the topic of child abuse was rarely discussed in the media. It was very much a taboo subject, and if it was discussed in a public forum, debates generally considered only neglect and physical cruelty. Little if anything was spoken publicly or through the media about the sexual abuse of children. Cleveland and ChildLine had a significant impact on this.

Further legislation was not passed until 1989 with the Children Act. This stated that children had the right to be protected from abuse, and sought to clarify much of the earlier legislation around the safeguarding of children. Further, it introduced the 'paramountcy principle' – the principle that the needs of the child should always come first in decisions about their welfare.

During the last two decades, child protection legislation and safeguarding systems have been strengthened considerably. They remain far from foolproof, however, as the recent (but thankfully rare) high-profile individual cases of abuse testify (Laming, 2003; 2009; Fraser, 2013). Today public debate about child sexual abuse is much more commonplace, following scandals in numerous significant organisations.

In 1997, the first child sex offenders' register was established. In 1999, the Protection of Children Act aimed to prevent sex offenders from working with children. It required childcare organisations to inform the Secretary of State for Health about anyone known to them who was unsuitable to work with children. The press have been instrumental in leading national campaigns to raise awareness, again triggered by individual cases such as the Sarah Payne and Soham murders in 2000 and 2002 respectively.

In 2002, it was made mandatory for all employing organisations to conduct Criminal Records Bureau (CRB) checks on all employees working with children and other vulnerable groups. This aimed to give assurance to employers about any criminal history of employees, and in particular to help identify those unsuited because of their past criminal activity to working with the most vulnerable, including children.

In 2012, the CRB merged with the Independent Safeguarding Authority to form a single body, the Disclosure and Barring Service (DBS). Employers must not knowingly employ someone who is barred by the DBS from carrying out certain activities which involve contact with children or vulnerable adults. Not all NHS staff or volunteers will need a DBS check. The requirement is dictated by the activities the individual undertakes and their access to patients when undertaking their particular role. The three different levels of DBS checks are:

- enhanced DBS checks for individuals who may have unsupervised access to patients;
- standard checks for individuals who may come into contact with patients but would be supervised when doing so; and
- basic checks, which may be appropriate for individuals who are in positions where they have access to public finances.

If a DBS check is carried out, the employer expects that those people unsuited to working with vulnerable groups will be identified at the earliest opportunity. Employers are also required to make a referral to the DBS if an employee or volunteer has harmed or poses a risk of harm to vulnerable groups and/or has been removed or dismissed (or has resigned) from their post.

In 2003, as a result of the inquiry by Lord Laming following the death of Victoria Climbié, the government Green Paper *Every Child Matters* was published (HM Government, 2004). This proposed significant changes to the safeguarding systems for children in England. Also in 2003, the Sexual Offences Act updated the legislation on offences against children, including grooming, trafficking and abuse of positions of trust.

In the same year, the *National Service Framework for Children – Standard for hospital services* was published (Department of Health, 2003). For the first time, standards were set for hospitals with regard to the design and delivery of services for children, the safety and protection of children in hospital, the quality of care and the suitability of hospital settings. Hospitals were required to place all children (aged under 16) who were in-patients on children's or adolescent wards, and not with adult patients.

In 2004, the Children Act created a new post of Children's Commissioner in England, and established new Local Safeguarding Boards and a duty of care for many agencies in safeguarding children. In 2006, the Child Exploitation and Online Protection Centre was formed

to tackle online child abuse across the UK. Following the death of baby Peter Connelly in Haringey, London, a further review of child protection services was published in 2009. Services were reviewed again in 2010.

Research into the abuse of children

Research into the signs or indications that an individual is abusing children within an organisational setting is limited. Whilst Erooga et al (2012) make it clear that there is no single characteristic that makes an abuser easily identifiable within an organisation, research on abusers in school settings indicates that they tend to be highly competent and popular with colleagues, supervisors and parents (Bithell, 1991; Shakeshaft and Cohen, 1995). Clearly, individuals may display these characteristics and not be abusers. Abusers in these settings will target vulnerable and marginalised children, who feel grateful for the attention and who are often likely to be disbelieved if they report the abuse (Shakeshaft, 2003).

Robins (1998) describes a grooming process from the perspective of the abuser, which involves selecting a victim, giving them attention and rewards, being supportive and understanding, and gradually increasing the amount of touch or other sexual behaviour. The purpose of this process is to familiarise the child with progressive sexual contact, to provide non-sexual experiences that they value and will not want to lose, to gain approval from parents and colleagues, and to learn information about the child that they can use to discredit them if they try to report the abuse.

Research into the responses of child victims of sexual abuse suggests that it takes an average of seven years to disclose information about abuse, and the younger it starts, the longer it takes for the child to disclose what has happened (Allnock and Miller, 2013). Disclosing information about sexual abuse as a child is difficult, and in their study Allnock and Miller found that 90% of young people who had experienced sexual abuse had negative experiences of disclosing their abuse, where people they told responded poorly. Reasons for not disclosing included having no one to turn to, not understanding that they were being abused, being ashamed or embarrassed, and being afraid of speaking out and not being believed (Allnock and Miller, 2013).

Attitudes towards celebrity

The constant presence of celebrities in our lives is evident through magazines, TV, cinema, the internet and social media. Public demand for information about the lives and habits of the rich and famous seems insatiable. This fascination has continued and grown over the last 50 years, and new forms of media mean that accessibility to celebrities has increased further than could have been imagined even 20 years ago.

At the height of Jimmy Savile's fame and popularity in the 1970s, the profile and longevity of celebrities on television was very different from today. With only three TV channels, and no internet or social media, there was less choice and a greater collective engagement with fewer TV programmes. Because of his TV and radio profile, and the huge and enduring popularity of programmes like *Top of the Pops* and *Jim'll Fix It*, Savile had a far longer career as a famous person than many of today's fleetingly famous celebrities.

Teenagers and celebrities

From the 1960s onwards, teenagers were gradually establishing a new identity. For the first time, young people did not want to be like their parents in terms of the clothes they wore, the vocabulary they used or the aspirations they held. New fashions and new information through the media of television and popular radio offered glimpses of glamour and exotic lifestyles most

had hitherto only dreamt of. Television in particular offered a revelation of new possibilities and aspirations for millions, and the presenters of TV programmes enjoyed a national level of fame and recognition.

For younger viewers, perhaps for teenage girls more than any other group, Savile's appeal was further enhanced by his proximity to famous singers and pop groups. Indeed, Savile himself responded to allegations about him liking young girls by deflection, saying that they only paid him any attention in order to get access to their 'pop heroes' (Bellamy, 2012).

During the 1960s and 1970s, the sexualisation of popular culture became more evident. For the first time, screaming teenage girls were overcome with the emotional intensity of their desire to see and have contact with their idols. As demonstrated by 'Beatlemania', this was just the first example of such public displays of intense feelings for celebrities (and the attendant vulnerability of young girls), and still persists today with the teenage adulation of the pop group One Direction.

Celebrities on TV

The characteristics of celebrities on TV (as opposed to those with careers in film, sport or music) are said to be distinct (Marshall, 1997). Domestic TV ownership increased dramatically during the 1960s, and in many cases replaced the dominance of radio as a means of mass communication and entertainment. Most households that had access to a TV had only one TV set. This was therefore a focus of family-centred attention, and programmes were generally aimed at a mass audience.

The milieu of TV created a particular type of celebrity or 'TV personality', unique in their familiarity, their presence in the home, their recognition by different generations and the intimacy they created (Marshall, 1997). In particular, hosts of TV shows developed a persona aimed at acting as a conduit between the guests of the show, the studio audience and the audience at home. They looked and spoke directly at the camera, and became associated with the particular event or purpose of the show (Marshall, 1997).

All these features conspired to create an aura of trust for the viewers – whether this was in guiding them through the latest pop acts on *Top of the Pops*, or in making the dreams of children come true in *Jim'll Fix it*. The TV audience knew Jimmy Savile, welcomed him into their homes, and trusted him to entertain them. His eccentricity, appearance and style reinforced his uniqueness and identity. There was no one else like him.

Celebrities and fans

Opportunities for meetings between ordinary young people in Leeds in the 1960s and 1970s and their celebrity heroes were rare. Seeing a famous person in ordinary surroundings was unusual and was perceived by some as exciting.

Research suggests that celebrities seen in the context of the everyday lives of fans can sometimes create confusion between perceptions of intimacy and the fact that they are strangers (Schickel, 1985; Ferris and Harris, 2011). The experience of seeing someone so familiar, famous or glamorous in a setting such as a restaurant, shop or hospital makes the ordinary extraordinary. Ferris and Harris (2011) found that in the context of fans' unexpected encounters with celebrities, deference or even reverence to the special status of celebrity was a constant behaviour.

Generally, encounters between celebrities and their fans are managed through promotional events, premieres, after-show receptions and organised meetings. Many celebrities do not seek spontaneous encounters with fans and, whilst being courteous to those who approach them, prefer to be left to pursue their particular activity without being disturbed. We heard from some

witnesses how Savile, however, craved attention. He understood the power of his celebrity profile and used it in a variety of ways. He knew that if he was photographed running a marathon for charity, or launching a particular fundraising campaign, publicity would follow. Generally such publicity was uncritical, respectful and superficial, and this type of publicity followed him throughout his career (appendix four).

Part two: The NHS

NHS: Policy and structures 1960 to 2000

This section offers a brief overview of the major structural and policy changes in the NHS over the 50-year period covered by this investigation, and their subsequent effects on the hospitals in Leeds. We will briefly consider:

- the major structural reorganisations between 1960 and 2006;
- changes to professional nursing roles; and
- changes in patient experience and behaviours.

These matters are considered specifically, as they had an impact on the organisation and delivery of services in Leeds General Infirmary, and on the behaviours of staff and patients in response to the access and influence of Savile and to his abusive behaviour.

The NHS from 1948 to 1974

The structure that emerged from the creation of the NHS in 1948 came about through a process of bargaining and compromise. It was also shaped by the historical legacy of voluntary and charitable institutions and the central dominance of the medical profession (Ham, 1992). Individual hospitals were run by a Board of Governors and overseen by a hospital management committee that ran groups of hospitals. These reported to regional hospital boards, which in turn reported to the Ministry of Health. Within the hospital, the senior team generally comprised a hospital secretary, a medical administrator and a matron. They had day-to-day responsibility and reported to the group secretary of the hospital management committee. Teaching hospitals had negotiated special arrangements and reported directly to the Minister of Health.

One of the proposed solutions to the various challenges facing the NHS in the 1960s and early 1970s was a reorganisation of its structure. It was suggested that health services at a local level should be unified and placed under the control of area boards. The resulting new structure came into operation in 1974. Ninety area health authorities became the main administrative units, with around 200 district committees underneath them. A separate mechanism for local citizen participation was established with the creation of community health councils. The aims of the reorganisation were to unify health services; to improve co-ordination of health and local authority services; and to introduce better management (Klein, 1989; Ham, 1992).

Leeds General Infirmary before 1974

Before the 1974 reorganisation, the Infirmary in Leeds (as a teaching hospital) was administered by a Board of Governors (with 27 members) under the chairmanship of Sir George Martin (1948 to 1961) and Sir Donald Kaberry (1961 to 1974). Their role was to oversee the running of a group of hospitals that included the Infirmary, the Hospital for Women (closed in 1984), the Maternity Hospital (closed in 1984), the Dental Hospital and the Ida and Robert Arthington Hospital (closed in 2008).

At the inception of the NHS in 1948, the teaching hospitals had retained a major say in the running of their own affairs and were in many areas free from outside interference. In particular, they had the freedom to appoint their own consultant medical staff and also to administer and make decisions regarding the use of often substantial trust funds. These freedoms were not afforded to non-teaching hospitals.

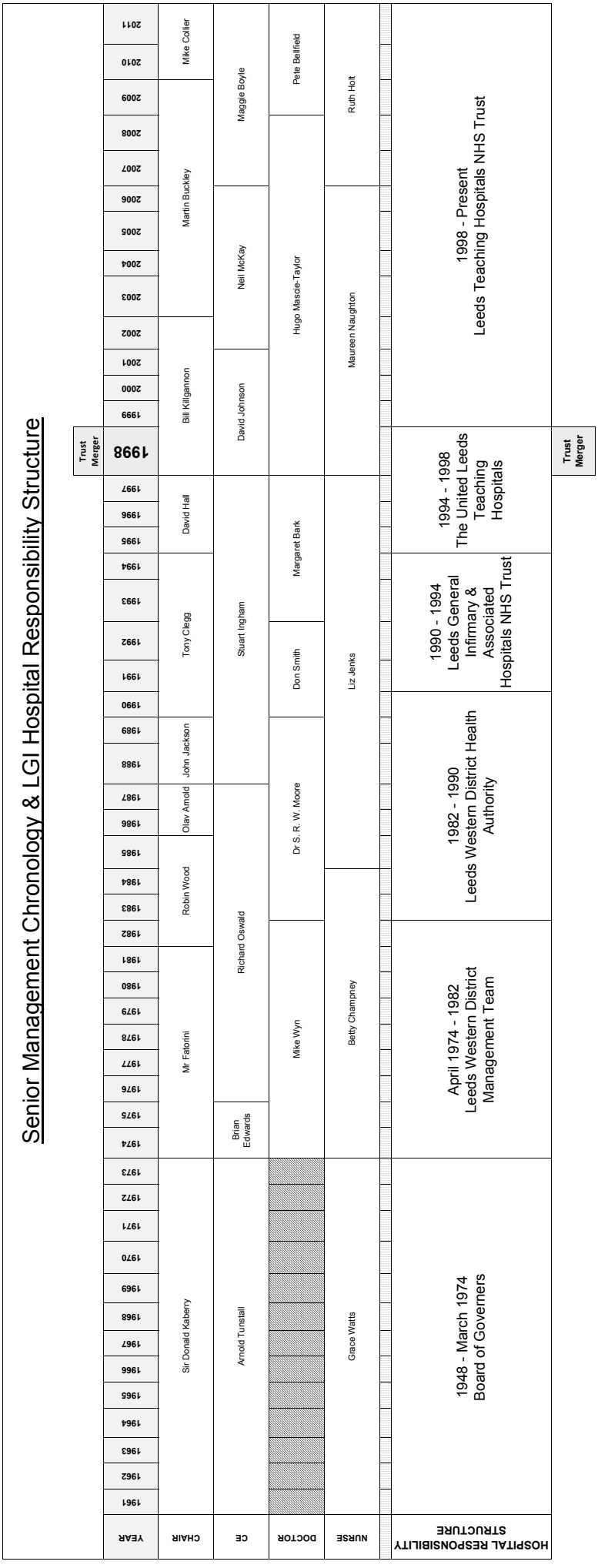
Before 1974, the highest level of 'management' below the Board was the role of secretary and chief administrative officer, which was occupied by Arnold Tunstall from 1957 to 1974. In Leeds, this position was known as house governor of the Infirmary. The position was supported by a number of assistant secretaries/deputy house governors and other administrative roles. The most senior nursing role at this time was that of matron (occupied by Grace Watts from 1958 to 1974), who was again supported by a deputy and a number of assistant matrons.

Leeds General Infirmary after 1974

After the 1974 reorganisation, which saw the implementation of a Leeds area health authority and, at a level below this, two district management committees (Leeds East and Leeds West), Arnold Tunstall (along with Grace Watts) left the hospital to lead the area health authority (source: witness statement N81; Brian Edwards, District Administrator, 1974 to 1976).

The new district management committees had oversight of the running of the hospitals on either side of the city. In the west this included the Infirmary, as well as a number of other hospitals. The new District Administrator was Brian Edwards. This role was part of a team which included other disciplines (medicine, nursing, finance, etc) and which governed via a system of 'consensus management' (DHSS, 1972). In 1976 he left the district and was replaced by Richard Oswald, who remained until 1988 (known as District Administrator until 1984 and District General Manager thereafter). Stuart Ingham became the last District General Manager of the Leeds West district in 1988. He became Chief Executive of the Infirmary when it became an NHS Trust in 1991, a role he occupied until the merger with the hospitals in the east of the city took place in 1998. The Trust merger is discussed later in this chapter.

Figure 3.1 provides a chronology of the various management structures in the hospital from 1960 to the present day, and the key personnel at the time.



Pressures and tensions in the 1970s

During the 1970s, industrial unrest by various groups of staff in the NHS and other sectors was considerable. Financial pressures were also a constant concern. Industrial relations deteriorated in Leeds during the 1970s and 1980s, with a number of strikes by hospital ancillary workers (including porters) during these years.

Managing services and keeping the hospital functioning became the major priority for the Board of Governors. In March 1973, the Infirmary was selected by national unions as one of the major hospital sites for planned strike action by ancillary workers. As tensions escalated, the ability of the Infirmary to treat patients became fragile.

> "In three days' time, the Infirmary could grind to a halt because of lack of fuel for heating, hot water and sterilisation."
>
> "As you know it has been necessary to stop the admission of waiting list cases to the general wards and the Brotherton Wing for the time being."
>
> Source: excerpts from letters from House Governor to Chairman, March 1973

> "The Secretary to the Board reported the admission of waiting list cases had been stopped with effect from Feb 26, and whilst Out Patients Clinic had been held it had been possible only to deal with patients who required no trolley or chair transport. So far as voluntary workers were concerned the Unions had agreed that only those who normally came to the hospital for regular duties were to be allowed through the picket lines… By good team work it had proved possible to deal with essential services without undue disruption."
>
> Source: minutes of Board of Governors' meeting, April 1973

Industrial unrest continued into the early 1980s, and the hospital had plans to deploy its workforce on a voluntary basis, asking them to increase their hours and take on other roles to keep services running (source: Leeds Western Health Authority, Board minutes, 15 June 1982).

Brian Edwards, District Administrator from 1974 to 1976, made a point of regularly visiting the porters and other staff and touring different parts of the hospital. This gave him more of a first-hand understanding of their pressures at that time. However, relations between 'management' and front-line staff remained difficult during this period (source: witness statement N80; Brian Edwards, District Administrator, 1974 to 1976).

The 1980s and 1990s

The incoming Conservative Government in 1979 had a set of strong beliefs that informed its economic policies, and therefore its policies in respect of the NHS. The Government's consultative paper, *Patients First* (DHSS, 1979), was its response to a 1979 Royal Commission on the NHS. This proposed that one tier of the existing administrative structure should be removed, and that district health authorities should be established to combine the previous functions of the district and area tiers. These new district health authorities came into being in 1982.

In Leeds two separate district health authorities were created (Leeds East and Leeds West). In Leeds West, which was responsible for the Infirmary, the senior team continued to be led by Richard Oswald as District Administrator and comprised the former district officers plus non-executive input, but without the oversight of the former area tier.

Within the Infirmary, internal pressures were becoming intense and were the main focus of senior management. These related primarily to staffing levels, financial constraints and demand for beds on the wards. Pressures on the wards were enormous. Beds were always in short supply, and for a number of years into the mid-1980s it was common for sisters on the Nightingale wards to be instructed by consultants to put up makeshift beds in the centre of the ward to accommodate extra patients.

> "The pressures on the wards were horrendous. It was routine practice to put extra beds in the middle of the ward and I had a memo from Grace Watts [matron until 1974] saying 'when the extra beds exceed 40 you will let me know'."
>
> Source: witness statement N202; employee early 1970s to late 1980s

In 1982, the Government commissioned an inquiry into management in the NHS, which was led by Sir Roy Griffiths, Deputy Chairman and Managing Director of Sainsbury's. This reported in 1983, and brought with it a significant shift in the existing leadership model in hospitals (Klein, 1989). Griffiths recommended that managers be appointed to all levels in the NHS to provide leadership, efficiency, cost improvement, staff motivation and change (Ham, 1992).

Management appointments took place by the end of 1985. Many managers were appointed with the task of addressing long-term financial problems in a number of hospitals. The dominant challenge for managers during the 1980s was to secure value for money and to improve the financial position of many hospitals (Ham, 1992).

In response to the introduction of general management in Leeds, there seems to have been a change in the title of Richard Oswald's post from District Administrator to District General Manager. A gradually evolving general management structure within the hospitals led to the setting up of management structures around clinical groupings of services. These changes were similar to those in many other hospitals at that time and replaced previous committee structures (Ham, 1992).

Financial pressures were a constant area of concern for the Board of Governors and its successor bodies. Proposals to cut costs and change patterns of care provision were received poorly, and added further tension to already strained industrial relations.

Nationally, financial pressures came to a head in 1987. Non-urgent admissions were cancelled in many areas of the country, job vacancies were not filled and wards were closed temporarily to save money. Faced with perceptions of a widespread financial crisis, the Government commissioned a review of the NHS.

Working for Patients (Department of Health, 1989) was the outcome of this review. It provided a further strengthening of the management culture with the introduction of an internal market. At a local level, health authorities were revised along business lines, with executive boards and statutory duties. Similarly, new trusts set up to run hospital services were also to have executive boards. By 1994, more than 400 hospitals (representing 95% of NHS activity) had become self-governing trusts (Klein, 2006).

In Leeds, Richard Oswald was replaced in 1988 as District General Manager by Stuart Ingham, and there was also a new Chairman (John Jackson, now deceased). The new team set about tackling their financial challenges and implementing a new management structure based on a model devised at Brunel University. Features of this 'Brunel Model' included tiers of management, with clearly defined roles and functions for each tier. It separated decision-making into five levels, from the Board to the ward. It was anticipated that this would clarify accountability arrangements and improve communication across different departments in the hospital. Because of the pre-existing rigid hierarchical structures, the anticipated improvements to communication from the introduction of the new management arrangements were slow to emerge.

In 1991 Leeds General Infirmary and its associated hospitals became a first-wave trust under the 'Working for Patients' arrangements (source: witness statement N157; Stuart Ingham, District General Manager, 1988 to 1991, Chief Executive 1991 to 1998).

The merger, 1998

In 1998, the trusts on either side of the city, United Leeds Teaching Hospitals (which included the Infirmary) and St James's and Seacroft hospitals, merged to form the Leeds Teaching Hospitals NHS Trust. The merger was a recommendation of the Leeds Review undertaken by the Leeds Acute Services Taskforce in 1996, which advocated improved integration and consolidation of clinical services across the city.

The first Chief Executive of the new Trust (from 1998 to 2001) was David Johnson, who had been the Chief Executive of St James's and Seacroft hospitals. The new Board was focused on the setting up of the new organisation, making new appointments and all the complex administrative arrangements that accompany major structural change (source: witness statement N156; David Johnson (now deceased), Chief Executive 1998 to 2001).

The cultural changes required to bring these two competitive and very different organisations together and make them greater than the sum of their parts tested the leadership of the inaugural Board and has tested successive Boards ever since (source: witness statements N156; N157; N218; N201; N213).

Changes to nursing roles, 1960 to 2000

Models of delivery of patient care have changed unrecognisably over the last 50 years. Technological advances in treatments, professional skills and education, pharmaceutical innovations, information available and new surgical procedures have inevitably changed clinical practices and patient experiences. Conditions requiring surgery that would have meant lengthy in-patient stays in the 1960s may now be treated as day cases, via out-patient services or through primary care services in the home or community. When patients are in hospital today, they tend to be in for much shorter periods of time before being transferred home. The clinical dependency of patients in hospital today is far higher than in the past, and the intensity of their needs and of the care they require is also greater.

As part of the Project 2000 changes to nurse education in the 1990s, nurse education moved from the hospital base to higher education (O'Dowd, 2008c). Student nurses today have full student status and are not rostered onto wards as a core part of the staffing team, as happened previously. They are also no longer expected to take charge of wards at night, supported by junior students or ancillary staff. This was the norm in many hospitals up to the late 1980s (source: expert opinion, Brooks, N255). As part of these changes, student nurses no longer live in the hospital nurses' home, but in student accommodation away from the hospital.

Present arrangements are a far cry from the practice of the 1960s and 1970s. Nursing practice was then overseen by a matron and a senior nursing administrator, and there was a strict and rigid hierarchy in the profession.

> “Miss Watts was Grace Watts. She was the matron… she was an excellent one as regards how the hospital was run. Everybody was terrified of her, including the consultants. She was a real old-fashioned, long black dress and white cap… and everybody was scared to death of her, including me. She was always picking on me about my hat.”
>
> Source: witness statement N29; student nurse in the 1960s

In Leeds, this hierarchy endured into the 1990s, and it was commonplace for first-year students to only converse with those in the second year of training, and so on up the hierarchy. It was very rare for a student to directly address a ward sister or doctor without being spoken to first (source: expert opinion, Brooks, N255).

At the top of the nursing hierarchy, the matron took the lead in all aspects of patient care, the cleanliness of the hospital and its day-to-day running. In the wards, the sisters were a powerful force and set and monitored the local rules of behaviour. Even at mealtimes there were demarcations, with the sisters often having their own dining room (O'Dowd, 2008a).

In the 1960s, 1970s and 1980s, nursing in the Infirmary was organised in a rigid hierarchical manner following the traditions of the Nightingale School at St Thomas' Hospital in London, under whose influence many of the matrons and sisters had trained. This rigidity was manifest in the ways described above and in others: for example, ward sisters had to be single and had to leave their post if they married, being able to return only on a part-time basis as staff nurses. Appointments to ward sister posts were made from a pool of those deemed competent as night sisters; ward routines commenced each morning with prayers; and the rules of the nurses' home restricting access for any male visitors were strictly enforced (Anning, 1966). Whilst professional standards were rigidly maintained, most wards were run in a way which produced a very formal and controlling atmosphere, which may have inhibited junior members of the nursing staff from speaking out if they had concerns.

> “But I think there was a real sense of hierarchy amongst nursing… So even though nursing was mainly female, it was still this rigid hierarchy. As I say, women were not senior in the place; apart from in nursing where there was also a very, very strong, rigid rules basis.”
>
> Source: witness statement N158; manager, mid-1980s to early 1990s

> “I would say when I went there, I mean, it was, it was very authoritarian, it was very traditional, it was – I mean, I can remember saying to people at the time 'It's locked in a time warp, this place'. I mean, it was awful when I went there, really.”
>
> Source: witness statement N154; Liz Jenks, nursing manager from mid-1980s and Chief Nurse, 1991 to 1998

Before the 1990s, the vast majority of nurses were female, and started training when they were 18 years old. Nurses in training in Leeds lived in the nurses' home on the hospital site, and the ward sisters (along with the home wardens) took the responsibility of protection and control over both the social and work life of the students extremely seriously (source: witness statements N214; N202; N159; N154; former senior nurses 1960s to 1980s).

On the wards, nurses worked closely with patients, and took the lead in all aspects of their personal care. The discipline and hierarchy of authority were strictly adhered to. Junior nurses (students or qualified) who dared to challenge or question any aspect of the care delivery on a ward could face possible disciplinary action at worst, or a humiliating reprimand from the sister (source: expert opinion, Brooks, N255). Ward routines were closely managed, and conformity and deference to authority were the order of the day (source: witness statements N214; N202; N159; former senior nurses 1960s to 1980s).

Throughout the 1980s there was a subtle relaxation of old disciplinarian work patterns in order to attract new recruits to the profession. Nurses were able to work shifts covering a full day, rather than 'split' shifts of morning and then evening on duty. Flexible working practices were introduced and some nurses were able to work part time (O'Dowd, 2008b). There was also an increased tolerance of ward sisters who were married. Discipline and hierarchy were still strong, however, and the protection of the professional standards of nurses both on and off duty remained a key part of the chief nursing officer role. These had replaced matrons following the recommendations of the *Salmon Report* of 1966 (Ministry of Health and Scottish Home and Health Departments, 1966).

The Nurses, Midwives and Health Visitors Act 1979 brought about the end of the 'apprenticeship' model of student education. This was resisted at the time by many of the large teaching hospitals, as they perceived it to be a threat to their workforce numbers. The Act created the UK Central Council for Nursing, Midwifery and Health Visiting, to be the one statutory body to oversee basic and post-basic training (Ousey, 2011). This was established in 1983, and produced the first nursing code of conduct that same year (UKCC, 1983).

The role of today's hospital nurses is a world away from that of their counterparts in the 1960s and 1970s – not only in terms of skills, education, age and gender diversity, but also in terms of assertiveness towards authority, professional accountability and the nature of patients' needs.

Changes in patient experience and behaviours

During the 1960s and 1970s, patients were in many ways expected to be passive recipients of care, and to be grateful for the attention of the doctor and nurse assigned to them. Regardless of the class or status of the patient in their daily life, once they were in hospital they were expected to defer to the clinicians in charge of their care. The autocratic leadership style of senior nurses and doctors did little to encourage patients to comment on their care, and complaining was seen as a problematic behaviour to be discouraged (Mold, 2011).

The reorganisation of the NHS in 1974 saw the introduction of community health councils, known generally as 'health watchdogs'. These bodies were aligned with a district committee and undertook visits to hospitals and surveys of specific areas of concern. They were abolished in 2000. Local participation was then taken on by patient and public involvement forums, which were replaced in 2006 by local involvement networks. Local Healthwatch committees are the current body responsible for patient participation and feedback. They were created in 2013.

Until 1985, with the introduction of the Hospital Complaints Procedure Act, there was no consistent approach across the NHS for handling complaints from patients. Each hospital had its own system. Patients rarely made formal complaints. Concerns raised at ward level would be

dealt with in discussion with the doctors or ward sister, and were very rarely escalated to any higher authority (source: expert opinion, Brooks, N255; witness statement N157; Stuart Ingham, Chief Executive 1988 to 1998). Because of their rarity, patient complaints were not routinely scrutinised by hospital boards. The 1985 Act brought in the legal right of patients to complain. It also made it compulsory for health authorities to establish a complaints procedure and to publicise this to patients. The response in Leeds to this mandatory requirement is described in chapter nine.

In 1991, *The Patient's Charter* was published. It set out explicit rights for patients, which ranged from general assumptions about care being free at the point of delivery to specific guarantees about waiting times (Department of Health, 1991). Its significance was in validating the importance of patients' views of their health service experience, and the fact that hospitals had to take these seriously (Crinson, 1998).

Patient choice, consultation and participation were not introduced into the lexicon of healthcare until the early 1990s, and were not acted upon in a systematic way until much later. Even today the NHS systems for engaging patients as partners in their care are variable, and the complaints system continues to be confusing and dispiriting (Clwyd and Hart, 2013). Complaints are more commonly reported today, however, than in the past.

Over the last 50 years, the status of patients has improved considerably. From being passive recipients of care with virtually no means of redress, little information and no clarity about their rights, patients today are often co-producers of their care (along with their clinician) and are encouraged to engage in dialogue about key decisions affecting them.

The market-driven changes in healthcare have strengthened the voice of patients, giving them access to vast amounts of information and an expectation of being able to make meaningful choices about their care. *The NHS Constitution* (Department of Health, 2009) set individual rights and responsibilities based on the guiding principles established when the NHS was created. Even today, however, for the most vulnerable – the elderly, children and those with mental illness or disability – the voice of the patient is not heard as loudly as it might be. Recent healthcare scandals such as those in Stafford Hospital have revealed the extent of fear and anxiety felt by patients and their carers, and the need to rebuild trust and compassion alongside information and choice in hospital care (Francis, 2013).

Recent reports into scandals concerning standards of healthcare in England have been reviewed as part of our research for this investigation (Francis, 2013; Keogh, 2013). We have also reviewed key reports specifically focused on the safeguarding of children and the identification of sex offenders in an organisational context (Erooga et al, 2012). In services such as hospitals, it is almost impossible to guarantee a service totally free from risks to the safeguarding of patients and staff. Hospitals are accessible buildings open to the public 24 hours a day. However, every hospital, however large and complex, can put in place a range of processes to minimise these risks, and should aim to protect its patients, staff and others using its services from harm.

Summary

This chapter has given broad consideration to some of the main societal and NHS-related contextual factors relevant to the period and issues covered by this investigation. It has illustrated dramatic attitudinal, legislative and cultural changes in wider society and considerable structural, technological and political changes in the NHS during these years. This historical context and the resulting challenges for the management of the Infirmary are important in understanding the environment in which Savile operated.

We next consider the specific nature of Savile's relationship with the Infirmary and how this gave him unrestricted access to its staff, patients and facilities over a 50-year period.

4 The Infirmary and Jimmy Savile

4 The Infirmary and Jimmy Savile

Chapter summary:

- Savile's origins with the Infirmary began through his relationship with the Head Porter, and a mutual interest in hospital radio.
- He nurtured a close relationship with the Board of Governors in the 1960s and early 1970s.
- He had a mixed reputation among Infirmary staff, being seen by some as a positive asset, a morale-boosting fundraiser, and by others as a disruptive nuisance who made some female staff feel uncomfortable.
- He was a hugely successful self-publicist and ensured an almost continual high profile in local press and broadcast media.

Introduction

Savile's relationship with the Infirmary endured over 50 years. From its initial origins with his voluntary involvement in the development of the hospital radio service, he gradually became a regular feature around the hospital, visiting as a celebrity when he would chat freely to patients and staff, describing himself as 'chief cheerer-upper' (Bellamy, 2012). This chapter provides an overview of Savile's relationship with the Infirmary between 1960 and 2011. In particular, consideration is given to the following:

- the origins of his connection with the Infirmary;
- his initial relationship with the Board;
- his general reputation in the Infirmary;
- his role in promotion and publicity; and
- his relationship as a patient.

In the late 1960s, he officially became a volunteer porter, and at least once a week, but often more frequently, would join the porters in the Accident and Emergency (A&E) or the X-ray departments and help transport patients around the hospital wards and departments. He also continued attending in an ad hoc fashion, with impromptu visits to wards and departments during the day and night. Alongside these visits, he maintained an extremely high media profile through the local and national press, and through his TV and radio work. This publicity was further enhanced by frequent fundraising activity through running marathons for sponsorship, photo-calls for the handing over of cash or cheque donations, or opening ceremonies for new services or new initiatives in Leeds.

Over the years, he became an unremarked-upon presence in the hospital, relatively unnoticed by staff and management, generally perceived as part of the Infirmary 'family' owing to the longevity of his relationship with them. It was this familiarity, this taking his presence for granted, that enabled his sustained and unquestioned access, including to the most vulnerable individuals in the hospital, to continue.

Savile's early days with the Infirmary

Savile's relationship with the Infirmary started in 1960, when he would occasionally help out on the hospital radio service, which was managed by the then Head Porter, Charles Hullighan (now deceased). They had known each other since they were children.

> "He [Charles Hullighan] knew Jimmy Savile from Jimmy Savile being two years old. Because his auntie lived near them… But then Charles went into the army when he was 14 so he didn't see Jimmy then until the 1950s."
>
> Source: witness statement N204; employee, 1970s

> "We had this patient radio service; it wasn't very much of one and Jimmy Savile came along on the scene and a sort of rumour… well I'm sure it was right – he bought a new Rolls Royce and when he bought it he asked for green shield stamps and he gave half of them to the Infirmary… and we bought a rather more refined radio system and that would be some time in the 1960s."
>
> Source: witness statement N214; Betty Vigrass (prev Champney), Director of Nurse Education, 1974 to 1977, then Chief Nurse until 1984

The above account of Savile donating Green Shield Stamps to the Infirmary is confirmed by the minutes of the Finance and General Purposes Committee meeting held on 15 July 1968.

During the 1960s, Savile would also attend the hospital fairly regularly as a 'celebrity' visitor. He organised concerts for patients featuring popular stars of the time performing, such as The Beach Boys, who performed at the nurses' home in 1969.

> "'They [The Beach Boys] phoned me before coming to England and asked if they could play at Leeds General Infirmary because they had heard about it and all the other show business people who have been here' Mr Savile said later."
>
> Source: YEP 5; 1969

Savile also, on occasions, worked unofficially as a voluntary porter during the 1960s (source: witness statement N62 and Victim ZC).

In 1968, a fire broke out in Martin Wing of the Infirmary and, whilst there were no injuries or fatalities, it resulted in a considerable amount of damage to the fabric and fixtures of the building. Savile took part in the clean-up operation and this greatly impressed the then Chairman of the Board of Governors, Sir Donald Kaberry (now deceased).

> “In the early hours of Whit Saturday 1968 there was a serious fire in the Martin Wing. Mr Savile heard about the fire in Cardiff and at 9.30 am the same morning telephoned the Infirmary to enquire about the patients and staff and the damage done. He cancelled his engagements for that week-end and by 5 pm he was working… helping to remove beds and clearing away the fire debris.”
>
> Source: citation letter to DHSS from Sir Donald Kaberry, 27 February 1971

Throughout his career, Savile used his celebrity position to endorse various campaigns and promotions. In 1968, around the time of this fire, he was active in the I'm Backing Britain campaign, which aimed to encourage people to offer their time and talents as volunteers to worthy causes.

> “That is when they were asking everybody to do two days voluntary in a hospital, or anywhere, but mainly in a hospital. And Jimmy rang Charles [Hullighan] up and asked him if he could do it. If he would take him on. So Charles couldn't do that without going before the Board of Governors… and they had a meeting and some agreed and some didn't… and then they said yes, you see, they had a vote and said yes and Charles was his boss.”
>
> Source: witness statement N204; employee, 1970s

Following a discussion with Sir Donald Kaberry, Savile was offered a temporary role as a volunteer porter in the hospital.

> “Jimmy made the unusual request to be allowed to work as a voluntary porter for two days a week for a month. After consultation the Chairman of the Board of Governors agreed to allow Jimmy to do this. For a month Jimmy worked in the Diagnostic X-ray Department… at the end of the month Jimmy had become so involved with patients and hospital work in general that he decided to stay on and he is still working here some two years later.”
>
> Source: citation letter to DHSS from Sir Donald Kaberry, 27 February 1971

In his written citation letter in support of an honour for Savile, Sir Donald also mentioned that there had been some initial reservations about the potentially disruptive impact of a celebrity working in the hospital, and explained how they had been quelled.

> “When Mr Savile offered his services as a voluntary porter I was a little concerned about the Press implications and how he would fit into a busy teaching hospital. My concern was wholly unfounded and he has done an extremely good job and is accepted by all sections of the staff as one of the best voluntary workers we have.”
>
> Source: citation letter to DHSS from Sir Donald Kaberry, 27 February 1971

Savile was confirmed as a volunteer porter later in 1968. He continued in this role throughout the 1970s to 1990s, with less frequent visits as he became older.

Throughout the duration of his association with the Infirmary, he would also regularly visit and attend events as a 'celebrity'. Many of these visits attracted publicity, but he also attended internal events, such as the annual Christmas Eve visit of the Leeds Minster choir, which sang carols to patients on the wards.

> "For a number of years he joined the church choir on Christmas Eve when we have sung round the wards… he would have been going round with a group of three or four boys of school age and five or six men choristers together with a couple of members of the clergy… I must say some of the older patients were very pleased to see him…"
>
> Source: witness statement N46; local clergy, 2000s

Early relationship with management

Prior to the 1974 NHS reorganisation, the Board of Governors was quite remote from the wards and departments in the hospital, and this distance was reinforced by the rigid professional and managerial hierarchies in the running of the organisation. Governors focused on their individual areas of responsibility and there was a formality about how they worked and how they related to the hospital. The House Governor, or Chief Executive, at the time was Arnold Tunstall (now deceased). We heard how he was adept at managing the relations with consultants and was a skilful people manager.

> "Arnold was a very unusual House Governor… but he was brilliant with the consultants. At five o'clock every evening there'd be a clinic. There was a waiter who'd come with a sherry tray. Arnold was absolutely brilliant at calming things down and keeping the place afloat."
>
> Source: witness statement N80; Brian Edwards, District Administrator, 1974 to 1976

Savile established a relationship with Tunstall (source: witness statements N20 and N214), and maintained contact with him even after Tunstall left the Infirmary for a more senior role. Following the 1974 NHS reorganisation, Tunstall went to the new Area Health Authority. He later became a Trustee of the Hospital Charitable Trust and was involved with the agreement to part fund a lithotriptor machine (used in the treatment of kidney stones) in the late 1980s, with the remainder of the funding raised in a campaign launched by Savile.

> "We [the Charitable Trustees] had a visit from Jimmy Savile. His reason was to make us aware of his wish to launch an appeal for half a million pounds to purchase the Urology department a lithotriptor… after Arnold and I had seen Jimmy we had a long talk with… the senior consultant… he was able not only to assure us of the need of the lithotriptor but was also kind enough to give us the benefit of his researches into the costings."
>
> Source: letter to Charitable Trustees from Dr GW Hawbrook, Chairman of the Trustees, 22 February 1988

Savile continued to influence the senior managers who replaced Tunstall. In the early 1970s, a former Deputy House Governor recalled an episode where he had received some complaints from consultants regarding car parking. Their particular concern was that Savile was parking his Rolls-Royce in the consultants' car park, which had limited parking space available, and that the vehicle took up two spaces because of its dimensions. The former Deputy House Governor took their concerns to the then House Governor Eric Hill (now deceased).

> "My first encounter with him was when he, he met me and said that he was the only porter who came to the Infirmary with a Rolls Royce, and I said, 'that's true, but don't park it in the consultants' car park'… A couple of doctors had said 'why is he allowed to park out there?'… he complained to the House Governor and the House Governor said to me that he is allowed to park there so in future when anyone said anything to me about Savile parking, I referred them to the House Governor."
>
> Source: witness statement N20; former Deputy House Governor, 1970s to 1980s

Although Savile was engaged in the hospital primarily as a porter, he made certain that he established a strong relationship with the senior management, and in particular, in those early years, with the House Governor as the lead manager in the Infirmary.

> "I had no jurisdiction over Savile or anything he did, and you know, any link he had with the managers at the hospital or the administrators was normally with the House Governor… At that time there was no, you know, I wasn't aware of any issues, the House Governor wasn't aware of any issues from memory. In other words there wasn't any reason to put any restriction on him…"
>
> Source: witness statement N20; former Deputy House Governor, 1970s to 1980s

Savile had a closer relationship with the Board of Governors in the 1970s than might be expected for an 'ordinary' volunteer, or a sporadic, or even regular, celebrity visitor. In addition to the strongly positive citation for his OBE in 1971, a condolence letter sent to Savile when his mother died in 1972 indicated that he was highly regarded by the Board as a force for good in terms of the public image of the hospital.

> "We were extremely sorry to hear about the passing of your mother and on behalf of the Board of Governors I should like to convey to you and your family our deepest sympathy. Please do not bother to answer this letter. I wanted you to know that your many friends at LGI were thinking of you at this time."
>
> Source: letter from Arnold Tunstall to JS, 16 October 1972

We were told by successive executives from the mid-1970s to the late 1980s of their very limited interaction with Savile, despite his continued presence in the Infirmary (chapter nine). In later years Savile visited the Infirmary far less frequently, and managers during the 1990s and 2000s

commented that they rarely saw him in the hospital. Our impression is that there was a much closer relationship between Savile and senior managers during the late 1960s and early 1970s than with those in subsequent years. We believe that the nature of his relationships with managers in the 1960s and 1970s set the tone for his future relationships with subsequent management. This was demonstrated by an uncorrected perception among clinical and support staff that he was influential and well regarded by senior managers. In reality, later relations with senior managers were characterised mostly by indifference to his presence in the organisation (chapter nine).

General reputation within the Infirmary

We heard mixed views about Savile's reputation in the Infirmary over the years. On the one hand, staff tolerated his open access to wards and departments because he was famous, perceived as popular with patients and with senior management, and because it was believed that he raised money and facilitated positive press coverage for the hospital. Some staff felt that he was an asset to the hospital, cheering patients up and raising morale. There was also the feeling at a personal level that he could facilitate introductions to other celebrities. On the other hand, others expressed concerns about his reputation: in particular, concerns about his behaviour towards young women, and the discomfort that many young female members of staff felt about being in close proximity to him.

> "The patients – that is the paradox of the man, isn't it. There were some patients who gained a great deal from having Jimmy Savile visit them."
>
> Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973–79, junior doctor to 1987 then consultant, Medical Director, 2009 to 2013

> "He was noisy and cheery, but by and large the senior medical staff there thought he was the bee's knees, because he raised the profile of Leeds General Infirmary, he raised a tremendous amount of money for good projects and the patients seemed to adore him."
>
> Source: witness statement N104; employee, 1960s to 1970s

> "And he did do good. At the end of the day if you think about all the stuff he did, however the money came, or however it was generated, he put it to good causes. He didn't have to run up and down the length of the country… nobody made him do it."
>
> Source: witness statement N45; employee, 1990s to 2010

Savile had a reputation for overstepping the boundaries of acceptable behaviour towards women. Societal changes were dramatic in this regard over the 50 years that Savile was associated with the Infirmary, but his behaviour was not modified to reflect these changes. In the context of the norms of the 1960s and 1970s, his apparently relentless flirtatious

behaviour towards young female staff may not, on the surface, have been considered extraordinary. However, in a busy hospital setting, it was seen by some as wholly inappropriate in terms of the disruption caused to ward procedures and the harassment of female staff.

> "The old ladies really loved him. They thought he was wonderful. The nurses however were not quite so keen because he was always a very touchy-feely sort of person. If he could touch or feel, he did, and we used to try and make sure we kept away from him, which I generally managed to do."
>
> Source: Victim FF; employee, mid-1970s

> "It was just he was a lech. That was the thing, that he liked younger women and he was quite a forceful personality really. If he got a woman alone he would like to feel her up."
>
> Source: witness statement N113; employee, early 1980s

> "We were all aware within the hospital that many of the nurses on the wards found him creepy, I think is the best way of describing it. There were rumours going round – hospitals are always full of rumours – though there was nothing to substantiate them and I can't give you any examples of anyone who came up to me or who I am aware of who made any official or formal complaint about him."
>
> Source: witness statement N11; employee, 1970s to 2000s

> "If you saw him and you were with somebody, or one of the nurses were in your presence, they would say, 'He gives me the shivers', and I could never understand why they thought that. I always thought he was just a bit of an eccentric and wearing track suits just to make himself popular! But it was amazing how many lasses thought he was creepy."
>
> Source: witness statement N103; employee, 1980s to present

> "I met a lady who started her nurse training here in 1980 and she said she met him in the corridor and the first thing he said to her was 'ring your mum and dad and tell them you're not coming home tonight'. She said she wasn't sure whether it was meant to be funny. She said it felt creepy…"
>
> Source: witness statement N5; spouse of employee, late 1970s

> “You didn't get too close and I remember being told that. One of the senior staff nurses just said to me, 'You don't get too close to him' and that was the kind of general feeling, that you sort of stayed away, not a nice man, just don't get too close.”
>
> Source: witness statement N239; Ruth Holt, staff nurse, 1980s, later Director of Nursing, 2006 to 2012

We heard from victims and witnesses that during the 1990s and 2000s the general, albeit reluctant, acceptance of Savile's tactile approach towards female staff was no longer felt by them to be tolerable. Although he remained unchallenged directly by staff in receipt of his attention, their responses and subsequent discussions with colleagues indicated a great deal of discomfort and disquiet at what many deemed inappropriate behaviour.

> “So it all seemed relatively, you know, okay at first, until he started reaching out like and kissing our hands and then it got kind of creepy… it wasn't asked, it was just creepy and it just made you feel uncomfortable and it's just like a normal individual wouldn't do that… he was just like 'well it's okay, I can do this. You know, they're staff in the hospital and I can give them a kiss on the hand' it was just horrible, just horrible.”
>
> Source: Victim W; employee, 2000s

> “He just got hold of my hand and just kissed me all the way up my arm, right up, right up to there, from my wrist to my shoulder… I was probably taken aback, a bit embarrassed. I mean, I was naïve, but I felt a bit embarrassed. I mean it wasn't abuse, but it was out of order.”
>
> Source: Victim RR; employee, 1990s

> “I went to shake his hand… he took my hand and kissed me on the back of my hand and then sort of multiple kisses going up my arm towards my shoulder… I think I just thought 'that's strange and inappropriate'… but I didn't feel confident enough to say, particularly because he was famous, to say, that's inappropriate… it definitely felt wrong and a bit 'yuk'. I don't really want to be near you. But it wasn't anything that frightened me…”
>
> Source: Victim P; employee, 2000s

This diversity of opinion regarding Savile was sustained throughout his years with the Infirmary. Some staff took his good deeds and charitable activities at face value, some were in awe of him because of his celebrity status, and some felt uncomfortable around him and saw his presence in the hospital as a disruptive nuisance. We explore this further in chapter eight.

Savile's role in publicity for the Infirmary

Throughout the duration of Savile's relationship with the Infirmary, he remained in the public eye not only because of his TV and radio work, but also because of his relentless self-publicity associated with charitable fundraising or promotional activity for the Infirmary and other organisations. In light of the various internal pressures and tensions in the Infirmary during the 1970s and 1980s (see previous chapter), attaining positive media coverage in the local or national press was important for the hospital (source: witness statements N77; N209; N81; N11).

After the initial warm relationship between Savile and the Board of Governors in the 1960s to the early 1970s, from the late 1970s onwards he seems to have had more distant relationships with subsequent senior managers. We spoke with every Chief Executive (or equivalent) in post from 1974 to 2013, many of whom told us they had little awareness of him, rarely discussed him and generally had little interest in him (see chapter nine). We found this reported sustained lack of awareness and interest in his role in the Infirmary at odds with his almost continual media presence in local and national press stories associated with the Infirmary.

Table 4.1 illustrates the extent of his media coverage in local press articles. In addition, we were informed that his weekly radio programme *Savile's Travels* focused largely on Leeds during the late 1960s and 1970s, and had up to 10 million listeners (source: witness statement N271; former BBC radio producer, 1960s–1970s).

Table 4.1: Local press articles

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
3/6/1968	Jimmy leads hospital clean-up volunteers	Publicity – volunteering after hospital fire	*Yorkshire Evening Post* (YEP) press cutting 142
7/8/1968	JS donates stamps providing new stereo turntables at LGI	Publicity – donates stamps to Infirmary	YEP 36
30/10/1968	Schoolchildren back Jimmy on his marathon run	Fundraising – Kidney Unit extension	YEP 164
16/4/1969	Jimmy Savile as a record 'food grabber'	Publicity – win money for Infirmary in 'food grabbing' competition	YEP 54
14/8/1969	Jimmy thanks young helpers of Infirmary	Publicity – receiving money raised by others for Infirmary's Kidney Research Fund	YEP 119
14/10/1969	Savile's travels will save lives	Fundraising – Kidney Unit extension	YEP 159
18/10/1969	Savile's travels help to save lives	Fundraising – Kidney Unit extension	YEP 49
22/10/1969	More pupils rally to Jim's call	Fundraising – Kidney Unit extension	YEP 4
27/10/1969	Jim takes on United at their own game	Fundraising – Kidney Unit extension	YEP 48
30/10/1969	His firework money is for Jimmy	Fundraising – Kidney Unit extension	YEP 145
8/11/1969	Jimmy Savile's marathon mania is spreading	Fundraising – Kidney Unit extension	YEP 44

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
17/11/1969	Injured Jimmy runs tomorrow	Fundraising – Kidney Unit extension	YEP 141
18/11/1969	Jimmy home in charity marathon	Fundraising – Kidney Unit extension	YEP 51
19/11/1969	Just three hours' sleep for Jimmy	Fundraising – Kidney Unit extension	YEP 31
19/11/1969	Savile marathon ends ahead of schedule	Fundraising – Kidney Unit extension	YEP 94
26/11/1969	Auntie Flo's big night out	Fundraising – Kidney Unit extension	YEP 93
28/11/1969	Jimmy marathon fund snowballs past £3,000 mark	Fundraising – Kidney Unit extension	YEP 95
1/12/1969	Jimmy's marathon fund gets a boost	Fundraising – Kidney Unit extension	YEP 53
1/12/1969	JS marathon fund succeeded dramatically in efforts to expand Artificial Kidney Treatment Unit at LGI	Publicity – handing cheque to Infirmary for Kidney Unit extension	YEP 52
20/12/1969	Girls give Jimmy £820 for fund	Fundraising – Kidney Unit extension	YEP 107
11/2/1970	Singers help hospital	Fundraising – Kidney Unit extension	YEP 3
9/3/1970	Cheque in… the end of a long walk	Fundraising – Kidney Unit extension	YEP 35
6/10/1970	JS inspects feet of volunteer walkers	Publicity – with Infirmary staff promoting sponsored walk for the Little Sisters of the Poor	YEP 118
4/11/1970	Near completion of kidney unit	Fundraising – Kidney Unit extension	YEP 79
4/2/1971	Jimmy opens new studio	Publicity – opens new broadcasting studio at Infirmary	YEP 73
15/12/1971	Jimmy remembers the old folk	Publicity – holiday relief porter at Infirmary on Christmas Day	YEP 80
27/2/1973	Mexico bound	Publicity/fundraising – Infirmary student nurse travels to Mexico for conference, funded by JS Infirmary Fund	YEP 6
23/7/1974	Gala gift for hospital	Publicity – receiving blood filtration unit on behalf of Infirmary's Kidney Unit	YEP 57
19/3/1975	Stars Mike & Wilma for charity walk night	Fundraising – recreational facilities for Casualty Department staff at Infirmary	YEP 129
3/4/1975	Show for the two Jims fund	Fundraising – recreational facilities for Casualty Department staff at Infirmary	YEP 122
25/6/1975	Gentleman Jim to lead the ladies	Fundraising – recreational facilities for Casualty Department staff at Infirmary	YEP 126

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
11/2/1977	Jimmy Savile's running mate	Fundraising – children's play area at Infirmary	YEP 149
1/3/1977	Charity marathon raises £2,000	Fundraising – children's play area at Infirmary	YEP 8
9/6/1977	JS presents Jubilee cake to children at LGI	Publicity – presenting Jubilee cake from the Queen to children at Infirmary	YEP 81
10/6/1977	Even losers share bonanza	Publicity – presenting presents to patients at St James's Hospital	YEP 124
1/2/1978	Jim opens new ward scheme	Publicity – opened improvement scheme for children's ward at Wharfedale General Hospital, Otley	YEP 151
2/2/1978	Jim'll collect it	Fundraising – Kidney Unit extension	YEP 163
14/8/1978	Jim pours out the cash	Publicity – collecting funds raised by others to purchase a whole-body scanner for St James's Hospital	YEP 98
13/10/1979	A triple bill as all action DJ spins into town	Publicity – presenting van at the Infirmary to NSPCC	YEP 120
22/12/1979	Jim fixes it for playtime	Publicity – opening children's playground at Infirmary	YEP 7
6/2/1980	Hospitals share £30,700	Publicity – receiving cheque on behalf of Infirmary for nine new nebulisers	YEP 46
4/3/1980	New garden project in LGI commences	Publicity – commencement of new Infirmary Coachyard Gardens works	YEP 166
4/6/1981	How's about that then... Jim fixes it	Publicity – opening new Infirmary Coachyard Gardens	YEP 109
8/3/1983	Jimmy Savile's marathon results	Fundraising – Kidney Unit extension	YEP 161
1/5/1984	Mile after mile… Jim pounds the charity beat	Fundraising – Kidney Unit extension	YEP 9
14/12/1984	Kids fix it for Children's Society	Publicity – presenting certificates in Infirmary boardroom to children who helped fundraise	YEP 84
17/12/1984	Jim hands over wheelchair cash	Publicity – presenting cheque to disabled man to purchase new wheelchair	YEP 143
12/5/1986	Mr Fix It visits hospital	Publicity – handing cheque to Colitis Clinic to purchase word processor	YEP 67
11/9/1986	Jim in bid to fix it for heart unit	Publicity – led the Variety Club Great Britain sponsored walk in support of Mountbatten Non-Invasive Heart Unit – Killingbeck Hospital	YEP 40
22/5/1987	Jimmy's pals turn out for fun run	Publicity – pals run without JS in aid of restoration fund at church hall	YEP 154

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
3/11/1987	Hospital 'kept Savile from bottle'	Publicity – portering at Infirmary kept him from the 'bottle and needle'	YEP 133
16/3/1988	Jim's out to fix it with kidney plea	Publicity – major appeal for funding towards machine to destroy kidney stones at Infirmary	YEP 135
31/1/1990	Jimmy gives £5,000 to appeal	Publicity – promoting and donating towards the Have a Heart appeal	YEP 20
31/7/1991	Sir Jim fixes it	Publicity – donating towards a blood and fluid warmer for Infirmary	YEP 66
3/12/1991	Sir Jimmy cheers up Stuart Guest during his visit to the LGI	Publicity – guest of honour at Infirmary, opening the refurbishment at A&E Unit	YEP 22
4/12/1991	L' of a shock for Jim	Publicity – unveiling plaque at Infirmary on reopening of A&E	YEP 174
24/12/1992	Lift-off for LGI keyhole unit	Publicity – launching vital building development at Infirmary	YEP 63
4/1/1993	Sir Jim takes a peep at new micro surgery	Publicity – launching a hospital unit to train surgeons to take pain out of operations	YEP 68
15/7/1993	Generous Jim fixes it for trainees at LGI	Publicity – asked by Infirmary to help in raising funds for the vital cervical smear computer	YEP 70
29/7/1994	Sir Jimmy relays more help for charity	Publicity – receiving cheque towards Anthony Nolan Bone Marrow Trust for Infirmary	YEP 113
20/6/1995	Sir Jim fixes it	Publicity – donating funds towards the purchase of the vital cervical smear computer at Infirmary	YEP 111
12/12/1995	Jim's £20,000 gift	Publicity – donating funds towards a clean air suite at Chapel Allerton	YEP 86
10/8/1996	Dunce's cap for Sir James	Publicity – visiting the Infirmary dermatology stand to promote the campaign against skin cancer	YEP 137
6/9/1996	Patients' thanks as Sir Jimmy fixes it	Publicity – thanks from patients at Chapel Allerton Hip Centre	YEP 24
28/5/1997	I promised you a rose garden	Publicity – officially opening Coachyard Gardens	YEP 83
15/8/1997	Sir Jimmy says a hearty thank you	Publicity – thanks medics who carried out his quadruple heart bypass surgery	YEP 157
30/8/1997	Sir Jimmy makes a start	Publicity – attends (as spectator) the fundraising walk in Roundhay Park in aid of the Leeds Radiology Department	YEP 175
1/7/1998	LGI renal ward upgrade	Publicity – Infirmary kidney patient association, £260k from the Leeds Hospital Fund	Leeds Teaching Hospitals NHS Trust newsletter

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
1/11/1998	Launch of major new Yorkshire Family Heart Study	Publicity – JS presenting £250 cheque in Ward 26 at Infirmary's Martin Wing	Leeds Teaching Hospitals NHS Trust newsletter
1/12/1998	Orthopaedic out-patients refurbishment in Infirmary's Martin Wing	Publicity – funded by Infirmary's Special Trustees for £160k	Leeds Teaching Hospitals NHS Trust newsletter
1/4/1999	Cheque presented to Sightsavers from an 'eyeball' held by Infirmary's Eye Department in October 1998	Publicity – JS presenting £800 cheque to Sightsavers	Leeds Teaching Hospitals NHS Trust newsletter
1/9/1999	Handing out £5 notes as a challenge to turn the cash into as much money as possible in a month	Publicity – Infirmary using JS to raise funds for Infirmary's child therapy unit	Leeds Teaching Hospitals NHS Trust newsletter
1/11/2001	Yorkshire Heart Centre fundraising stall	Publicity – attending stall in aid of Yorkshire Heart Centre	Leeds Teaching Hospitals NHS Trust newsletter
1/2/2002	Sponsored 'lie down' for Chapel Allerton Hospital in the summer of 2001, raised £16k – doubled by Special Trustees for theatre equipment	Fundraising – theatre equipment at Chapel Allerton Hospital	Leeds Teaching Hospitals NHS Trust newsletter
1/5/2002	Gift of a computer to N Ward at Seacroft Hospital as a thank you (after visiting ward to see his relatives)	Publicity – JS donates a computer	Leeds Teaching Hospitals NHS Trust newsletter
5/11/2002	Readers push appeal through £1.5m mark	Publicity – the Heartbeat appeal benefiting from celebrities' fundraising	*Yorkshire Evening Post* online article
1/2/2003	Cheque for £500 to cardiologist towards the Leeds-based national heart research fund	Fundraising – JS presenting cheque to cardiologist raised through a sponsored walk for heart research undertaken by a Trust consultant	Leeds Teaching Hospitals NHS Trust newsletter
1/1/2004	Helped three overseas doctors take part in new hospital exchange visit to Infirmary	Fundraising – donated £2,200 to Leeds Teaching Hospitals NHS Trust's Overseas Partnering and Training Initiative (OPTIN) – money for flights and accommodation	
1/6/2004	£150 to cancer research clinic centre at St James's University Hospital – responding to family appeal	Fundraising – personal donation to cancer research	
1/10/2004	JS meets the doctors benefiting from previous gift of £2,200	Publicity – JS meeting doctors at Infirmary who have benefited from OPTIN donation	Leeds Teaching Hospitals NHS Trust newsletter
18/1/2005	Jim steps in for tsunami	Publicity – three medical staff from Infirmary flying to assist in tsunami, funded by JS	*Yorkshire Evening Post* online article

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
1/2/2005	JS funding of £1,500 towards OPTIN for a team of three going to tsunami-hit Sri Lanka	Fundraising – sending medical team to Sri Lanka to provide aid to tsunami victims	Leeds Teaching Hospitals NHS Trust newsletter
1/6/2006	Walk for Skin event raises money for research into skin disease	Publicity – presenting cheque to British Skin Foundation for funding raised in Leeds walk event	
15/7/2006	The day our Jim fixed it for the doctors of the future	Publicity – donates to Infirmary to fund medical student scholarships	*Yorkshire Evening Post* online article
30/10/2006	A national treasure	Publicity – charity achievements	
31/10/2006	Fix it for Jim to be Freeman!	Publicity – requests for JS to be made a Freeman of Leeds for his charity and volunteering work	
1/11/2006	Launch of new scholarship scheme for junior doctors (LURE) at Infirmary	Publicity – launching scholarship scheme in the post-graduate suite at Infirmary	Leeds Teaching Hospitals NHS Trust newsletter
1/11/2006	Campaign now under way for tribute to city's favourite son	Publicity – strong campaign under way for JS to be made a Freeman of Leeds	*Yorkshire Evening Post* online article
1/11/2006	It's cry freedom for our Jimmy	Publicity – strong campaign under way for JS to be made a Freeman of Leeds	
22/11/2006	We'll fix it for Sir Jim	Publicity – strong campaign under way for JS to be made a Freeman of Leeds	
14/12/2006	Sir Jimmy Savile passes state-of-the-heart test	Publicity – testing the new state-of-the-art cardiac ultrasound training facility at Infirmary	
9/6/2007	Sir Jim fixes it for finest medical talent	Publicity – presenting the Sir Jimmy Savile Trophy to junior doctor	
1/11/2007	Inaugural Sir JS Trophy presented to West Yorkshire Foundation School	Publicity – presenting trophy at Infirmary	Leeds Teaching Hospitals NHS Trust newsletter
1/3/2008	St James's University Hospital Eye Clinic staff and JS complete 137 miles (static) bike ride, raising £400 for Yorkshire eye research	Publicity/fundraising – involvement in sponsored bike ride for Yorkshire Eye Clinic	
27/8/2008	Build a statue to honour Jimmy	Publicity – statue requested of JS to be constructed in Roundhay Park for his fundraising and volunteering services	*Yorkshire Evening Post* online article
29/8/2008	Trophy moment as junior doctor wins Sir Jimmy's award	Publicity – JS presents the Sir Jimmy Savile Trophy to junior doctor	
30/8/2008	Infirmary medic wins Sir Jimmy Savile award	Publicity – JS presents the Sir Jimmy Savile Trophy to junior doctor	

Publicity and the Leeds Teaching Hospitals (and predecessor organisations)			
Date	**Headline/description**	**Theme/brief**	**Press reference**
1/11/2008	Sir JS Trophy awarded to best presentation at West Yorkshire Foundation Doctor presentation day	Publicity – presenting Sir JS Trophy at West Yorkshire Foundation day	Leeds Teaching Hospitals NHS Trust newsletter
3/7/2009	Sir Jimmy's award to junior doctors	Publicity – handing out prizes to junior doctors for the best research projects in West Yorkshire hospitals	*Yorkshire Evening Post* online article
1/9/2009	West Yorkshire Foundation School presentation at Infirmary	Publicity – presenting trophy at Infirmary	Leeds Teaching Hospitals NHS Trust newsletter
9/12/2010	Leeds students' thank you to Sir Jimmy	Publicity – students' thanks for funds donated to the Leeds Undergraduate Research Enterprise allowing them to take part in advanced research	*Yorkshire Evening Post* online article
1/10/2011	£50k personal donation research fellowship for care patient in Bexley Wing	Fundraising – donation from the Sir Jimmy Savile Charitable Trust	Leeds Teaching Hospitals NHS Trust newsletter
1/12/2011	Tribute to JS	Publicity – tribute to JS – donating vast sums over the years, some of which included: £50k to PET-CT scanner, West Yorkshire Foundation School trophy, campaign lead for creation of LIMIT suite in original home at Wellcome Wing, 137-mile bike ride for Yorkshire eye research, assisting in funding the first lithotriptor at the Infirmary, raising money for clean air enclosure operating tent at Chapel Allerton, delivering turkeys to stalls at Christmas, writing cheques for deserving departments, donating funds to buy presents and decorations for respiratory clinic, request to create a Savile institute (CVD and stroke research) for heart patients at the Infirmary announced at the time of funeral	

We were told how Savile was always pleased to attend the launch of a new hospital service, provided that the press were invited, and that he was happy to hand over cheques raised by other people for various causes in the hospital. His involvement in these events always guaranteed a photograph and free publicity. We heard examples of how he would sometimes attend events in the hospital, uninvited, where donations from fundraisers completely unconnected with him would be presented to hospital staff. He would take centre stage, present the cheque, have the photograph taken and then leave. The subsequent media coverage would invariably focus on Savile and his role, however peripheral, to the event.

> “Whenever there was some function going on, because they used to have bring and buy sales and raffles and all sorts, coffee mornings, and he always managed to turn up, and she always reckoned that somebody tipped him off… I think they used to just tolerate it… but he always managed to turn up with a photographer in tow.”
>
> Source: witness statement N261; employee, 1960s

In terms of local press coverage, a mutually beneficial relationship with the Trust developed over the years, with Savile taking centre stage to open, launch or promote services or campaigns, and even in recent times the Communications Department in the Trust continued to use him and his celebrity status in this way.

> “When we have invested in a new piece of equipment or opened a new unit, often we would get someone well known to come along and cut the ribbons and declare it open… So because Jimmy Savile was a local person and a well-known Leeds celebrity I would say he was possibly a default choice for people in Leeds”
>
> Source: witness statement N209; employee, 1990s to 2000s

Savile's local media profile was perceived to have benefits in raising the profile of the Infirmary in Leeds. Traditionally, health services in Leeds were structured in two halves, east and west: St James's Hospital and Seacroft Hospital in the east, and the Infirmary in the west. We were told that staff generally had an allegiance, sometimes fiercely held, to one side or the other. The older hospital, the Infirmary, had its roots in the city centre as the teaching hospital, and was closely aligned to the University. St James's had humbler origins as the hospital associated with the Victorian workhouse, but over the years had grown and also become a significant teaching hospital with many new building developments during the 1970s and 1980s. Also, during the 1980s, St James's developed a strongly positive profile as a consequence of the popular TV documentary *Jimmy's*. This was a documentary that told the stories of various patients and staff in the hospital, and was broadcast for a number of years. This added to the sense of rivalry and loyalty.

> “Anecdotally, a lot of the difference was in the attitude of the clinicians. I think the LGI clinicians considered themselves to be a superior breed to the St James's clinicians… to the extent that some LGI consultants were proud of the fact they had never set foot in St James's.”
>
> Source: witness statement N213; Martin Buckley, Chair 2003 to 2009

We were also told by senior clinicians that Savile was aware of this rivalry, and that his loyalty rested firmly with the Infirmary. His pursuit of publicity was seen by many as a positive asset for the Infirmary, and was perceived as a way of redressing any imbalance in public and staff perceptions of the two hospitals.

> “Consultants, when I was a junior doctor, were very proud to be working at the Infirmary. St James's Hospital was the workhouse… and they did not like the idea of seeing new buildings going up and kudos being taken away from this place [Infirmary]. So Jimmy Savile was very much a leverage tool, who provided a lot of support for that particular aspect of the politics, and I think they would have allowed him to do anything because he did so much to redress that balance.”
>
> Source: witness statement N11; employee, 1970s to 2000s

In the 1980s and early 1990s, Savile spent far less time in Leeds as his attention moved to the development of the Spinal Injuries Unit at Stoke Mandeville Hospital, and subsequently to Broadmoor Hospital. His TV and radio commitments meant that more time was spent in London and the South East than during the previous decades. However, he occasionally would appear and re-engage with his role as porter, or present cheques to various good causes in the hospital or the city. He also engaged in a small number of local campaigns.

> “Due to the successes of the Security Awareness weeks that have been held in previous years, it was decided to hold a Security/Fire Prevention Road Show. This was launched by Sir James Savile OBE on 17 July 1995 and visited all Trust sites.”
>
> Source: Trust Board minutes, 17 October 1995

Savile used the Infirmary as a base for much of his fundraising and publicity-generating activity, whether for causes in Leeds, Stoke Mandeville or national charities. This is examined further in chapter five.

Later years

By the late 1990s, Savile had developed a serious heart condition. In 1997, he was admitted to Killingbeck Hospital in Leeds for cardiac surgery under the care of cardiologists Professors Alistair Hall and Mohan Sivananthan and surgeon Professor Kevin Watterson. The surgery was a success and he made a good recovery (source: YEP 169; 9/8/97).

Periodically he would still visit the Infirmary and talk to staff and patients. Although his celebrity profile was waning compared with the heights of the 1970s, his eccentric appearance made him instantly recognisable, especially to older members of the public, patients and staff.

During the last 10 years of his life, Savile was in failing health and visited the Infirmary infrequently. This was usually connected with presenting cheques for certain initiatives, or attending launch events for new services.

He maintained a close relationship with both Alistair Hall and Mohan Sivananthan from after his surgery in 1997 until his death in 2011, and the three regularly met socially (source: witness statements N69; N63; N179).

Savile died in October 2011, and the Trust and Leeds as a city mourned his passing. His body lay ‘in state’ at the city's Queens Hotel before being taken in an elaborate cortege around the city centre, including passing the Infirmary, where porters lined up in a quasi guard of honour.

Reactions to the revelations about abusive behaviour

The broadcast of the *Exposure* documentary 'The Other Side of Jimmy Savile' in October 2012 painted a picture of Savile as a serial predatory sexual offender, and a paedophile. The extent of the revelations and the depths of depravity in Savile's behaviour reported by victims in the ensuing weeks were shocking to most people. This included the Trust Board and staff, volunteers and patients across the hospital.

Even though in his later years he had become less relevant to the leadership of the organisation, his association with the Trust in general, and the Infirmary in particular, was common knowledge. Responses to the revelations were emotional and included shock, hurt, disbelief, anger and disgust.

> "My personal knowledge of him is not reconciled to some of the more serious allegations of sexual abuse and things that are being made. That is not the man I met."
>
> Source: witness statement N48; employee, 1990s to 2000s

> "In the early days of the helpline we had the staff phone calls coming through to me and those were, you don't have to hear very many, or even more than one, to hear they were fairly gruesome… It's shocking. It's awful. Just not what you expect anywhere, never mind a hospital where people are supposed to be safe."
>
> Source: witness statement N239; Ruth Holt, staff nurse 1980s, later Director of Nursing, 2006 to 2012

> "I felt sorry for the victims. Sorry in two ways; firstly that it had happened and the second was that they either felt they couldn't speak out or if they did speak out that nothing was done. So those people… were failed; I mean outrageously failed by Jimmy Savile, but in a way failed by the whole system and whole culture which didn't seem to recognise the problem or fail[ed] to deal with the problem when it had recognised it. So it's a sort of sad day all round…"
>
> Source: witness statement N220; Hugo Mascie-Taylor, medical student in Leeds, 1969–74, junior doctor 1975–86 in Leeds and elsewhere, consultant St James's Hospital, Leeds, 1986, Medical Director, 1998 to 2008

> "I was surprised, I was surprised. I mean I was very surprised really. Probably the age thing surprised me… I thought he was gay, so who am I to judge, but I could see knowing the era that with a 15-year-old or 16-year-old who was out with a celebrity… but the ten-year-olds and things, that really surprised me."
>
> Source: witness statement N179; clinician, 1990s to 2000s

> “People were saying, kind of, you know, ‘he’s not a bad bloke is Jimmy, you know and I’ve known him for a few years’. For that to come out, were just, phew! And after doing the guard of honour, it was a massive kick in the teeth.”
>
> Source: witness statement N296; former employee, mid-1980s to 2000s

> “Sad. I am a Leeds person through and through. I am very reflective. I am getting emotional about it. I am very reflective about retiring and it is sad that this is a blot on the Infirmary.”
>
> Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973–79, junior doctor to 1987 then consultant, Medical Director, 2009 to 2013

Conclusion

This chapter has described the nature of the 50-year relationship between Savile and the Infirmary and, in particular, his initial entry to the organisation as a volunteer porter and subsequent approval from the Board of Governors. This welcome and endorsement set the tone for continued and unchallenged access across the hospital for decades.

Mixed views were expressed about his reputation, ranging from those convinced of his positive motivations to raise funds for those less fortunate, to those wary of his seemingly constant presence and the disruption that his presence on wards and patient areas seemed to cause for hospital systems and processes. In particular, concerns were expressed about his contact with female staff members. Many were also indifferent to his work in the hospital, to the extent of his access and influence there and to the potential risks he posed.

A review of local press articles (table 4.1) on Savile and the Infirmary demonstrates his considerable success in attracting positive coverage, with a sustained media profile in Leeds that endured throughout his years of association with the Infirmary.

The revelations about Savile in 2012 came as a shock to many in the Infirmary. As more information has been disclosed through the media over the subsequent months, even those initially reluctant to accept the allegations have begun to realise what kind of man Savile really was, and the impact he had on their organisation and the people who use it and work in it.

5 Fundraising

5 Fundraising

Chapter summary:

- Savile's involvement as a fundraiser at the Infirmary (and its associated hospitals), and subsequently Leeds Teaching Hospitals NHS Trust, started in the late 1960s, by which time he was already established as a volunteer porter.
- He was involved in a number of major projects and numerous minor fundraising activities.
- He used the Infirmary as a base to receive charitable funds for other hospitals outside Leeds, notably Stoke Mandeville Hospital.
- Frustrated by NHS bureaucracy, he would on occasions try to circumvent good governance processes to secure funds or equipment.
- Whilst current arrangements for the governance of charitable funds have been found to be comprehensive, the circumstances surrounding a reported 'Savile bequest' to create a Leeds Heart Institute have been examined and indicate that the reports of the bequest were not founded in fact, and that adequate checks were not made before this was communicated more widely.

Introduction

This chapter examines Savile's role as a fundraiser for services at the Infirmary, and also how he used his position there for other fundraising activities.

We will explore:

- the ways in which Savile raised funds, and the projects and clinical areas he supported;
- from the evidence available, the amount of funds donated, raised or associated with him during his time at the Infirmary (1960 to 2011); and
- whether fundraising and charitable funding at Leeds Teaching Hospitals NHS Trust had, and continues to have, appropriate governance and management arrangements.

We have taken a broad view of fundraising, and in looking at Savile as a fundraiser we have also considered his role in brokering funding from third party organisations and in the provision of advice to medical and other staff about how to attract funds for particular projects. Details of all press articles referred to in this chapter are included in appendix four.

Context

Since 1767, when it raised £442 in subscriptions (Anning, 1963), the Infirmary has accumulated large deposits of charitable funds from legacies, bequests and donations. These have included property, works of art, furniture, jewellery and cash. Today the Leeds Teaching Hospitals NHS Trust holds the majority of its charitable funding in a single trust named the Leeds Teaching Hospitals Charitable Trust, which is registered as a charity (no. 1075308) and is therefore governed by the rules of the Charities Act 2011.

Within this overarching Charitable Trust are a number of separate funds, each with its own purpose. Since 1969, there has existed a fund under Savile's name, which has only ever held a modest balance of a few thousand pounds and today has a balance of £5,000. This fund, originally named the Jimmy Savile Marathon Fund, became the Jimmy Savile Infirmary Fund in 1973 and has remained as such ever since.

When the two former Leeds trusts were merged in 1998 to form Leeds Teaching Hospitals NHS Trust, there existed four separate charities covering the Infirmary, St James's Hospital, Seacroft Hospital and the former Killingbeck Hospital. These arrangements had the potential to be administratively complex and so, with advice from the Department of Health, these charities were dis-established and re-established as a single charity using the powers available to the Secretary of State under section 11 of the NHS Community Care Act 1990.

The standing orders (rules of operation) for the Charitable Trust state that it is overseen by a board of up to seven trustees, appointed by the Secretary of State for Health. This includes representation from the Hospital Trust Board and the local commissioners of healthcare, plus a number of paid officers led by the Secretary to the Trustees. The Charitable Trust covers the staffing costs from its resources, but all of those employed are on the payroll of the Hospital Trust and are therefore subject to its policies and procedures.

The Trustees meet on a regular basis (at least four times a year) to make funding and investment decisions, working to the mission statement, aims, objectives and standing orders of the charity (these are available by contacting fundraising@leedsth.nhs.uk).

As well as the Charitable Trust, there are a number of other independent charities associated with services provided by the Hospital Trust but which are independent of it and have their own trustees and terms of reference, such as the Renal Patients' Association and the Children's Heart Surgery Fund.

The nature and origins of Savile's fundraising at Leeds

Since the late 1960s, the name of Jimmy Savile has been associated with charitable fundraising, in addition to the celebrity status he gained as a disc jockey and broadcaster. Savile's first forays into fundraising at the Infirmary appear, unsurprisingly, to have been associated with the hospital broadcasting service, which he is known to have supported with advice and expertise in the 1960s (source: *On Air* – hospital radio magazine – Issue 100, September/October 2004). He also, as a number of press reports show, facilitated access to some of the top popular music acts of the day, including Petula Clark and Englebert Humperdinck, who performed at the Infirmary or gave interviews for the hospital radio (source: YEP 5; 9/6/69).

Savile's upbringing gave him a background in charitable giving and fundraising. He was inspired, in particular, by his mother, who raised money for a convent close to the family home (Bellamy, 2012). This possibly made him receptive to the worthy causes that presented themselves to him as he went around the hospital.

Following his support for the hospital radio, the next project that Savile took on, in 1969, was to champion the renal dialysis service at the hospital. This work seems to have established a particular methodology for his fundraising, which he repeated many times over the years. For this reason, it is worthwhile outlining a little of its detail.

The renal dialysis service supported patients with kidney failure, who often required treatment three or four times a week. At the time, like many other services at the Infirmary, it was under pressure, with a lack of facilities, equipment and staff (source: YEP 159; 14/10/69). However, it possessed two hitherto unused artificial kidney machines but had no space to accommodate them. To put these life-saving machines into action required funding for building work (capital) and funding for staff (revenue). Savile became aware of the situation and felt it was a cause he could support. He could see the difficulties from the perspective of the renal patients (source: YEP 159; 14/10/69) and that there appeared to be an obvious solution by cutting through some of the bureaucracy that existed at the time.

An analysis of Savile's methodology shows it to be simple: identify and publicise the cause through the local media, undertake a fundraising event (he ran a marathon from Skipton to Leeds in November 1969) and ask the public to donate by way of sponsorship (source: YEP 164, 119, 159, 49, 4, 48, 141, 51, 31, 94, 95, 93, 53 and 107; 1969). He also engaged with the Infirmary's staff, including the physician in charge of the renal unit and the Board of Governors.

Savile's style of fundraising was successful by the standards of the day (he raised £7,000 for the renal dialysis service) and he used similar approaches many times, lending his name and celebrity status to 'worthy causes'. It also endorsed his credentials as a focus for fundraising at the Infirmary, leading the then Board Secretary, Arnold Tunstall, to write to a group of potential donors in 1971 to inform them:

> "that Jimmy Savile is available to receive donations on behalf of the Infirmary most Monday evenings."
>
> Source: letter from Board of Governors' Secretary, 7 November 1971

And again in 1973:

> "Jimmy Savile periodically 'officially receives' donations towards Infirmary research funds, and I would suggest that your [Girl] Guides come along to the Infirmary on the next occasion when Jimmy is receiving money."
>
> Source: letter from Board of Governors' Secretary, 8 January 1973

We were told that Savile used the Infirmary boardroom on Saturday mornings to receive donations. Many of the press cuttings from the time confirm this, with some of the published photographs showing him receiving funds in locations around the hospital (source: YEP 119, 14/8/69; YEP 165, 19/4/79; YEP 148, 6/1/81). This began to cement Savile's reputation as a celebrity fundraiser in the public's mind and presented him with numerous opportunities for coverage in local and national newspapers and on TV. The 1969 Skipton to Leeds marathon was a prime example, with many articles published before and after the event including how he still attended for his volunteer portering duties after the run (source: YEP 17; 1970). This episode paved the way for Savile to become known as a charity fundraising celebrity associated with the Infirmary, going on to receive decades of highly positive media coverage. The Infirmary had the services of a unique fundraising presence operating in a totally new way, actively supporting causes rather than passively receiving funds from donations, bequests or legacies. This mutually beneficial relationship endured for the next 40 years.

Table 5.1 shows a chronological record of Savile's fundraising activities at the Trust and predecessor organisations. It was compiled from fundraising records and is supported by press cuttings of the time. It is unlikely to be a complete catalogue of his fundraising, owing to the long-standing national requirement to keep NHS finance and charitable records for a maximum of eight and six years respectively (NHS Business Services Authority, 2011). Mostly, funds were raised by the public at large and held within a charity external to the Infirmary called the Jimmy Savile Charitable Trust (charity no. 326970) which, as the records we hold show, has only ever been used to fund items of relatively low value over several years, including TV sets, computers and similar items.

Table 5.1: Record of Savile's fundraising

Year	Descriptor	Source	Amount
1968	JS personal donation for hospital broadcasting	Leeds General Infirmary Yearbook	£50*
1968	200,000 Green Shield Stamps from purchase of Rolls-Royce bought two turntables for hospital broadcasting	YEP 136 Trustee minutes	£509*
1969	Marathon to raise money for the Renal Dialysis Unit and invited donations – funds raised went into JS Marathon Fund, a separate fund within the then Leeds General Infirmary Trust funds	YEP 4; 31; 48; 51; 52; 53; 93; and 10 others Trustee minutes	£7,000**
1973	JS Infirmary Fund (created from public donations following closure of the above) funds a student nurse to attend the International Congress of Nurses in Mexico	YEP 6 Trustee minutes	£350**
1973	JS Infirmary Fund purchases four portable TV sets for wards	Trustee minutes	Unknown value**
1974	JS Infirmary Fund purchases an electric organ for patient entertainment functions	Trustee minutes	£536**
1979	Marathon raises funding for children's play area at the Infirmary	YEP 7	£4,000**
1980	JS asks Leeds Junior Chamber of Commerce to raise funds to refurbish rose garden at the Infirmary	YEP 166	£20,000***
1988	JS launches funding appeal for lithotriptor	YEP 135 Trustee minutes	£600,000***
1990	JS personal donation towards Have a Heart appeal at the Infirmary and Killingbeck Hospital	YEP 20	£5,000*
1991	JS personal donation towards a blood and fluid warmer at Infirmary	YEP 66	£500*
1993	JS helps raise funding for Leeds Institute for Minimally Invasive Therapy (LIMIT) suite	YEP 68 Board minutes	£330,000***
1993	JS Urological Equipment Fund buys camera and imaging software	Trustee minutes	£20,000**
1995	Donation (probably from external JS charity) helps to fund cytology training system	YEP 111 Trustee minutes	£6,500**

Year	Descriptor	Source	Amount
1995	Donation (probably from an external JS charity) helps to fund clean air theatre at Chapel Allerton Hospital	YEP 86	£20,000**
2000	JS helps to broker funding from British Heart Foundation for cardiac research MRI scanner (although all of the funding came from the BHF)	YEP archive	£2,000,000***
2002	Donation (probably from an external JS charity) helps to fund orthopaedic equipment at Chapel Allerton Hospital	Leeds Teaching Hospitals NHS Trust newsletter 2002	£16,000**
2002	JS Infirmary Fund buys computer for N Ward at Seacroft Hospital	Fund records	£860**
2004	Donation towards travel costs to support Overseas Partnering and Training Initiative (OPTIN)	Leeds Teaching Hospitals NHS Trust newsletter 2004	£2,200**
2007	Donation from the Sir Jimmy Savile Charitable Trust funds Foundation Doctor Prize	Fund records	£1,500**
2007	JS part funds Leeds Undergraduate Research Enterprise (LURE) Donation from Sir Jimmy Savile Charitable Trust	Witness statement N52	£300,000**
2009	Donation from Sir Jimmy Savile Charitable Trust for 'the Savile Fellowship in Positron Emission Tomography/CT Research'	Trustee letter	£50,000**

Key

JS = Jimmy Savile

Items shown with * and coloured blue are personal donations by JS

Items shown with ** and coloured pink are from public donations, either via the JS Infirmary Fund or other JS charity

Items shown with *** and coloured grey are JS-brokered funds from third parties, eg British Heart Foundation

Amounts shown are approximate in some cases but, overall, demonstrate that Savile was associated with approximately £3.5 million in funds raised over the years for the Infirmary.

Table 5.1 shows a gap in fundraising activity concerning the Infirmary between 1980 and 1988. This was when Savile was engaged primarily in fundraising activities for Stoke Mandeville Hospital, whose appeal was launched by him at the beginning of 1980 (source: YEP 10; 22/1/80). Even though Savile was fundraising for another hospital, a total of seven press cuttings from the *Yorkshire Evening Post* dating from 1981 to 1983 show or report him receiving funds for Stoke Mandeville Hospital at the Infirmary (source: YEP 136, 148, 150, 64, 23, 17, 170). One witness we spoke to also recalled Savile using the Infirmary boardroom on Saturday mornings to receive money from local children's groups, for example Cub Scouts, that was destined for Stoke Mandeville Hospital (source: witness statement N204; employee, 1970s). This demonstrates how Savile remained in the local limelight, and also indicates a lack of interference from the Infirmary Board of Governors at the time, as he used the facilities of the Infirmary to raise money for

another NHS hospital. One witness was asked if there was a managerial decision made with regard to whether Savile could use the Infirmary premises to receive funds for Stoke Mandeville Hospital. The reply was:

> "Yes. The house governor agreed that."
>
> Source: witness statement N20; employee, 1970s and 1980s

On the whole, Savile's major fundraising activities at the Infirmary did not involve depositing funds into the Jimmy Savile Infirmary Fund which, as available records show, has only ever maintained a modest balance of a few thousand pounds. Whether this was a deliberate ploy on Savile's part is unknown, but it does appear that he was frustrated by the slow processes of the Trustees of the Jimmy Savile Infirmary Fund, preferring to deposit funds in the Jimmy Savile Charitable Trust instead, as the following extract from the Infirmary Trustee minutes (4 September 1973) shows (these Trustee minutes relate to the Infirmary Charitable Trust, a predecessor body to the Charitable Trust):

> "Jimmy Savile Infirmary Fund.
>
> Consideration was given to a letter received from Mr Jimmy Savile stating that it took a long time to authorise expenditure from his Fund and asking if he could consult with the Hospital Secretary to authorise expenditure.
>
> It was decided that Mr Savile's request [to consult the Hospital Secretary] be approved, provided he had the authority of Mr Eric Hill, at present House Governor of the Infirmary."

And from 10 January 1979:

> "The Secretary reported that he had received a telephone call from Jimmy Savile asking whether it would be possible to transfer funds temporarily from his Infirmary Fund to Broadmoor Hospital. The request had not yet been confirmed in writing."

Whilst the outcome of the Broadmoor Hospital request was negative, the bypass of normal approval processes, which involved the whole body of Trustees who made their decisions at regular meetings, gives an indication that Savile was able to influence the Charitable Trustees to deviate from their normal procedures.

Major project funding at the Infirmary

Larger projects supported by Savile saw him both acting as a broker of funds and working as a fundraiser with other external agencies such as the local Chamber of Commerce or charities. In that role he had dealings not only with the hospital, including the hospital management and Charitable Trustees, but also with the British Heart Foundation, Yorkshire Television, and

equipment manufacturers and suppliers. Where Savile championed these schemes (the Lithotriptor appeal in 1988 and the LIMIT suite in 1992 – see below), the donated funds came from one of two externally held and independent Savile charities: the Jimmy Savile Charitable Trust (charity no. 326970) and the Jimmy Savile Stoke Mandeville Charitable Trust (charity no. 283127). However, there is no evidence that any funds from the latter came to Leeds.

It is our view that one of Savile's strengths as a fundraiser was his ability to think laterally when faced with a funding problem, perhaps sometimes shaming or challenging the NHS into matching the funds raised by himself or others, as with the Lithotriptor appeal in 1988. He had little tolerance of what he saw as overly bureaucratic NHS processes which, in fact, were in place to ensure probity and good governance. He also had a habit of placing conditions on his donations, and this made some less keen to work with him.

Below are brief descriptions of Savile's larger projects.

Discussions regarding Clarendon Wing, 1986

There was an ongoing management debate in the hospital in the mid-1980s to improve the facilities in the Clarendon Wing of the Infirmary. The possibility of Savile's involvement in fundraising for this was considered by the Leeds Western Health Authority Management Group, but not pursued.

> "Approximately £1m would be needed to refurbish each of the large areas in the Clarendon Wing. Mr Tinston [one of the General Managers] expressed some doubts about the whole question of moving departments and raising funds and felt that we should await the outcome of the review. The question of approaching Mr Jimmy Savile for his help was raised but this did not have wholehearted approval."
>
> Source: Leeds Western Health Authority District Management Group minutes, 6 October 1986

Lithotriptor appeal, 1988

Lithotripsy is a method of obliterating kidney stones by focusing a concentrated beam of sound waves on them, causing them to shatter and be expelled from the body. At the time of the appeal in the late 1980s, the Infirmary had to send patients elsewhere for this treatment, which was less than convenient and meant that resources went to other hospitals. The urologists at the Infirmary were very keen to have a lithotriptor of their own.

> "The proposed machine marked a major advance in treating patients with kidney stones. Mr XXX [a urologist] reported that Jimmy Savile was very keen to launch an appeal for this project and that the Special Trustees [Infirmary Charitable Trustees] had been approached and had agreed to donate £1 for every £1 raised in the public appeal."
>
> Source: Leeds Western Health Authority minutes, 15 March 1988

> “On Thursday last, when at LGI with Arnold Tunstall [Secretary to the Trustees at the time], we had a visit from Jimmy Savile. His reason was to make us aware of his wish to launch an appeal for half a million pounds to purchase for the Urology Department a lithotriptor. Jimmy maintains that apart from the value of the apparatus to the Department, such an appeal would be of value in restoring the prestige of LGI which he maintains is at least tarnished (regrettably I feel I have to agree with his opinion).”
>
> Source: letter from LGI Charitable Trustee, 22 February 1988

Magnetic Resonance Imaging Scanner (MRI) appeal, 1992

(This appeal does not appear in table 5.1 as Savile did not eventually provide funds.)

In the early 1990s, the Infirmary was in need of a newly developed type of scanner, magnetic resonance imaging, to provide improved diagnostic services to patients. It launched a local appeal to raise the money for one or more of these expensive machines.

The debate played out below shows that Savile was willing to negotiate a discount, but only if one specific manufacturer was engaged. This would have been contrary to applicable procurement rules, which required a tendering process, and from the discussion would not have met the requirements of the consultant radiologists who would operate it.

> “The detail of a major contribution to the MRI appeal by which Sir James Savile has offered to fund one of the machines was explained to the Board. It was noted that this would be a major contribution to the success of the appeal. The conditions imposed by Sir James were not, at this stage, felt to be restrictive.
>
> The Chairman mentioned that Sir James Savile might be able to obtain a substantial grant towards the Appeal if certain Japanese equipment was obtained. It was understood that the Consultants concerned were not enthusiastic about this offer.”
>
> Source: LGI Charitable Trustee minutes, 27 August 1992

> “The funding had reached a level at which the first machine could be bought subject to negotiations on the price. Sir James Savile’s offer would probably not be taken up because of the quality of the machine’s imaging and problems with its magnetic field. Tenders would be organised very shortly and the machine would be operational by the end of May 1993.”
>
> Source: United Leeds Teaching Hospitals Board minutes, 10 November 1992

Leeds Institute for Minimally Invasive Therapy (LIMIT) suite, 1992

This facility was created on the sixth floor of the Wellcome Wing at the Infirmary to facilitate the training of surgeons in 'keyhole surgery' techniques. It had closed circuit TV and computer links with operating and lecture theatres at both the Infirmary and other hospital sites, and housed a purpose-built office base for Savile.

> "The development of a Minimally Invasive Surgery Centre in part of the 6th floor Wellcome Wing.
>
> It was noted that Sir James Savile had agreed to fund half of the cost [£165k] and would use his good offices to reduce the building costs. The balance between the estimated building costs and the actual building costs would be spent on equipment for minimally invasive surgery. It was also noted that the principles behind this should be examined on subsequent occasions."
>
> Source: United Leeds Teaching Hospitals Board minutes, 8 September 1992

A former Medical Director told us:

> "One of his [Savile's] insidious things was that to give money he always wanted something and the thing he wanted most at the Infirmary was an office."
>
> Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973 to 1979, junior doctor to 1987 then consultant, Medical Director, 2009 to 2013

This was Savile's first allocated office in the Infirmary and our belief is that it appears to have become part of the design for the LIMIT suite because he was a major donor to the scheme. Following the closure of the Wellcome Wing building in the mid-2000s, he was moved to another office in the older part of the Infirmary. This matter is examined further in chapter six.

Leeds Undergraduate Research Enterprise (LURE), 2007

The final major project with Savile's involvement was one hosted by Leeds University Medical School to support and fund the research interests of undergraduate medical students. With others, Savile was a major donor to this project, which is still providing scholarships today. Up to £300,000 was donated from his external charity, the Jimmy Savile Charitable Trust.

As a witness told us:

> “The scholarships are about £12,000 each. He [Savile] has funded different numbers in different years. I think the first he funded either five or six and he did that on an ad hoc basis for two or three years. Then he committed £300,000 to the programme and we just drew it down year on year so in the end we did not actually claim the full amount that he had pledged. But he funded it over six, seven years. [Q. What was the source of that money, do you know?] A. It came from his Charitable Trust. [Q. His own Charitable Trust?] A. Yes.”
>
> Source: witness statement N52; University of Leeds employee, 2000s

The Leeds Heart Institute

An issue that has come to light during the course of the investigation is the possibility of establishing a Heart Institute based in Leeds funded by a legacy from Savile's estate. The first mention of this publicly came as part of the eulogy delivered at Savile's funeral service by Professor Alistair Hall (cardiologist) on 9 November 2011. It was also reported on the same day by local BBC news (*BBC News Leeds and West Yorkshire*, 9 November 2011).

No such bequest has materialised. We therefore sought to further clarify the origins of the Heart Institute story, and the governance process that underpinned its announcement.

The potential bequest was also reported within the Trust in the organisation's 'Team Brief' for November 2011 as follows:

> “On the day of Sir Jimmy Savile's funeral in Leeds it was announced that a generous bequest from his estate will be used to create The Savile Institute at Leeds General Infirmary, devoted to improving outcomes for heart patients across Yorkshire.”

The announcement also featured in the Leeds Teaching Hospitals NHS Trust's staff newsletter for December 2011/January 2012. There are conflicting reports about whether or not the apparent bequest had been verbally reported to the Trust Chairman and Chief Executive before it was included in the eulogy delivered by Professor Hall. We found no evidence that it had been discussed formally by the Trust Board.

Karl Milner, former Director of External Affairs and Communications, told us:

> "The nature would have been this is the bequest, this is what is being sought, have we got a problem with that. Because I can't make that decision, can I? So, you know, it's unrealistic to think that I was going to make a decision like that on my own, and that's not what I did. So, you know, so I referred that to the Chair and to the Chief Executive. Whether that then went to the whole Board, at that point, I'm not sure. You'd need to check the minutes."
>
> Source: witness statement N77; Karl Milner, Director of External Affairs and Communications, 2010 to 2014

We were told by the then Chairman, Mike Collier, that he had only been made aware of the alleged bequest on the day of the funeral. He told us that, owing to the extensive publicity following this announcement, there was an oral report to the next Board meeting and that the Chief Executive had instructed Karl Milner to identify more details and report back.

Savile's will makes no provision for such a bequest. We therefore thought its announcement was unusual in that it was not based on any evidence.

We were informed that in the period between Savile's death (29 October 2011) and his funeral (9 November 2011) a meeting took place between a small group of clinicians and Karl Milner, the then Director of External Affairs and Communications to discuss how best to maximise the chances of securing some of Savile's accumulated charitable funds to resource a Heart Institute in Leeds.

One witness who was present at this meeting told us:

> "We wanted money to come to cardiology, and we wanted money to come to Leeds… although this money was not allocated to any particular purpose, there was a sort of unwritten 'understanding'… Most of it, if not all of it, would be coming to LGI… It was sort of an innocent way of creating a need – and put sort of mild pressure on the Trustees to look at just – not just other possibilities but also cardiology, because he [Savile] was here quite a lot of the time."
>
> Source: witness statement N63; clinician, 1990s to 2000s

This was felt to be legitimate by the small group involved because it was understood from their personal knowledge of Savile that he would have wanted to support heart services in Leeds, and that the funds held in his charity (the Jimmy Savile Charitable Trust) had been given in good faith by the general population for good causes.

> "The poor women and the poor fundraisers who have given money to good causes, they are still good causes."
>
> Source: witness statement N63; clinician, 1990s to 2000s

Part of the plan to secure these funds for heart services in Leeds was for one of the cardiologists to produce a written specification identifying how £4–5 million of funds might be used.

> "I knew we needed a fibre cath lab. I knew we needed a kind of scanner for CT and nuclear scans, so I just put them together. Yes, I was asked to put something on paper in order for them [the Trust and the Trustees of the Jimmy Savile Charitable Trust] to have something."
>
> Source: witness statement N63; clinician, 1990s to 2000s

Following the initial proposal, a meeting to discuss it took place with clinicians from the Trust and two of the Trustees of the Jimmy Savile Charitable Trust.

To date, none of this charitable funding has been secured for a Heart Institute but a lesser amount of approximately £200,000 has been donated for ongoing cardiac research.

One witness has reported to us that Savile, on more than one occasion, talked about a major donation to heart services in Leeds, so it is understandable that after his death there was a desire to make this a reality.

> "As I say it was only a high level discussion but not in a, there was no firm kind of proposal discussed at that meeting although that concept of a heart institution, if you like, for the research – as you say there were different types of descriptions of it – was the subject of the conversation that [the cardiologists] had had with Jim over the years."
>
> Source: witness statement N48; former senior manager, 2000s

It appears that no due diligence was undertaken to establish that Savile had bequeathed funds for a Heart Institute in Leeds prior to the public announcement being made. The announcement of the supposed bequest, whether at the funeral or during subsequent communications, may therefore be discounted as wishful thinking.

Commentary

We considered the extent to which any special access or privileges, or lack of supervision and oversight, resulted from Jimmy Savile's celebrity status or fundraising role within the organisation.

Our impression is that, overall, Savile's fundraising role and celebrity status did lead to an unusual degree of both access and influence (examined further in chapter six). We have also identified that his celebrity status and pursuit of publicity combined with his record of fundraising (together with his personal style and connections) are likely to have given Savile greater longevity within the Infirmary and greater access and influence than either of these factors alone might have done.

From our investigation of Savile's activities, we discovered that there were seven victims (three of whom were in other hospitals in West Yorkshire) who encountered him at, or in proximity to, what could be described as a fundraising or charitable event (see chapter seven). It is our conclusion that his attendance at these events, some of which he was invited to and others where he attended uninvited, afforded him the opportunity to abuse people.

We have considered the question of what motivated Savile to engage in fundraising at the Infirmary. Our conclusion is that, looking at the extent of his fundraising at the Infirmary, it seems that his motives might not just have been a cynical creation of a smokescreen to conceal his intentions to abuse but that he may also have had a genuine desire to improve services for some patients. He also appeared to enjoy the debate with senior staff and doctors, and the power, influence and status that this gave him with them.

> "I thought, thought he was very intriguing. I thought there was a lot more – my impression was there was a lot more to the man than people saw."
>
> Source: witness statement N51; clinician, 2000s

Two examples that are cited in table 5.1 – his involvement in the funding of the cardiac research MRI scanner in 2000 and his involvement with the Overseas Partnering and Training Initiative in 2004 – allowed him to form friendly relationships with a number of medical consultants, some of which endured until his death in 2011.

Some observers have reported that what he did and how he did it usually involved the expectation of a payback for him personally. An illustration of this is his contribution to the funding of the LIMIT suite, where he secured an office for himself.

As an outsider to the NHS, Savile's streetwise pragmatism with regard to 'cutting through red tape' made some managers and non-executive directors understandably nervous because, on occasion, his methods were outside procurement rules. For example he would approach suppliers of equipment directly to secure discounted rates rather than via the prescribed tendering processes. Operating outside the system, he was able to alter the priority-setting and decision-making processes concerning fundraising within the hospital. The reality was that some things happened because he sponsored them, not because they were the most worthy or important projects, or a priority for the hospital or its commissioners. Some consultant medical staff did recognise that Savile might be able to help to access funding for some projects (Lithotriptor, LIMIT suite, LURE) where no other funding was available, so they approached him directly.

We have considered the measures in place today to both prevent a potential fundraiser or donor gaining a similar foothold in the organisation and to ensure that charitable funds and donations are channelled in appropriate ways for patient benefit. This latter issue includes how the guardians of charitable funds (the Trustees) work with the management of the organisation and the Trust Board to understand its priorities.

Conclusion

The Charitable Trust provides the vehicle by which to manage donated funds and as a registered charity is subject to the rules and scrutiny provided for in the Charities Act 2011; its Trustees are appointees of the Secretary of State and as such are subject to the Nolan Principles.

We have been told that the different priorities of the Charitable Trust (or its predecessors) and the Trust have caused confusion and may have delayed funding decisions. This relationship requires constant examination and attention, with mutually agreed priorities that reflect the needs of the patients of the Trust and the requirements of the local and regional commissioners of healthcare. Recognising that issue, former Trust Chairs have been members of the Board of the Charitable Trust since before Savile died.

The popular view of Savile that existed before news of his sexual assaults came to light was of a prolific fundraiser for charitable causes. Our investigation into his fundraising shows that whilst he did contribute a small portion of his personal wealth to health projects and services, the vast majority of funds with which he was associated came from public donations into one of the 'Savile' charities. He also provided a focus and figurehead for a number of projects and gave advice to others.

Savile's full motives for his fundraising activities will never be known, but many of those interviewed had always felt that chief among them was a quest to self-publicise. We now know that, on occasion, it also gave him opportunities to abuse.

6 Access and influence

6 Access and influence

Chapter summary:

- From the 1960s to the 1990s, Savile wielded a high degree of influence, well beyond the scope of any of his individual roles as a volunteer porter, fundraiser, donor or celebrity.
- He enjoyed unique access to wards and departments in his role as a voluntary porter, as a celebrity and as a fundraiser.
- He was rarely questioned about his level of access.
- Weak internal controls up to the early 2000s in the hospital's support services contributed to Savile having unrestricted access to patient care areas.
- He developed a number of significant relationships with people at the Infirmary.
- He utilised facilities and staff resources in inappropriate ways.

Introduction

In considering Savile's access to, and influence within, the Infirmary we focus on seven key themes. From our investigation, we believe these matters were significant in influencing his unique level of access within the organisation. We are aware that Savile was present in many areas of the hospital, but concentrate here on the matters which have featured consistently during the investigation. They are:

- Savile's role as a porter;
- unrestricted access;
- security at the hospital;
- access to the mortuary;
- offices and other privileges;
- celebrity; and
- significant relationships at the Infirmary.

Savile's role as a porter

Porters play a vital role in the smooth running of a hospital. Over each 24-hour period, they move patients to and from wards and departments, transport equipment, specimens and furniture, and transfer deceased patients to the mortuary. A hospital could not function without porters. The Trust today employs 270 porters (source: e-mail from LTHT Estates and Facilities Department, 14 January 2014). In the course of their work, porters will come across many people rendered vulnerable by their age, medical or mental condition.

Savile's voluntary portering was officially endorsed in 1968 by the Board of Governors as part of the I'm Backing Britain campaign of that year, but there is evidence that he was undertaking the role informally before that date:

> “I started in the Trust in 1961 so I was there throughout the sixties. I'm not sure what times Jimmy Savile would have started working in the Trust, but from my point of view he was just there in the background portering, so he was a familiar figure portering… It wouldn't have been my first year [witness saw Savile portering] because my first year was 1961, so it would have been '62, '63, something like that.”
>
> Source: witness statement N62; employee, 1960s to 2013

Savile had a long association with the porters at the Infirmary, with accounts of him undertaking portering duties from the 1960s through to the 1990s. Many we spoke to described Savile wearing the distinctive white coat that porters wore during the early part of his association with the Infirmary. Some spoke about his porter's jacket being customised with his name embroidered on the pocket. He mainly connected with the porters in the Accident and Emergency (A&E) and X-ray departments, areas that would have given him wide access to many wards and departments.

We heard how the culture in portering services had allowed the development of customs and practices that remained in place over a period of some 40 years until the early 2000s.

There are accounts from the portering staff that suggest that, up until the 2000s, internal controls, for example processes relating to recruitment and selection, training and induction, sickness absence and line management, were inadequate:

> “Well, I can only go on my experience but it's usually somebody you know. You used to get, you know, it was people that knew you. XXX lived across the road from me he knew my dad, my mum and dad, right, so I got the job through that really, you know what I mean.”
>
> Source: witness statement N160; employee, early 1980s to present, referring to the early 1980s

> “I don't remember doing any training for the first 20 years at least.”
>
> Source: witness statement N160; employee, early 1980s to present

> “Basically you just shadowed somebody for… probably two weeks… and then you just picked it up. There were no sort of induction, you know… you just shadowed somebody and then you just got hang of it and then you were left to your own devices.”
>
> Source: witness statement N182; employee, mid-1980s to present, referring to the 1980s

> “Saying that, they're very slack here… you got your wage but we hadn't got no contract of employment, nothing at all… they had people coming and going as they wanted… He [the supervisor] tried his best but he just sat in the office all day long. He gave me a rota sheet 'This is what you're working next week.' No, it was very, very slack.”
>
> Source: witness statement N216; employee, late 1980s to early 2010s, referring to the 1980s

There are also accounts relating to the lack of day-to-day management of porters within the organisation into the 1990s. However, in 1969, the Department of Health and Social Security had issued a report on portering services recognising the need for good management, skill and expertise in relation to those services (DHSS, 1969). We have not heard any witness evidence to suggest that this guidance was followed, although there will no doubt have been examples of good and diligent portering practice. Overall, it would appear that portering services operated within what effectively was an uncontrolled and unregulated environment for a long period of time. It is within this environment that Savile worked as a volunteer porter:

> “We used to drink on night shifts, we used to drink. We did play darts. Couldn't play pool 'cos we didn't have a pool table, but we played cards for money. And we played dominoes for money and we used to drink.”
>
> Source: witness statement N76; employee, early 1980s to present, referring to the 1980s

> “We'd bring girls in [to the porters' lodge], you know, on a night out, they'd go back t' nurses' home, I'd bring my girl in, 'How you doing lads?'”
>
> Source: witness statement N76; employee, early 1980s to present, talking about portering services in the 1980s and 1990s

> “I've never left site on nights. For a drink. When I were in [general portering] there were a bit of a culture, you know, with my pals for an hour in the afternoon on a weekend… it depended who were on, because we played a lot of dominoes and cards as well. But you know, if it were a case – you would sort of do your work and then probably – on a one-night shift probably from about three o'clock 'til five 'til dinner wagons come across, or we went over to get them, there were no harm in it, so it were a case of we went for a couple of pints, come back and then get stuck into the dinner wagons, and then the rest of your duties.”
>
> Source: witness statement N182; employee, mid-1980s to present, talking about portering services in the 1980s and 1990s

> “I could say it myself that porters would go out for a few beers. I've done it myself. I've come back to the hospital in them days, had a few too many or a few sherbets, and there used to be a room down in outpatients, 12A, with a big reclining chair in it and a bed. And if we're on an early shift especially, we'd go in there and sleep it off… And supervisors or managers knew about it. You know, you'd say to security 'one of the lads is in there getting their head down.' Fine, no problem.”

Source: witness statement N296; employee, mid-1980s to late 2000s, talking about portering services in the 1980s and 1990s

> “I'll be honest with you, they were drinking as well. You know, I mean, they didn't get drunk. We had a couple of tins of beer; we had a fridge full of beer and spirits and what-have-you… it were more like a bleedin' nightclub. Clarendon Wing was even worse. The consultants used to come over with 12 bottles of whisky in a box. They'd put it on the table, 'help yourself'. You know, we used to – you know, marvellous but the job always had a happy atmosphere 'til some bright spark started complaining that we were all – anyway – all that stopped.”

Source: witness statement N216; employee, late 1980s to early 2010s, talking about portering in the 1990s

There has been a process of modernisation in portering services since the 2000s that has made significant progress in addressing this environment (see chapter nine).

We heard that Savile was not universally popular amongst the porters, but we found that he was in the main accepted by them. Many spoke about him ingratiating himself, for example, by providing televisions and microwaves for the porters' lodge (source: witness statements N110; N103; N203; N182; N61). In frequenting the porters' lodge, having a cup of tea and sharing jokes with the porters, Savile undoubtedly normalised his presence amongst this group. He became to some extent part of their everyday life at the Infirmary. We heard that he could be engaging company and many of the porters found him to be down to earth and approachable.

We conducted 18 interviews with current and ex-porters who were contemporaries of Savile. They expressed mixed views about him: some enjoyed their interaction with him and saw him as 'one of the lads' and a useful colleague. Others were more circumspect or were unsure about how they felt about him. Many spoke about his ability to pick and choose the portering duties he undertook, a privilege that would have enabled him to control which areas of the hospital and which patients he had access to:

> “He came to do portering duties, the ones he wanted to do, he cherry-picked the jobs he wanted, and we came into contact quite regularly with him.”

Source: witness statement N110; employee, early 1980s to present, talking about the mid-1980s

> "With the A&E it were like an intercom and they'd intercom jobs, you know 'We've got a patient for Ward 7', and he'd go 'Ah, finish your tea, lads, I'll go do that'."
>
> Source: witness statement N182; employee, mid-1980s to present, talking about the mid-1980s

Savile at times picked jobs which would bring him into contact with the young and vulnerable. For example, we have been told that there would be a list of patient names on a board in the X-ray Department who needed to be taken either to or from X-ray and from this it was obvious who was male, female or younger or older (according to the wards they were being transported to or from).

> "They had a big whiteboard with all the wards on for patients and where they were going in X-ray, and he'd have a look at the board and nominate himself to go and do that job… the patient's name was on the board, and the ward, so if you were familiar with the hospital, even if it was just a surname, you'd know if it was a male or female ward."
>
> Source: witness statement N286; employee, mid-1980s to late 2000s, talking about the mid-1980s

> "He'd [Savile] just turn up, 'Right, what's on the board?' [on which there was a list of patients waiting for a porter], and he would go and get a patient, he would choose his own. That is how he did it, if a patient were ready to go it would save going back to the ward, and he would take his pick. Nobody questioned it."
>
> Source: witness statement N76; employee, mid-1980s to present, talking about the early 1990s

Opinion varied amongst the porters as to whether or not Savile worked solo as a voluntary porter. Some asserted that he would always be accompanied when moving patients and others told us that he worked alone and that they were happy to let him do so. Despite this divided opinion, we heard compelling accounts from many of his victims and others that Savile was unaccompanied when he worked as a porter. It is clear, based on evidence we heard, that on many occasions he worked unsupervised and unaccompanied as a porter at the hospital in a way that could not happen today with an equivalent celebrity. Thirteen of his victims who were patients at the time had abusive encounters with Savile when he was working alone as a porter.

Unrestricted access

It is evident from the porters' accounts that, despite some misgivings, Savile's presence was accepted, and he was able to move freely around the Infirmary at all hours of the day or night in the guise of a volunteer porter or as a celebrity:

> “He just used to turn up, you know. We'd be doing night shifts, just walk in to what we called the old back door which is the Martin Wing entrance, really. Sometimes he'd pop in during day, you know, just walk in, have a chat with lads. He, he used to get porters tellies basically, so that's probably why we welcomed him in… he would just sort of come in, do jobs – you know, during – when he were sort of – after midnight, early hours, following when he'd been doing 'is DJ-ing somewhere… I don't know if he were a law unto himself, but because of his celebrity status, he sort of basically had run of the place, you know.”

Source: witness statement N182; employee, mid-1980s to present, talking about portering in the 1980s

> “Let's say he'd finished in London or Manchester, wherever he was doing his radio and his television work. He would come back here. Actually Jimmy Savile lived half a mile away, just off Belle Vue Road, and the house is still standing where his mother lived and where he lived. But he would always drop in here [porters' lodge] for a cup of tea, even at night.”

Source: witness statement N11; employee, late 1960s to late 1990s, talking about portering in the 1970s and 1980s

> “I would see him all over hospital. Even places where you wouldn't have expected him… In passage-ways, down in basement.”

Source: witness statement N181; employee, late 1980s to mid-1990s, talking about portering in the late 1980s and 1990s

The view that Savile had unrestricted access in the Infirmary is shared by other groups of staff and patients, as illustrated by the following remarks (representing nurses, doctors, security staff and patients):

> “Jimmy Savile was around the hospital all the time. He just had free run of the place.”

Source: statement by Victim S; staff member, late 1960s

> “I wouldn't have thought it strange, he was, he had a passport to go anywhere, I mean, he would, because he was, he was instantly recognisable, nobody took it seriously.”

Source: witness statement N250; former employee, 1970s to 1990s, talking about the 1970s

> “Jimmy Savile… suddenly appeared from nowhere in the accident and emergency department… it was very strange because staff just went through the motions… But I was a bit in awe of him because he was a celebrity… I think the staff were really sort of quite indifferent really… it's just he had access to all areas.”
>
> Source: witness statement N208; employee, mid to late 1980s

> “He could go where he wanted, there were no questions asked, he could come in when he wanted, he had free access to everything.”
>
> Source: witness statement N110; employee, early 1980s to present, commenting on the 1980s and 1990s

> “You couldn't work at the Leeds General Infirmary without seeing him about.”
>
> Source: witness statement N116; employee, mid-1980s to mid-2000s, commenting on the 1980s and 1990s

Notwithstanding the lack of management controls in the portering service over many years, we heard that Savile had access to areas of the hospital and its services that would be highly unusual for any porter, especially a voluntary one. It is our view that this level of access was available to Savile on account of his celebrity status, rather than his role as a volunteer porter.

He would often make unannounced visits to wards and departments. His visits included the A&E resuscitation room, visiting wards to accompany clinical staff in ward rounds, and we had one report of him assisting a nurse in giving a child who was an in-patient, in intensive care, a bed bath:

> “What I do remember about him is that he would – when Jimmy Savile, when he would walk in [to A&E], he – he would make a beeline for the people that he knew were his allies – not 'allies' but he certainly got on well with some very senior people, so he would sort of walk in.”
>
> Source: witness statement N283; employee, early 1980s to mid-1990s, talking about the A&E Department in the 1980s

“Jimmy sat with us because he had come into the Casualty Department. I don't know whether he was there working but he was there in the resus room when this 15-year-old girl came in… She had been through a windscreen, badly cut, very bad hands and face lacerations and needed many hours of reconstructive surgery on many occasions… Jimmy was just sat there and he was holding her hand and every time she became extremely distressed or had difficulty answering questions, he would help. So I actually clerked her with him there.”

Source: witness statement N11; employee, early 1970s to present, talking about the late 1970s/early 1980s

“He was allowed free rein everywhere. When I worked in theatre he even came into theatre.”

Source: Victim S; talking about being a nurse in the early 1970s

“I had had a bad fall at home and fractured my spine and they said I wouldn't walk again so I was lying flat on boards, no pillows, and it was the second day I was in and Jimmy Savile came round. He was not on his own, he had nurses and doctors with him.”

Source: Victim C; early 1970s

“She [the nurse] said it was nice, when the ward was quiet in the middle of the night, all the patients were sleeping and not moving or were not calling for you, she said it was nice to have somebody [Savile] to come and have a chat.”

Source: witness statement N74; Bernard Atha, associated with LGI since late 1940s, first as an employee and latterly as a non-executive director and charity trustee

“As I say I were offered this bed bath [whilst on intensive care] and they came and they started. There were a nurse to me left hand side, Savile to me right side and they started washing me with a sponge and like a face cloth… He [Savile] offered the question, he said 'Do you want me to wash down there?', but he did it before, before I had a chance to answer.”

Source: Victim LL (male); mid-1980s

This was not the only report of him being present in intensive care:

> "There was a lady had been admitted and she was being ventilated because that was thought to, thought to be best for her condition. And whilst setting up this lady's ventilator and making sure that a tracheal tube was in the correct position, I was at the head end of her bed, and when I looked up, I saw Jimmy Savile at the foot of the bed, and I thought this was a bit strange, but there were other doctors that had come in with the admission and they didn't seem to be perturbed by this."
>
> Source: witness statement N238; clinician, early 1980s

A number of people we spoke to mentioned seeing Savile in the Infirmary at night: five in the 1960s, 10 in the 1970s, 17 in the 1980s and four in the 1990s.

Historically, caring for patients in hospital at night carries more risk than during the day, as there are fewer staff on duty and reduced availability of support services (for example, diagnostic services and senior medical staff). Savile's unrestricted access to the Infirmary, together with the capacity pressures at the hospital during the 1970s and 1980s (see chapter three), meant that it was difficult for staff to supervise him.

In the 1960s, 1970s and 1980s, it was common for student nurses to be left in charge of hospital wards at night, overseen by a night sister who would cover six or more wards. Two students and an auxiliary nurse would be expected to care for a full ward of 30 or more patients. Leeds General Infirmary was not unusual in this regard, as has been confirmed by the Director for the UK Centre for the History of Nursing and Midwifery:

> "Certainly it was absolutely normal for students to be left in charge of wards. There would be a ward, there would be a Night Sister who would come and do controlled drugs and whom you could turn to if there was an issue… but yes, certainly student nurses would have been in charge on nights. Even on a busy, sort of 30-bed medical ward it wasn't unknown."
>
> Source: witness statement N255; Dr Jane Brooks, Director, UK Centre for the History of Nursing and Midwifery

Some witnesses we spoke to recalled students being in charge of wards at night at the Infirmary:

> "Sometimes there would be a staff nurse on one of the wards [at night] but, often, it was just two students… It was – my second year, I remember being in charge of a paediatric ward of 35 children."
>
> Source: witness statement N174; talking about being a student nurse at the Infirmary in the late 1960s

> “But as a newly, no, as a third year student nurse – We were in charge – On nights. So it, was it short-staffed, yes. Because why were student nurses in charge on nights, you know. And, you know, we were, quite often there'd be on a Nightingale ward two of us down this side, and if you was a third year you were more senior than the other student you were working with.”
>
> Source: witness statement N269; student nurse, late 1980s to early 1990s

> “I felt like I had far too much responsibility [as a student nurse], but again it just seemed as if it was the norm. It was more when you went on to nights, and we – I want to get this right; I don't think it was in our first year, I think it was in our second year, I can remember… we were two second-year nurses in charge of the ward.”
>
> Source: witness statement N283; employee, early 1980s to mid-1990s

Often during the 1970s and 1980s, because of increasing numbers of patients, there would be additional beds set up in the middle of the ward. No additional staff were made available in these circumstances. This was stressful for the staff concerned and, not infrequently, Savile would come onto the wards to talk with patients and disrupt the nurses' work.

> “I genuinely thought it was inappropriate him being there, nothing else. I used to think what's he doing in a hospital at night?… I think we thought he shouldn't really be around hospitals. And I often have these recollections of talking to the nursing officer and saying 'Jimmy Savile's around again' and being a bit annoyed about it… I can't remember a specific example of him being disruptive but having him hanging around was annoying… And what he used to do was come in sometime late at night in the early hours of the morning.
>
> Most of the time I saw him was something like two or four o'clock in the morning, and what he did was he came to the canteen to talk to the nurses and it used to annoy people because they wanted to go for a fag or a quick nap or read the paper… My overwhelming memory is of him sat on his own or talking to young student nurses.”
>
> Source: witness statement N94; staff nurse, 1980s

Some witnesses told us Savile also had a habit of chatting up student nurses working on nights, inviting them to meet him for 'breakfast and fun'. Some were flattered by this attention and went with him after work; others felt it unwelcome. We found no evidence that these concerns were escalated. We were told of occasions when nurses on night shifts were having their meal breaks in the canteen and would leave immediately if Savile entered to avoid having to join him. Whilst we are not drawing parallels with Savile's activities, this was also the time when the 'Yorkshire Ripper', Peter Sutcliffe, was at large (1975 to 1981) and anxiety levels among women in the Leeds area about personal safety were acute.

> “We had the Yorkshire Ripper to contend with and we had Jimmy Savile to contend with at night – well any time of the day – but there were only two of us on a ward at night and it was normally two students… so when one went for their break there would be one nurse and 35 patients to look after. You were literally on your own… There were several occasions when I was on nights when somebody had made a hoax call to the LGI to say ‘I am going to kill a nurse tonight so you had better look out’.
>
> It was usually at night that he [Savile] would be floating about. You saw him in the daytime and that is when he would be taking patients to various places, but at night he would be lurking around… It was quite a difficult situation for somebody who supposedly had this celebrity status to actually say ‘Please leave the Department’, even if we were in charge.”
>
> Source: witness statement N6; employee, 1975 to 1981

Security at the hospital

Following the ITV *Exposure* documentary in October 2012, there were suggestions in the press that Savile had keys to areas of the Infirmary. These were based on the hypothesis that he was able to have keys on account of his celebrity status. Whilst we found no evidence that Savile had been given keys (beyond those for his own offices at the hospital from the 1990s onwards), it is clear from witness interviews that the security system for the management of keys throughout the 1970s, 1980s and into the 1990s was variable and at times poor. Compared with today, security in the hospital was rudimentary during the early part of Savile’s association with the Infirmary. Nevertheless, we found some documentary evidence that the Board of Governors had been concerned about security at the Great George Street entrance to the hospital during the early 1970s:

> “They [Board of Governors] supported the Committee of Surgeons in their suggestion that thought should be given to the appointment of a Hall Porter who would man the outer desk at the front door of the Infirmary and be in a position to assist visitors and medical staff arriving for interviews, in addition to adding dignity to the institution. It was felt that such an appointment might improve security in the vicinity of the front door.”
>
> Source: Board of Governors meeting minutes, 7 June 1971

We heard accounts of keys to secure areas of the hospital being kept in unlocked cupboards during the 1980s and 1990s, with little or no record of who was accessing them and for what purpose:

> “Most people used to collect the keys from there [Great George Street security office] and deposit them back there and we had hundreds if not thousands of keys in there. In fact, there were that many keys in there we could not even shut the door half the time, but the area itself was secure because security staff would keep going to the rest room and the door that led from the reception desk into the rest room used to be locked of a night time. [Asked: Did he (Savile) ever gain access to those keys?] ‘I never saw it, but I can’t say that any… officers at the time didn’t pass him one or two or lend him one… We didn’t have the real control on keys that we should have done in those particular days.”
>
> Source: witness statement N103; employee, mid-1980s to present, talking about security in the 1990s

We asked a witness if keys to staff residences on site were locked away:

> “No, they weren’t. They were just there [at the Great George Street security office], so if they’d [staff] gone off to the toilet or whatever they were there and available. When that reception closed down they then went for a short time to Brotherton reception. At the Brotherton reception they were locked away in the room at the back when the receptionist wasn’t there, but the intention always was for them to go to Jubilee [Wing]. Eventually they went to the Jubilee reception, and they were there for a lot of years, and when they first went there they were not locked away. There was no cupboard to lock them in. Eventually they had one made, but we are talking three or four years down the line before a cupboard became available to lock them in, so they were left on there as well.”
>
> Source: witness statement N54; employee, mid-1990s to present, talking about the management of keys prior to 2002

We heard that Savile courted the security staff at the hospital, as he had done with porters, giving them gifts and engaging them in banter:

> “Jimmy Savile was always friendly with the Security Department and on a couple of occasions, he brought the Department bits and pieces – for argument’s sake, a colour television for the rest room, a microwave. Now and again, Jimmy would actually go into the rest room and have a cup of tea with the lads, have a bit of a laugh and a joke with the car park attendants. So he had a pretty good relationship with us.”
>
> Source: witness statement N103; employee, mid-1980s to present, talking about the early to mid 1990s

The impression given is that Savile manipulated his relationship with the security staff and porters at the Infirmary to gain access to restricted areas:

> "Yeah, there'd be a message on the radio from control, and the request may have come from one of our managers or whatever, 'please can you open this door for Jimmy Savile?'."
>
> Source: witness statement N110; employee, early 1980s to present, talking about security in the 1990s

> "I first saw him [Savile] when he put his head round the door [of the porters' lodge]. It must have been about 12 o'clock at night, one o'clock in the morning… 'Everything alright?' 'Yes.' 'Right then' and put his keys, get the keys, take the keys [to the nurses' home] and go off… and he used to go to the nurses' home with a couple of girls so we didn't bother, you know and said 'Well'… Then about four or five o'clock in the morning he'd come back and put the keys down [in the porters' lodge] and go away."
>
> Source: witness statement N216; employee, 1980s to late 2000s, talking about an incident in the 1990s

The question of whether or not Savile had access to keys is unresolved. Some witnesses believe he did have, or could have had, access to keys. Whilst we have not been able to confirm this through documentary evidence, we have been given no convincing explanation to the contrary. In light of this, it is our view that Savile probably had access, on occasion, to keys at the Infirmary.

The Trust has invested heavily in security systems over the last decade, as it has modernised its support services. However, during the course of the investigation, we were able to access without challenge decommissioned parts of the Infirmary, including staff residences and underground service tunnels. We were also able to gain access to areas that are still in use and where access should be restricted. This was escalated to the Trust Board at the time and the specific issues we raised were addressed promptly.

Mortuary

Savile spoke about his interest in the dead in media interviews spanning many years:

> "The morticians are now my friends, so I help them on occasions to do their job, which I consider a tremendous life honour, being able to handle people who have just gone to heaven… When I lay those bodies away, I look at good muscles, good organs, good brains, beautiful eyes, liver and kidneys, and I think 'What a waste'."
>
> Source: interview with Lynn Barber, *Sunday Express*, 22 May 1982

He also spoke about spending five days with the dead body of his mother:

> “We hadn’t put her away yet and there she was lying around so to me they were very good times. They were not the best times. I’d much rather that she hadn’t died, but it was inevitable, therefore it had to be. Once upon a time I had to share her with a lot of people. We had marvellous times. But when she was dead she was all mine, for me.”
>
> Source: interview with Anthony Clare, *In the Psychiatrist’s Chair*, Mandarin, 1993

The mortuary at the Infirmary provides an essential service within the hospital. It provides storage for the bodies of deceased patients, viewing of the deceased for relatives, release of the bodies of the deceased to funeral directors and post-mortem services, including HM Coroner’s post-mortems. Since 1993, the mortuary at the Infirmary has also provided these services to the city of Leeds.

Porters are responsible for moving deceased patients from wards to the mortuary, and for moving them from the mortuary to the chapel of rest if relatives wish to view the bodies out of office hours. There are accounts of Savile taking bodies to the mortuary in his role as a voluntary porter:

> “Logic clearly dictates that if he was a porter, under routine circumstances he would have had access to the mortuary because he would have been delivering bodies at some stage or other. I am aware that he may well have actually volunteered to do that job on occasions from anecdotal information from other porters.”
>
> Source: witness statement N180; employee, early 1970s to present

> “Me and another porter got this job for the mortuary, to lay him [the deceased person] out – two o’clock in the morning or something like that – and he [Savile] jumped up in front of me, to go for it.”
>
> Source: witness statement N160; employee, early 1980s to present, referring to the early 1980s

The majority of those we spoke to told us that there were always two porters required to transfer a deceased patient to the mortuary, as two people are required to lift the body on and off the trolley safely. One witness explained that there was a different procedure for babies, and that it was possible for one porter to move the body of a deceased baby:

> "I think the only time [a porter would move a deceased patient on their own] is if it were a child, basically… I've moved unfortunately quite a lot of deceased patients, you know, but probably a child – they used to have – I think they've still got it, they call it the silver box, but that tends to be sort of newborns… Yes [a porter would work on their own], if it were say a new-born baby or a premature baby, yes, because they would put it in like a – basically a silver box on wheels."
>
> Source: witness statement N182; employee, mid-1980s to present

We have explored whether Savile may have had access to the mortuary at the Infirmary outside his role as a voluntary porter. In doing so, we have established that the perception amongst some mortuary staff was that Savile was friendly with the Chief Mortician (now deceased) at the hospital from the late 1970s to the mid-1990s, and that he would visit the mortuary to see him socially:

> "I understand that both from comments made, and from memory and recollection, that he may have either been a personal friend or been friendly with… the Senior Mortuary Lead [Chief Mortician] here for a number of years here in the '70s."
>
> Source: witness statement N180; employee, early 1970s to present, talking about the 1970s to early 1980s

> "I saw him [Savile] in the mortuary once, when he was having a word with [the Chief Mortician]."
>
> Source: witness statement N186; employee, mid-1980s to present, talking about the mid-1980s

> "And when the other lads [mortuary staff] come back, after they'd been out, I says 'Oh Jimmy Savile's been', you know, and they [said] 'Oh, he often pops down to see [the Chief Mortician]'."
>
> Source: witness statement N188; employee, early 1990s to present, talking about the early 1990s

We heard that security and operating procedures pertaining to the mortuary at the Infirmary were not stringent until the early 1990s, indicating that internal controls in this area were poor:

> "The porters and security, if they needed to move a body from a ward into the mortuary – When there was no staff there, because we finished at five o'clock. So anything that happened after that, until eight thirty the following morning, we [mortuary staff] wouldn't know about till eight thirty."
>
> Source: witness statement N186; employee, mid-1980s to present, talking about the mortuary in the 1980s

> “If the body’s unwrapped, I wouldn’t think – not totally unwrapped, I’m just, it’s the tape’s been taken off, the card’s still there, it’s still cocooned from maybe the neck downwards, the viewing is just for the face… Not totally stripped off unwrapped, you know, I mean, it’s just, they show the face for the viewing. So we just assume that there’s been a viewing… but we don’t check the [record] book just because a face is showing – To see if there’s been a viewing. Or we didn’t, we didn’t do… Probably we should have done, but I mean, there’s a million things that we should do – Isn’t there, you know what I mean? And that didn’t seem important, whether there’d been a viewing [of the body] or not.”
>
> Source: witness statement N186; employee, mid-1980s to present, referring to the mid-1980s

> “It [the mortuary] was always locked at all times and the only access was for the mortuary staff themselves, and the porters had access to a key, obviously; who were responsible for that, whether it was signed for or not, I couldn’t tell you that.”
>
> Source: witness statement N187; employee, early 1970s to late 2000s, talking about procedures prior to the 1990s

> “He [Savile] could’ve got in [to the mortuary] at night time, ’cos it were just a key, you know, you go get a key, um, ’cos you know I’ve forgotten my keys at home, and gone to Head porter – Proved who I were – And he’s let me in. And said, you know, ‘Do I want anywhere else opening?’ and I’ve said ‘No, just open the office, there’s a spare – there’s a spare key in the office’, you know, for us in case of mishaps, we have our own keys, and, er, so it’s – it were easy to get in.”
>
> Source: witness statement N188; employee, early 1990s to present, talking about the early 1990s

There appear to have been turning points in 1987 when a new tier of management was introduced to modernise the mortuary, and again in 1993 when the Infirmary became responsible for providing mortuary services for Leeds as a city and security and operating procedures for the mortuary were strengthened and tightened:

> “The mortuary on-call service only came into existence in 1993 when we absorbed and took out the contract with Leeds City Council to replace the public mortuary.”
>
> Source: witness statement N180; employee, early 1970s to present

> "I think they [management] wanted to bring the mortuary up to sort of, bring it out of the, sort of, not the last century but sort of try and modernise it and put in procedure, put in place procedures that weren't in. It was very much as was in the '50s and '60s; you sort of just did things because you'd always done things like that, or whatever, and we had to start introducing proper procedures that were written down and carried out."
>
> Source: witness statement N187; employee, early 1970s to late 2000s, referring to the late 1980s

Today, access to the mortuary at the Infirmary is restricted by swipe card access, and there are operating procedures in place to ensure it is secure.

We established that Savile visited the mortuary in his role as a volunteer porter, and that he visited it socially to meet his friend, who was the Chief Mortician until the mid-1990s. However, we also heard more macabre accounts of Savile speaking and possibly acting unacceptably in relation to the mortuary.

Two witnesses told us that Savile claimed to have had jewellery made from glass eyes taken from bodies in the mortuary at the Infirmary. Whether these claims were made merely to shock his listeners, they again indicate and reinforce the notion of Savile's fascination with the bodies of the deceased (the witnesses were completely unconnected; we therefore do not believe there was any collusion between them):

> "I looked at his hands and he had these gross, big silver rings with bulbous things and I sort of went, 'Yes, mm,' always be polite to your superstar, 'Yes, Jim.' And he said, 'D'you know what they are? They are glass eyes from dead bodies in Leeds Mortuary where I work and I love working there, and I wheel the dead bodies around at night and I love that.'"
>
> Source: witness statement N149; employed in the media, 1970s

> "I do remember seeing this ring he had on that looked like an eyeball and – and I must've mentioned it to him and he said 'It's made from the eyeball of a dead friend'."
>
> Source: witness statement N222; employee, early 1970s

One witness we spoke to, who had encountered Savile whilst training as a nurse at Broadmoor Hospital in the 1970s, told us that in conversation, Savile had asked the student and a staff nurse how they kept themselves busy at night. They informed him about their professional obligations and the care and observation of patients. This witness went on to tell us that Savile claimed that when it was quiet at night at the Infirmary, he visited the mortuary and interfered with the bodies of deceased patients at the Infirmary, including claiming to have performed sex acts on the bodies:

> "And that – that's when he [Savile] told us about what he did up at – Now I've got to make it quite clear now, I don't know whether it was Leeds General Infirmary or St James's, I believe it was Leeds General Infirmary, and his words were to the effect 'What – what we often do is get ourselves down into the morgue at night and have a muck about'… Well, bearing – at the time I was only a 20-year-old kid, and, you know, I was a bit wet behind the ears, I – I didn't fully understand, but X, that was with me, sort of said to him 'Well, how – how d'you mean, Jimmy, what – what is it you – ?' He [Savile] said 'Well, depending on what's down there at the time, but we can get them out and –', and he, he went on to relate how they set the bodies – he kept saying 'they', so he, he couldn't have been on his own with this – how they set the bodies – that what happens when before you – well, rigor mortis sets in, you can move the body into different, sort of, stances or formations. And, apparently, he [Savile], he was saying that they used to put the bodies together, male and female, and he also said that they took photographs and also that he got involved in some of the photographs… I mean, I – I was a little bit upset because I had no concept, in those days, of – while I'd heard of necrophilia, because of a virtue of – several of the Broadmoor patients would've been diagnosed with that, but I didn't fully understand what it meant, and part, part way through I just wandered off… Well – he [Savile] used the phrase that you don't – it's not so common nowadays, he talked about gamaroosh… It means oral sex… Well, that he [Savile], he'd go down on them and gamaroosh and muck about in that way."
>
> Source: witness statement N270; former nurse at Broadmoor Hospital, late 1970s

We have no way of proving Savile's claim that he interfered with the bodies of deceased patients in the mortuary in this way. However, we sought the opinion of an expert, to establish if the acts claimed were theoretically possible. After due consideration, their conclusion was:

> "A degree of posing would be possible with some support of the body in the pre-rigor mortis phase and by the simple laying of one body on top of another once rigor mortis was fully established. It would be possible to manipulate the body to some extent alone by exploiting the effects of rigor mortis but it would be more easily attained if more than one individual was involved."
>
> Source: extract from the report of Dr Jennifer Bolton, Home Office Pathologist for the North East of England, 21 January 2014

Throughout the course of the investigation, we have been unable to ascertain the exact level of inappropriate access that Savile may have had to the mortuary, and to deceased patients, at the Infirmary. In the absence of hospital records of mortuary attendance, we cannot confirm if Savile had unsupervised access to the bodies of dead patients, and we have found no evidence to suggest that the Chief Mortician he was friends with facilitated any such access. However, what we do know is:

- Savile publicly declared his interest in the dead;

- he was friends with a member of the mortuary staff and visited the mortuary to see this individual;
- we heard the claim that he interfered with the bodies of deceased patients in the mortuary; and
- there was a lack of stringent procedures regarding the mortuary at the Infirmary until the late 1980s at the earliest.

In light of the claims about the glass eye jewellery and Savile's interference with the bodies of the deceased, it is evident his interest in the mortuary was not within accepted boundaries.

Savile's offices and other privileges

It has been reported in the press that Savile had offices or suites of rooms at some of the NHS hospitals he was associated with. Whilst there is no evidence that he had a suite of rooms at the Infirmary, he did have three dedicated offices in succession, from 1992 until his death in 2011. Before this time, in the 1960s and 1970s, he appeared to be able to use the office of the Head Porter, Charles Hullighan (now deceased), at will. Savile arranged to meet four of his victims who were not patients or staff at the Head Porter's office in the late 1960s.

His first office in 1992 was part of the Leeds Institute for Minimally Invasive Therapy (LIMIT) suite, a clinical training and research centre in the Wellcome Wing of the Infirmary that pioneered minimally invasive (keyhole) surgery techniques. We were told that Savile had this office fitted out to his own specification (source: witness statements N243; N181; N85). He had been involved in raising funds for the LIMIT suite and was closely associated with the lead clinician who pioneered this surgery at the Infirmary. Following the closure of the LIMIT suite in 2006, his replacement office was located at the Great George Street entrance to the hospital. This office was required by another department and he was relocated again in 2009. Savile's third office at the Infirmary was at the rear of the old nurses' home. This was available to him until his death in 2011.

As far as we have been able to ascertain, it is not usual for individual fundraisers or donors to have offices at the NHS hospitals they are associated with and we have not found any record of any formal decision on the part of the Trust Board or any of its committees to allocate Savile an office on site. This is discussed further in chapter nine. Many of those we interviewed as part of the investigation were unable to provide any satisfactory reason as to why he had an office at the hospital in the first place, other than the fact he was involved in the funding of the LIMIT suite (again, this is explored in more detail in chapter nine):

> "Why the decision was taken at the time that Jimmy should have an office I don't know."
>
> Source: witness statement N161; employee, 1980s to present

> "And then, [Savile] had, as I understand it, been involved in fundraising for the organisation, and as part of that the organisation had considered it appropriate, for whatever reason, to allocate him an office so that he was able to be on site."
>
> Source: witness statement N201; Maggie Boyle, Chief Executive, 2007 to 2013

From the accounts of the victims we have interviewed, we do not believe that the offences disclosed to us during the investigation took place in any of Savile's three offices. Some of his earlier assaults took place in either the Head Porter's office or other unidentified rooms (late 1960s, early 1970s).

It is our view that having a dedicated office base to some extent further legitimised Savile's presence at the Infirmary, and was indicative of the influence he was able to wield, in being allocated an office in the first place (see chapter nine) or in terms of no objection being raised to that allocation.

Savile had what appears to have been official access to Infirmary staff in support of his role as a fundraiser and celebrity. He was assigned support from hospital staff for many years.

We heard that, from the mid-1980s, one of the porters managed Savile's mail for him, and arranged events for him to accept charity donations for a number of causes, some of which were not related to the Infirmary. We were told that this arrangement had been agreed by one of the House Governors at the hospital in the early 1970s, and had continued:

> "I used to allocate about fifteen minutes to an hour a day on that [dealing with Savile's correspondence]… Any letters that came in to Jimmy Savile used to come to me directly, yes. I used to read them, and, well, yeah, answer them myself as well… I was one of his signatories, you know, most of these things, 'Can I have a signed photograph?' So I mean Jimmy didn't sign photographs, it was me!"
>
> Source: witness statement N285; employee, mid-1980s to early 1990s

In the late 1980s, another member of hospital staff began to look after Savile's correspondence and deal with enquiries for him:

> "[We asked if the arrangement was formal or informal] I'm not sure how it ended up to be honest. We did employ [member of staff] and [they] didn't want to retire, but I don't think we employed [them] to look after Jimmy Savile."
>
> Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973 to 1979, junior doctor to 1987 then consultant, Medical Director, 2009 to 2013

From 2005 until 2010, this member of staff was also a Trustee for the Jimmy Savile Charitable Trust. They were paid by the hospital until September 2007. After this date, they received an honorarium from the Charitable Trust.

Savile also appeared to have enjoyed access to car parking facilities at the hospital, with accounts of him parking his many vehicles in what was then the consultants' car park at Great George Street (YEP 74, 1968). One witness we spoke to recalled being invited to join Savile in his car:

> “One afternoon he came up to the ward and was very insistent that myself and another junior staff nurse went with him to his new car in the consultants’ car park at the LGI.”
>
> Source: witness statement N223; employee, 1970s

> “Jimmy always used to get his car parked, and he used to seem to always be able to get into the hospital car park when he wanted to… and one just accepted that he had an entrée into getting [into] the hospital and getting parked where other people couldn’t. Because even in those days, when most consultants had a car, but very few junior staff did, you still found it difficult to get parked on the front drive to get into the Infirmary.”
>
> Source: witness statement N245; former employee, 1980s to 1990s, talking about the 1980s

Parking in the consultants’ car park is a privilege that we do not believe was extended to other volunteers. We heard how it was not unusual for Savile also to park his campervan at the hospital, and that this was accepted as just being the norm:

> “My boss asked me ‘Jimmy Savile needs a wake-up call in the morning. Can you make sure you get him a cup of coffee and wake him up at eight o’clock.’ I said ‘What do you mean, wake him up?’ He said ‘Just knock on his caravan door with a cup of coffee and that’ll be fine.’”
>
> Source: Victim K, early 1970s

A recurring theme is the paucity of internal controls within the organisation regarding Savile’s privileges over many decades.

Savile as a celebrity

Savile understood the power of his celebrity profile and used it in a variety of ways. For example, if he was photographed running a marathon for charity, or launching a particular fundraising campaign, there would be lots of publicity.

Many people interviewed as part of the investigation have attributed Savile’s unparalleled access and influence at the Infirmary to his status as a national celebrity and a fundraiser with local roots. The connection has been made by several witnesses who observed that over the years the hospital benefited from its association with Savile (see appendix four):

> “Talking about the things that he was involved in, he was somebody who one heard about in the ’70s and ’80s as a hospital porter who did good work. The hospital gained some celebrity out of the fact that he was a celebrity.”

Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973 to 1979, junior doctor to 1987 then consultant, Medical Director, 2009 to 2013

> “For many years he was a fund-raiser for the University Hospital and he clearly had an association with both LGI and St James’s… and that kind of thing in my world is really, really important because those kind of figures, celebrities, are the kind of people that you need to boost the reputation of a hospital.”

Source: witness statement N77; Karl Milner, Director of External Affairs and Communications, 2010 to 2014

Savile’s influence was such that he was able to use the hospital as a base for activities that were not related to the Infirmary, and it would appear that no one thought, or felt able, to question him. One witness recalled him filming a television series at the hospital on keeping safe and the disruption this caused on the children’s ward:

> “He would refuse to let the children have their dinner, and he would make them all sit on the beds and play, and everything had to be just so, so he could film it. I would see that these children need their dinner, and I can’t not give it to them, and it used to be two o’clock before I was serving dinners sometimes when he was filming it.”

Source: Victim JJ, former employee, early 1980s

We heard how Savile would use the Infirmary boardroom in the early 1980s to receive donations for the Stoke Mandeville Spinal Injuries Unit and other hospitals (source: YEP 148 and 150, 1981; YEP 64 and 23, 1982; YEP 17 and 170, 1983). He also used the Infirmary for publicity for his *Jim’ll Fix It* television programme (source: YEP 56, 1977; YEP 165 and 121, 1979).

In the early 1980s, Savile was the celebrity focus of a major national public health campaign to encourage the wearing of seat belts. Using the slogan ‘Clunk Click Every Trip’, this was a high-profile campaign which was eventually followed by legislative changes enforcing the wearing of seat belts. Savile was filmed for the campaign in the A&E Department at the Infirmary (source: witness statement N250; former employee, 1980s to 1990s).

Savile’s celebrity status has to be considered within its historical context, and within the context of public reactions to meeting a famous figure or childhood hero. It was also accepted by many that Savile could facilitate access to other celebrities and pop stars. In the 1990s and 2000s, despite his waning stardom, Savile continued to have influence, or continued to be unchallenged, when arguably he was less well known to a younger audience. Some contemporary managers within the Trust have commented on this, for example:

> “Frankly, as his star was waning publicly he was less use to the hospital in that symbiotic relationship.”
>
> Source: witness statement N77; Karl Milner, Director of External Affairs and Communications, 2010 to 2014

Savile's significant relationships

We believe that, in addition to his celebrity, there are also some key aspects of Savile's personal style which facilitated him having access to the hospital. Witnesses spoke about his ability to portray himself as different people, appealing to others' expectations of him. This appears to have enabled him to foster relationships with a diverse range of people, from porters to hospital consultants.

We heard how he would at times seek to flatter those he came into contact with, often giving them a 'grade uplift', or referring to their level of seniority if he perceived them to be in a position of authority:

> “But of course, he always gave everybody a title bump.”
>
> Source: witness statement N64; employee since 2001

> “He used to address me as 'boss lady'.”
>
> Source: witness statement N214; Betty Vigrass (prev Champney), Director of Nurse Education, 1974 to 1977, then Chief Nurse until 1984

During his early association with the Infirmary in the 1960s and early 1970s, Savile established a close relationship with the hospital management (chapter four).

In some cases, the relationships Savile fostered at the Infirmary extended beyond the hospital boundaries. He developed a number of relationships with Infirmary staff throughout his association with the hospital, at times using them as his personal assistants. At least two contemporary witnesses felt that Charles Hullighan, the Head Porter at the Infirmary until 1981, worked at least as much for Savile as for the Infirmary, and also that later, Alan Franey (Deputy House Governor) may have fulfilled a similar role.

There is evidence from a breadth of witnesses that Hullighan and Savile were frequently in each other's company around the hospital and that the relationship between them had developed significantly to the point where Hullighan was largely perceived in the hospital as Savile's 'right hand man'.

> “I always thought it was strange, in that people allowed a man to do, spend so much time, looking after Jimmy Savile. Everybody called Charlie Hullighan Jimmy Savile's PA.”
>
> Source: witness statement N202; employee, 1970s to 1980s

Charles Hullighan had a broad-ranging managerial remit that not only included portering services but extended to the post room and the hospital radio station. His role as Head Porter was considered to be powerful (Hullighan retired in 1981):

> “Charlie Hullighan was, you know, had a little empire… it was quite a prestigious job in those days to be the Head Porter… There were a lot less managers around, you see, in those days.”
>
> Source: witness statement N7; employee, 1970s to 2000s, referring to the 1970s

A former manager who was asked 'What was the relationship like between Savile and Hullighan?' said:

> “Very close. Very close indeed and in fact often, in my view, to the detriment of doing his own job, basically.”
>
> Source: witness statement N229; former manager (now deceased), talking about the early 1970s

It is clear from witness and victim accounts that, prior to having his own office at the Infirmary, Savile used Hullighan's office as a base and would frequently arrange to meet people there, including some of those that he went on to abuse. There is also evidence that their relationship extended beyond the hospital, with Hullighan often accompanying Savile on his external engagements both locally and further afield:

> “And if he [Savile] wanted to go training, say on a Sunday he wanted Charles [Hullighan] to drive the Rolls.”
>
> Source: witness statement N204; employee, mid to late 1970s

One witness recalls having seen the two men together in a town parade in a small town in Scotland when they were on holiday:

> “The person who was with him [Savile] was Charlie Hullighan who was in the car in this procession.”
>
> Source: witness statement N62; employee, talking about an event in the 1970s

Similarly, Savile enjoyed a close relationship with Joe Tyrer (now deceased), the porter he was originally assigned to work with in the 1960s. He credited Tyrer with 'teaching me everything I know about being a porter' and once remarked of him, 'To me he was like a brother' (source: YEP 11; 1998). Tyrer accompanied Savile and his mother when he went to Buckingham Palace to collect his OBE in 1972. Following Tyrer's death in 1998, the date of his funeral was postponed to ensure that Savile could attend (source: YEP 11; 1998).

Savile's association with Alan Franey, former Deputy House Governor at the Infirmary, also extended beyond the workplace. He was seen as a close associate of Savile by staff from different levels and departments in the hospital:

> "Basically he was in thrall of Savile… He seemed to be sort of very, very keen to be in his company and basically, I suppose a little bit… enchanted by him probably. You'd see them fairly regularly, on a daily basis almost sometimes. Basically it were a sort of very friendly, jokey type relationship as far as I could see."
>
> Source: witness statement N229; manager, 1960s to 1980s

> "Alan Franey used to be over us and it was 'Jimmy's coming, Jimmy's coming!' He dropped everything… and off he would swan so we didn't see him for the rest of the day. He was the only bloke I could go back and say he had an intimate relationship with him, as in he knew him."
>
> Source: witness statement N76; employee, 1980s to present

Documentary evidence shows that the two men became running mates, completing marathons together in the early 1980s (source: YEP 173, 1981; YEP 19, 1982).

Some we spoke to suggested that Savile helped Franey in his career within the Infirmary and told us of a perception that his association with Savile somehow protected him from being challenged:

> "I think he [Franey] was perceived to be a bit kind of untouchable because of his relationship with Savile."
>
> Source: witness statement N251; Rachael Allsop, Deputy Director of Human Resources, 2000 to 2004, then Director of Human Resources until 2009, speaking of her experience as a junior manager in a neighbouring hospital in the mid-1980s

Savile also had significant relationships with some consultant medical staff who he met when he was a patient (see chapter four). He also formed a small number of key relationships with other medical consultants related to his expertise as a fundraiser.

For example, he acted as a kind of mentor to a young consultant who sought his advice on a range of fundraising matters. The individual involved was intrigued by Savile's knowledge of and involvement with the music industry, enjoying discussing his musical heroes with Savile:

> “In summary, my impression was he was an intelligent man, he put on a show most of the time, and essentially, as I say, my question was always very much musically-related, because I'm a big music fan, and of course this man was mixing with the legends around the world which people fed off.”
>
> Source: witness statement N51; employee, 1996 to present

Savile's celebrity was reinforced and given increased longevity by his fundraising activities and vice versa. It also gave him another source of power and influence, because he was perceived to be an astute fundraiser and gave the impression of generosity. It is our view, based on what we heard, that he was sought out by others who needed to raise funding for research, facilities or equipment. Over the years, a number of consultant medical staff asked for his advice and support as a source of expertise, as a broker of funding from other organisations or as a direct funder.

This role and influence gave him further access to other organisations and opportunities (for example, the Leeds Undergraduate Research Enterprise at Leeds University Medical School).

An example of Savile exercising his influence was given by one witness (a manager) who had an irate call from him when she was planning to move equipment for which he had helped raise money to another hospital site, as the services that the equipment supported were relocating. He did not want the equipment to be moved but was unsuccessful in his attempt to stop it:

> “And so he rang and in his way expressed his unhappiness that I had moved the [equipment] when he gave money for its purchase.”
>
> Source: witness statement N155; employee, late 1970s to early 2000s

There was a clear perception amongst many victims and witnesses that Savile's influence at the hospital rendered them helpless to report his actions:

> “I knew that all the money – there was a big thing with how much money he had raised for the hospital… Who is going to believe me, particularly in those days when money – well like it is today – was short?”
>
> Source: Victim S, late 1960s

> “I didn't think anybody would believe a word I said about either of the things that happened because Jimmy Savile is almost put on a pedestal by everybody.”
>
> Source: Victim R, mid-1990s

Conclusion

Savile had a unique level of access to the Infirmary for a period of 50 years. Some of the privileges he enjoyed appear to have been officially sanctioned in the early part of his association with the hospital (1960s and 1970s), for example parking in the consultants' car park and having use of the Infirmary's staff for his personal business. We believe this was not the norm for a volunteer, but it set the tone for how he was perceived by staff and patients.

His access and influence partly related to his ability to adapt to, be part of and exploit a range of subcultures in the hospital, so that he became accepted in different settings. This is illustrated by the nature of Savile's relationship with the porters and security staff, which, over the years, could be described as a form of grooming, demonstrated by the provision of gifts and other small tokens. Savile's 'invisibility' was a result of this and provided him with opportunities to abuse as a consequence.

A number of factors contributed to both the level of access Savile had and the perception that his access had been approved. We found that, until the 2000s, there was an absence of robust internal controls in the portering and security services at the Infirmary. This adversely affected standards of behaviour, discipline, training and recruitment. These services, and portering in particular, were the focus of Savile's presence in the Infirmary, and the absence of rules may well have influenced the freedoms he enjoyed in his work in the hospital.

When Savile was formally sanctioned as a volunteer porter in the 1960s, Joe Tyrer was assigned to look after him. Charles Hullighan appeared to have assumed a similar role, although there is doubt as to whether or not this was an official duty or a result of the two men's long-standing friendship. Whilst Savile at times had official access to hospital staff to deal with his administration, no senior manager appeared to have responsibility for 'minding' Savile in the Infirmary, as would be commonplace with visiting celebrities today. Savile's day-to-day presence at the Infirmary had become 'invisible' to those in charge. In addition, to many staff in wards and departments, he was regarded as 'part of the furniture'.

A common perception was that Savile was engaged in positive and beneficial activity for the Infirmary. We heard how this belief inhibited patients and staff from criticising or challenging him. This perception, and people's attitude and reaction to it, protected Savile for 50 years and meant that concerns about him were not reported.

In turn, the senior management of the Infirmary after 1974 were focused on the various pressures and difficulties associated with running a large teaching hospital. As the frequency of Savile's visits to the Infirmary decreased in the 1990s and 2000s, senior managers were not aware in any detail of his whereabouts or what he was doing in the hospital. He was only really visible to them when he attended publicity events (chapter nine).

7 Abusive encounters

7 Abusive encounters

Chapter summary:

- As part of this investigation, 60 victims gave evidence of abusive or inappropriate behaviour at the hands of Savile during his time at the Infirmary.
- Of these, 33 were patients at the time, and of these 19 were aged 16 or under.
- Abusive encounters took place in wards, corridors, offices and other hospital locations, in a nearby café, in Savile's mother's house and in his campervan.
- Three encounters involved other people who assisted Savile.
- Eight demonstrated his premeditation and willingness to 'groom' his victims and, in some cases, their families prior to committing abuse.
- Forty-three victims were assaulted in public areas within and outside the hospital.
- Savile intimidated and humiliated 10 of his victims following their initial assault.

Introduction

This chapter is structured in two parts. In part one we present summary reports of the individual accounts of those who came forward as part of the investigation to tell us about unwelcome, inappropriate and abusive contact they had with Savile. They included a broad range of people: former and current staff, former patients and their relatives, and other people external to the hospital, but who were invited to meet with Savile on hospital premises. We also include a small number of accounts from relatives or colleagues of people who told them of abusive or inappropriate encounters with Savile.

We would like to formally acknowledge and commend the courage and candour of all who shared their experiences with us, and thank them for permitting us to tell their stories.

In trying to understand what happened during Savile's years in the Infirmary, it is important to take the time to read these accounts and to remember that for the majority of the victims, at the time of the offence they were either trying to do a job supporting or caring for others, or they were at their most vulnerable, as patients.

In part two we describe some of the patterns and themes emerging from these accounts, and highlight those that struck us as particularly significant in trying to understand what happened between Savile and his victims.

We considered a number of factors in our assessment of the credibility of these accounts. The standard of proof applied was consistent with that applied in civil legal cases, the 'balance of probabilities', in that, taking into account all factors, it was more likely than not to have happened. We also considered the recent updated guidance published by the Crown Prosecution Service (*Guidelines on Prosecuting Cases of Child Sexual Abuse*, 17/10/2013), which sets out the approach that a prosecutor should take when dealing with child sexual abuse cases. This was not a criminal investigation, but the publication provides helpful guidance on assessing the credibility of a child or young person who makes allegations of sexual abuse; the

relevance being that the same considerations are relevant to adult victims of childhood sexual abuse. Advice is to look closely at the credibility of the allegation overall, not simply the credibility of the witness.

All accounts were considered in the context of factual details such as confirmation of period of employment (for staff), and where possible confirmation of dates of hospital admission (for patients), and what could be established from archived documents and other relevant witnesses' accounts. Owing to the duration of the period of Savile's offending, documents from the earlier accounts have been difficult to source, for example patient records. In some cases they have either been destroyed or contain only scant information. We are confident about other relevant factors (outlined in chapter two) which we have relied on in assessing the credibility of each account.

This level of rigour meant that in a very small number of cases (two individuals) we excluded accounts that we believed had been embellished. These cases, however, were very much a minority.

We were approached by a witness who reported an abusive encounter as a patient in the late 1950s. We were unable to connect the account given with Savile. Similarly, we made contact with a witness who reported being the victim of a serious sexual assault whilst they were a patient at Seacroft Hospital (which is now part of the Trust) in the 1970s. However, after further investigation we could not be sure that the person whom the witness described as being their abuser was Savile. We have not included these accounts in the figures below, or in the subsequent narrative.

Taking all evidence into account we believe we were told of genuine and serious allegations of sexual abuse, of unwelcome contact and of inappropriate behaviour perpetrated by Savile.

The following tables illustrate in summary the numbers and nature of victims who came forward to the Leeds investigation.

Table 7.1: Summary details of victims as reported to the Leeds investigation

Descriptors	Numbers	Timeframe
Patients (Leeds Teaching Hospitals)	33	1962–1999
Leeds General Infirmary	*30 (+1 unknown)*	*1964–1999*
St James's Hospital/Chapel Allerton Hospital	*2*	*1962–1982*
Others (visitors; those invited to meet JS on the Infirmary site)	8	1968–1972
Staff	19	1969–2009
Total	**60**	**1962–2009**
Other hospitals (Wheatfields Hospice, Leeds; High Royds Psychiatric Hospital, Leeds; Dewsbury Hospital)	4	1969–1988

Table 7.2: Patients abused by Savile in Leeds Teaching Hospitals (Infirmary; St James's; Chapel Allerton; Seacroft)

Patient descriptors	Numbers	Timeframe
Children	19	1962–1999
Adults	14	1968–1990
Male – children	*10*	*1964–1994*
Male – adults	*5*	*1968–1990*
Female – children	*9*	*1962–1999*
Female – adults	*9*	*1968–1980*
Age – under 10 years	*6 (aged 5–8 years)*	
under 16 years	*12 (aged 11–16 years)*	
Over 16 years	*14 (aged 17–75 years)*	
	1 age not specified	

Table 7.3: Visitors and victims external to the hospital

Visitors/others	Numbers	Timeframe
Children	7	1968–1972
Adults	1	1972
Male	*0*	
Female	*8*	*1968–1972*
Age – under 16 years	*7 (aged 14–16 years)*	

Table 7.4: Staff abused by Savile

Staff	Numbers	Timeframe
Female	19	1969–2009
Male	0	
Roles	Administrative – 10	1970–2007
	Clinical – 8	1969–2009
	Student – 1	1980s

High-risk encounters

Following presentation of the individual accounts of abusive encounters below, we also include two cases where circumstances exposed the witnesses to a potentially high risk of significant abuse. We include these 'near misses' as they demonstrate Savile's intentions clearly, and may have a resonance with other victims or 'near' victims of his abuse who thus far have felt unable to come forward.

Part one

The summaries of victims' and witnesses' accounts below are presented in a particular style to protect their anonymity; for example, we have not included specific ages. So far, we have been able to interview 50 of the 60 victims who have come forward. We have not been able to interview them all owing to submission of late information, in some cases their poor health and logistical difficulties. These cases will be followed up and investigated in due course. The accounts below describe the experiences of those we have interviewed.

(We refer to Savile as JS in each of these accounts.)

Female patients – children

In the early 1960s, BB was a girl aged under 10 years old who was admitted to the children's ward at St James's for the treatment of a problem she had lived with since birth.

She recalls that JS came on the ward and talked to her, sitting on her bed as she lay there. He was wearing a white coat and a clown's red nose which he squeaked to amuse her. Sitting on the bed, he took her hand and asked if she would like to make his clown's nose squeak. He put her hand in his trouser pocket. BB pulled her hand away as she didn't feel comfortable about doing this and could feel something in his pocket that made her fearful.

As an adult she realised that what she could feel in his pocket was his erect penis and how this made her feel scared. This memory has had a lifelong impact on her. BB didn't tell anyone, including her parents, about this incident specifically, but did tell them she didn't like being in hospital.

In the early 1960s, J was a girl aged under 10 years old who was in the children's ward at the Infirmary having suffered a fracture following a fall. She was wearing a plaster of Paris cast on her leg and had been an in-patient for a while.

During this time JS had occasionally visited the ward and had befriended her and her mother. He also visited them during her subsequent out-patient appointments. After her final clinic appointment he offered to take them out for lunch to a local café across the road from the hospital. During the meal, J recalls that her mother left the table to visit the lavatory.

JS sat alongside J and, whilst continuing to talk to her and look at her face, he put his hand under the table and inside her underwear, touching her genitals. She panicked and looked out for her mother, who soon returned to the table. JS stopped touching her on her mother's return.

As they left the café, J told her mother 'I don't like him.' She recalls her mother telling her 'Shut up, it's Jimmy Savile.' Having been chastened by her mother, J did not mention the incident to anyone else, but still finds the memory extremely distressing.

In the early 1970s, M was aged under 10 years and lived a significant distance from Leeds. She had a condition that required specialist treatment and was referred to the Infirmary for this by her doctor.

She was made aware that JS would come to her house and pick her up to take her for this treatment in his car, as he was opening the new clinic at the hospital. This was an exciting time for their family. JS arrived in a small car that would only accommodate two people. This meant her parents would have to travel separately, whilst M had to travel alone with JS.

On arrival at the hospital, she and JS initially looked at the new technical equipment which would be used to treat her condition; then he took her to a room with no windows. He kissed her on the area of her body that required treatment and said that he was paying to make her pretty. After her treatment, her parents left for a short while to get something to eat. JS kissed her again on the area of her body that was being treated, and told her again that he was making her pretty. M did not tell her parents, but recalls being scared of JS.

Six months later, she needed more treatment, a fact that she dreaded. JS picked her up from home again in the small car. In the car he kissed her. He then put his hand up her skirt and touched her genitals. M was so afraid of having further contact with JS, that prior to her third visit to Leeds for treatment she caused herself to have an accident so she didn't have to go back. This was serious enough to require treatment in her local hospital. JS visited the family after this to see how M was after the accident, which in itself had a significantly traumatic impact.

JS was always welcomed by her parents when he visited their home, and at the time M was perplexed and resentful at their response to him. She took it to imply, wrongly, that they knew what he had done and were happy to accept it. Her experience with JS has had a major and lasting impact on her.

In the early 1970s, TT was aged under 16 years and was admitted for investigations to the Infirmary. After undergoing a lengthy procedure, she was instructed to lie flat for at least 12 hours, and to keep her head and neck still.

Lying on her trolley in the recovery room, she waited for someone to take her back to the ward. She was in pain and very anxious and tearful. JS came over to her and spoke kindly to her, saying 'There's no need for those tears, Uncle Jimmy will sort it.'

He pushed her trolley into the lift. She was not accompanied by a nurse, and there was no one else in the lift. After the doors closed, JS stood behind her head at the end of the trolley and fumbled at the back of her neck, trying to untie the hospital gown ties. He then put his hands into her gown and touched her breasts. TT wanted to scream, but made no sound. She was extremely distressed.

When she got to the ward, he left. The nurses helped to move her from the trolley to the bed. TT didn't tell her parents or the nurses about what had happened, even though she recalls them being very kind to her. She said 'I felt dirty', and she didn't think anyone would believe her.

In the early 1970s, T was aged under 16 years old and had had recent abdominal surgery. She was a patient on an adult ward in the Infirmary. A school friend's father was a porter and had offered to ask JS to visit her as a treat.

JS came to see her on the ward when her grandmother was present at the bedside. He was friendly and chatted to her. Sitting on the bed, he asked to see T's scar on her lower abdomen. She lifted her nightdress and showed him. He put a stethoscope on her stomach, pretending to listen, then kissed her stomach. He then put the stethoscope in her ears and whispered 'I love you.'

Her grandmother shouted at him to 'Get off my grand-daughter.' He stood up, apologised and left the ward. T recalls her mother reporting the incident to the Ward Sister. T does not think the Sister said anything about it to either T or her grandmother.

In the early 1970s WW was aged under 18 years and was admitted to the Infirmary for investigations. She was an in-patient for a number of weeks and frequently saw JS 'wandering about' the ward where she was a patient. He often chatted to her and one day offered to take her to a nearby newsagent's to buy sweets and magazines for the ward. In the shop he chatted to the staff and introduced WW as his friend. She then returned to the ward with him and he went on his way. The sweets and magazines were later delivered to the ward and the staff shared them between the patients.

Later on a man believed by WW to be a porter came to the ward and spoke with her, saying 'Jimmy Savile wants to see you.' He took her off the ward, down some stairs and along a corridor. WW remembers there were pipes along the walls. Eventually they arrived at an office. The man opened a door and JS was in the room alone, leaning against the wall. WW entered and the door was closed behind her. JS did not speak to her at all, but pulled her to him and forcibly kissed her, putting his tongue into her mouth.

JS spoke only once to ask if she was 'on the pill'. WW was not, and told him so. WW was then forced to masturbate JS, after which JS said 'You've got to go.' He knocked on the door and another man opened it and motioned to WW to follow him. She had not seen this second man previously, but again considered him to be another porter. He didn't escort her all the way to the ward, and she had to find her own way back.

On reflection, WW thought this incident was expected by JS as thanks for the sweets bought earlier. When she returned to the ward she tried to tell the nurses, but only got as far as saying 'Jimmy Savile' when they laughed at her, and so she said nothing further.

Later still, she told her father who was an administrator in another hospital. She thought he didn't believe her. Months later she told her mother what had happened. She thought her mother believed her, but her mother told her that no one else would.

In the early 1990s, CC's teenage daughter was admitted onto an adult ward for neurological surgery. She was cared for in a side room off the main ward following the operation. CC recalls that her daughter was very sleepy following the operation. Her mother and grandmother stayed with her round the clock as they were so concerned about her. On the evening after her operation, JS came onto the ward and spoke with CC, telling her that some years ago his brother had been on this ward and had had surgery. He was kind, and showed empathy for their anxiety. He told them they should go home, and as he was staying on the ward all night, he would sit with CC's daughter so she wouldn't be alone.

Overwhelmed by his kindness, CC and her mother went home for the night. Next morning, CC spoke with the nurses who confirmed that JS had stayed all night by her daughter's bedside.

A few days later JS came to take CC's daughter for a scan, but she refused to go with him, not giving any particular reason but insisting on not going with him and on being accompanied by her parents. During her time in hospital CC's daughter commented that she didn't like JS but didn't want to say why. Her attitude towards him was sustained following her discharge from hospital and over subsequent years.

When the revelations about JS came out in 2012, CC was horrified at what might have happened to her daughter that night. Sadly CC's daughter is now deceased and so she will never know the truth, a fact that causes her significant anxiety and distress.

In the late 1990s, U was aged under 16 years old and was admitted regularly for monitoring on an adult ward at the Infirmary. She recalled two occasions where JS had contact with her.

First she spoke of being pushed by JS along a corridor in a wheelchair. He stopped the chair in front of a door. She thinks this was not a door to a ward or department, but rather a store cupboard. A nurse was walking along the corridor towards them, and as she approached he moved the wheelchair, pushing her back along the corridor. U was confused and asked the nurse why JS was pushing her.

JS became angry and walked off, saying 'I'm not pushing this little bitch any more.' U recalls that the nurse admonished her for upsetting him, but then took her on to her destination.

Later, and possibly the same day, JS came onto the ward. He stood at U's bedside, putting his face very close to hers in a menacing manner. He put his hand under the bedclothes and penetrated her vagina with his fingers. He then attempted to force her to masturbate him, but she says she 'played dead' so he was unable to achieve this. He then stopped and verbally assaulted her. U didn't report this incident to anyone.

Female patients – adults

In the late 1960s, ZM was a young woman who was in the Infirmary after facial surgery. On the same day as JS ran a marathon from Skipton to Leeds, her father bumped into him as he left the hospital after visiting his daughter. JS was entering the hospital and was about to start his shift as a porter for the evening. ZM's father gave JS some money as a donation to the marathon fund and mentioned that his daughter was a patient.

Still sweaty and wearing his running gear, JS entered the side room where ZM lay on her bed. She recalls that he was accompanied by another man she recognised as having something to do with a teenage magazine about pop music. JS jumped on the bed and sat alongside ZM, placing his arm round her shoulder. ZM recalls being embarrassed as she was only wearing a thin nightdress with shoulder straps.

JS pulled one of the straps away from her shoulder, holding it away from her skin so he could peer down her nightdress and look at her body. ZM recalls the other man suggesting that JS get off the bed and sit on a chair, but he remained on the bed.

After a while a nurse popped into the room and asked if everything was all right. Receiving a positive response, she then left. JS and the other man left soon afterwards.

Although ZM recalled to us that 'nothing had happened', the anxiety JS made her feel by his actions on that day has had an enduring impact on her.

In the late 1960s, ZN was a young woman in her late teens, and was admitted as a patient to the Infirmary for surgery on her face. She was cared for on a ward where her bed was located in a four- or six-bedded bay. One day following her operation, when she recalls her face still felt 'wet and raw', and she was sitting in her bed, JS entered the bay pushing a trolley. He greeted her and offered her a bunch of grapes.

JS then came over to her and, standing close by her bedside, placed his hand on her back and began rubbing it, saying 'Everything will be alright'. ZN was wearing pyjamas with a strappy, loose-fitting top in a 'baby doll' style at the time. JS continued to rub her back, then with his other hand began rubbing her chest, moving his hand towards her breasts. ZN recalls she was in pain following the surgery, and was 'a bit in shock' at the attention from JS, and concerned

that he kept moving his hands over the top of her breasts. Suddenly another female patient walked into the bay, and JS immediately stopped touching ZN. She recalls he said 'Ooh, gotta go' and departed swiftly from the bay. ZN did not tell anyone of her encounter with JS, but remembered it in some detail, and still finds the memory of it upsetting.

In the late 1960s, GG was a young woman admitted to the Infirmary on a female surgical ward for an operation on her hip. She met JS for the first time when he entered the ward as part of his portering duties. GG recalls that she was the only young patient on the ward at the time.

On entering the ward, JS went round to see all the patients unaccompanied by any staff, and kissed each woman on the back of their hands. When he came to GG's bedside, he sat on her bed and stroked her arms, put his hands under the covers and stroked her leg, asking why she was in hospital. She disclosed the problem with her hip. He replied 'I know what you've been doing with your boyfriend to get that', implying sexual activity. GG recalls that, at the time, she was not sexually active and was both shocked at the implication of his comment, and upset by it.

He refused to leave her bed until she gave him a kiss on the lips, which she reluctantly did so he would leave. Nursing staff were on the ward at the time, and GG recalls watching them give disapproving looks towards JS, but none intervened to protect her from him. At the time, she presumed this was because he raised money for the hospital.

A month later, following her surgery, she was walking along the corridor accompanied by another patient when JS, who was pushing a different patient in a wheelchair at the time, left this person to charge towards GG, blocking her way and forcibly hugging her. She found this very upsetting, but didn't report anything to the nursing staff.

In the early 1970s, QQ was a young woman patient in the Infirmary, where she was treated for a back injury. She was on strict bed rest in a side ward off a main ward which was for male patients. JS entered the ward and her side room.

He came over to her as she lay flat on the bed, unable to move, and kissed her, inserting his tongue into her mouth. She pulled away as best she could, but he then put his hands into her hospital gown and touched her breasts.

Again she pulled away, and he stopped, glaring at her as she recalls 'as if to say, you are stupid, over-reacting' and laughed at her as he left.

Clearly upset, she told the Sister of his behaviour. She responded by saying 'Oh that's Jimmy, that's just his way.' QQ didn't feel able to tell anyone else and has kept this to herself ever since.

In the early 1970s, ZD was in her twenties, and an in-patient at the Infirmary. Concerts took place quite regularly for patients who were well enough to leave their wards to attend. On one occasion, she attended with a fellow female patient she had befriended. Her friend periodically suffered fits, and during the concert started to feel unwell, as if a fit was developing.

They both left the concert hall (which she thinks was a lecture theatre) and went outside. She recalls JS taking charge of the situation, helping her friend to lie down on the ground and reassuring her. Some nurses and a doctor saw to her friend's clinical needs, helped her to a trolley where she could recover properly and then left them alone with JS.

JS brought over a chair for ZD to sit beside the trolley, and another for him to sit beside her. She said she felt 'trapped' by this arrangement. He put his hand on her leg, underneath her clothes and tried to touch her genitals. She crossed her legs and pushed him away, but he also put his other hand down the neck of her nightdress. She was struggling to get away from him when a nurse and doctor came into the room and he stopped. He said to them 'Oh I was just comforting her, I was making sure she was alright.'

ZD then got up and ran back to the ward. She said 'I didn't tell a soul.' She didn't want there to be any fuss, or to be the centre of attention. She also felt that, because of the high esteem in which JS was held, she wouldn't be believed. For the remainder of her hospital stay, whenever he came on the ward she would hide until he had gone.

In the early 1970s, following a fall, C was admitted to the Infirmary with a fractured spine. At the time she was in her forties. She was nursed in a flat position.

JS accompanied the doctors and nurses on a formal ward round as they visited each patient. On arriving at her bedside, he asked what had happened to her. He then told her that what she needed was a man, and that he would be back later that night at 3am to see her.

At the time, she felt this to be a humorous remark and laughed, as did the doctors and nurses. She also told other staff and her friends about the encounter, as a humorous anecdote.

On reflection now, with the benefit of hindsight, she believes his comments were inappropriate and should have been challenged.

In the early 1970s, H was an in-patient in the Infirmary on the neurosurgical ward, recovering from an operation on her spine. This meant she had to remain on bed rest lying flat. From her bed, she could see into the next bay of four beds on the ward.

In this other bay of four beds, H observed a young female patient, who she described as having brain damage, sitting next to her bed in a chair. H observed JS enter the ward and approach this patient. He kissed her cheek. He then ran his hands up and down her body and in H's words 'molested her'.

H recalls wanting to call a nurse to alert them to this but couldn't see staff on the ward at that moment. Later, when a staff nurse came to take her blood pressure, H told her what she had seen. In response, the nurse shrugged her shoulders and walked away.

H spoke of her anger at this response and of her fear as she lay in her bed that JS would come and do the same thing to her. She didn't report it to anyone else.

In the early 1970s, L was a young woman admitted to the Infirmary with complications following pneumonia. She recalls being in a bed on a Nightingale ward and seeing JS enter the ward one evening.

In full view of the ward, the Sister spoke with him and asked him to leave, which he did. L noticed he was wearing a large white jacket that was far too big for him.

Later, as the nurses were in a meeting in the middle of the ward, possibly handing over information from one shift to another, JS came back to the ward. Speaking to no one, he crept past the nurses and walked to L's bedside. At that moment, L was taking a call on the patients' phone, which in those days was a large machine on wheels that had been pushed to her

bedside. L was speaking with her mother-in-law. Undeterred, JS asked who was on the phone, took the receiver from L and began to talk with her mother-in-law. L recalls feeling annoyed at him as he interrupted their conversation.

Using his oversized coat to shield himself from any onlookers, standing by the bed and chatting to her mother-in-law, he put his hands down his trousers, which she recalls were grubby with an elasticated waist, and pulled the material tight over his erect penis. She recalls that he stared at her and at the same time flicked his tongue in and out 'like a lizard', which she recalls she found unsettling.

A nurse came over and told him brusquely that Sister wanted to see him. L heard the Sister challenge him for being on the ward, and for wearing the oversized coat. He left the ward. The Sister then approached L and asked her if he had done anything to upset her. L said 'no', thinking she would not be believed, but she felt sick and anxious about the experience.

During the early 1980s, A was admitted for surgery at the Infirmary. In her seventies, she was described by her daughter as a proud and dignified woman. As part of his portering duties, JS took her in a wheelchair from the ward to another department for investigations.

She was wearing a theatre gown that tied at the back. En route, whilst alone with her in the corridor, he undid the ties at the back of her gown and ran his fingers up and down her naked back.

A was extremely distraught, so much so that when JS entered the ward on a subsequent occasion, she tried to prevent him from pushing her in a wheelchair and, in doing so, injured herself. A didn't tell any staff about the experience. Her daughter (who told us of her mother's experience) says she would have been 'too proud' to say anything. A is now deceased.

Male patients – children

In the mid-1960s, ZC was a boy aged under 10 living in Leeds. He suffered a fractured arm as a result of a fall and was successfully treated at the Infirmary. A short period after the plaster cast was removed, his arm was broken again and, accompanied by his aunt, he came to the Accident and Emergency (A&E) Department for treatment. He recalls being very distressed and in a great deal of pain.

After he had been assessed by a doctor, a nurse came into the cubicle and advised them that he would need an x-ray and said 'We'll get our nice porter to take you down.' A porter with longish white hair wearing a white coat came in and said he would take ZC to have his x-ray, saying 'Uncle Jimmy will look after you.' ZC had no idea who this person was other than that he was a porter.

JS took him in the trolley to x-ray and his aunt stayed in the A&E Department. After a while in the corridor, JS pushed the trolley through some doors and up against a wall, and stood at ZC's head, stroking his face and telling him it would be all right. With his other hand he went under the bedclothes and touched his genitals.

ZC recalls, 'I was terrified about what he was doing.' He cried out, and a nurse entered the room. ZC recalls her wearing a blue uniform and having an air of seniority about her. He told her 'That man touched me.' JS was standing behind him and told the nurse that all he had done was pat

ZC on the head, making out that he was comforting the boy. Appearing to believe JS, the nurse took no further action. ZC had his x-ray and a cast put on his arm and went home later that day. He didn't see JS after the x-ray.

At home, he disclosed what had happened to his mother. She became angry and told him to stop telling lies, and punished him. Consequently he told no one else. About three years later, he saw JS in different circumstances and realised that the porter from the Infirmary was actually this celebrity figure. Still, he did not disclose his experience to anyone.

The incident has had a major impact on his life, as 'It took away my childhood innocence when I was most vulnerable.'

In the late 1960s, Z was aged under 16 years and was a patient on a children's ward in the Infirmary following an accident where he had sustained some fractures.

One day a nurse asked Z if he would like to be visited by JS, and he responded positively. JS visited him later that day and sat on a chair at his bedside. The nurse who had accompanied him left them to talk. After a while JS asked for the screens to be pulled round the bed as he wanted to discuss 'some private things' and he didn't want the other children to hear, as they might become jealous. JS moved his chair closer to the bedside and offered to scratch Z's leg under the plaster cast. He moved his hand up the boy's leg and touched his genitals. After a while JS left the ward, returning later to see Z and bringing some soft drinks. JS tapped Z's chest, 'pretending he was a doctor', and then moved his hands downwards, again touching his genitals. Z did not tell anyone as he felt his parents would have thought he was making it up.

In the late 1960s, NN was aged under 16 years old and was admitted to the Infirmary following a fall, having suffered a possible fracture. He was accompanied to hospital by his mother.

At that time, JS was working as a porter, and took NN in a wheelchair to the X-ray Department. His mother followed behind. NN was distressed and in a lot of pain. Whilst in the corridor pushing him to the X-ray Department, JS reached down and put his hands into his clothes and onto his penis, asking him 'if he liked it' and 'Has the pain gone away now?'

NN recalls being in too much pain to respond to him. He also has a memory of hearing the clicking of his mother's heels along the corridor. He doesn't recall if anyone else was present in the corridor.

At the waiting area in the X-ray Department, JS stood beside the boy with his back to his mother, who was standing at the other side of the room. On the pretence of rearranging the blankets over NN's knee, JS again put his hands into NN's clothes and masturbated him. After a few moments, NN cried out for his mother and JS quickly 'fiddled' with the blankets, commenting that he thought they were slipping off.

NN recalls JS staring at him when he called for his mother with 'evil staring eyes', which he found intimidating. After the x-ray, NN and his mother didn't see JS again. NN didn't tell anyone about this incident.

In the early 1970s, ZL was a young boy aged under 10 who was a patient on a children's ward where he was recovering from surgery following a trauma to his arm. JS visited the ward and spoke kindly to him and to some of the other children who were patients at the same time.

JS visited the ward a second time, and ZL recalls waking up with the curtains pulled around his bed, so he couldn't see the rest of the ward. JS was seated at the bedside with his hand under the covers and touched ZL's genitals. ZL asked him what he was doing and JS replied that 'The doctor told me to do this.'

Following the injury to his arm, which he recalls as very painful, ZL was anxious that the doctors were going to 'chop my arm off', and so was particularly unsettled at JS mentioning the doctor in respect of his abusive behaviour. ZL told no one about this experience.

In the early 1970s, E was a boy aged under 16 years old and was admitted to the Infirmary for an operation on his knee. The night before his surgery, JS came onto the ward and told him he would be taking him down to theatre the next day for the operation. E recalls being flattered by this attention from the celebrity.

Next morning, after E had received medication to help him to relax prior to surgery, JS collected him from the ward and took him on a trolley to the theatre. In the lift, where they were alone, JS stroked his neck and placed his hand under the sheet and touched his genitals. E was sedated and drowsy and does not recall reacting to this. After surgery, he told his friends about his experience but felt he was not believed. He did not report the incident to any staff.

In the early 1970s, Y was a boy aged under 16 years old in the Infirmary for a chronic clinical problem. He recalls being on a children's ward, and during his stay a film crew visited. They filmed JS pretending to take his blood pressure for a TV programme.

As the film crew moved to another part of the ward, JS remained seated by Y's bedside. He put his hand under the bedclothes, rubbing his hand up and down Y's thigh before touching his genitals. He smiled at Y initially, but then stared at him in what Y describes as 'a threatening way', before walking away.

Y tried to tell his mother what had happened, but felt she did not believe him. There was no further action taken.

In the mid-1980s, LL was a boy aged under 16 years old who was admitted to the Infirmary following a serious accident where he suffered injuries to his head and back. He recovered on a ward with mainly adult patients.

LL was in a coma for a while, and when he regained consciousness his parents were at his bedside on the intensive care unit. JS was also present. At the time, LL didn't know who JS was. He recalls that JS was often 'hovering about' the ward, and LL assumed he was a member of staff working to help the nursing team.

One morning LL was offered a bed bath. He was unable to get out of bed at the time, and agreed to this assistance. JS accompanied the nurse and talked to her whilst she was giving LL the bed bath. LL recalls 'He was chatting her up.'

JS then offered to wash him 'down there', referring to his genitals. LL didn't raise any concerns at the time, because he thought JS was a member of staff, and having a male person attend to his intimate hygiene needs was less embarrassing than the young female nurse. LL told his mother that JS had been to see him, but didn't disclose any details.

Male patients – adults

In the late 1960s, ZZ was a young man and a student at Leeds University. One night, he became acutely ill with breathing problems and was taken by ambulance to the A&E Department at the Infirmary. Lying on a trolley, he was treated by a doctor and advised to stay in overnight for assessment. JS was present in the department and pushed ZZ to a cubicle to rest.

After an hour or so, ZZ recalls being aware of someone stroking his forearm, and a hand under the blanket touching and massaging his genitals. He recalls that JS was standing beside him wearing theatre 'scrubs' and 'big jewellery', including a neck chain, ring and bracelet. ZZ swore at JS, telling him to go away, and he 'scurried away'. There was no one else around.

ZZ told his friends about this incident, but did not formally report it to any staff. He recalls he may have said 'There is something weird about JS', but can't remember if he told anyone in the hospital at the time. Until the revelations in 2012, ZZ had gone through life thinking he was the only person this had happened to.

In the late 1970s, N was a young man working in the Leeds area. One evening he was admitted to the Infirmary A&E Department with severe stomach pains.

He was greeted by a nurse, two porters and JS. Wheeled to a cubicle, he got undressed and put on a theatre gown. He lay on a trolley, as the nurse left for a short period to get some pain relief for him.

Alone in the cubicle with JS, N recalls that JS remained standing by the trolley, talking to him and reassuring him. Then, JS put his hands between N's legs, and touched his groin and penis. 'It was nothing short of being groped', he recalls. N swore at JS and jumped off the trolley, falling to the floor. JS left quickly.

The nurse returned, asking N what he was doing on the floor. N told her that JS was a 'pervert'. N wanted to leave as quickly as possible. He took some medication for pain relief, got dressed and, despite being in a lot of pain, left.

N told his friends about the incident, but thought they did not believe him, and they made remarks about his sexuality that he felt were insulting. He thought of reporting it to the police, but because of JS's celebrity and popularity at the time, felt he wouldn't have been believed and so remained silent on the matter.

In the early 1980s AA was a young man in Chapel Allerton Hospital for an operation on his knee. The doctor informed him that JS was on site as they were opening a new part of the hospital.

In conversation, AA told the doctors that he was a keen long-distance runner, and had beaten JS whilst running in the recent Leeds Marathon.

Following his surgery, AA woke to find JS sitting on the foot of his bed bouncing up and down to wake him up. JS asked him about the marathon and then proceeded to repeatedly call a nurse over to give 'this kid a bed bath'.

The nurse giggled and did not take this request seriously. AA didn't want a bed bath, but JS was insistent and continued to demand a bed bath for AA for an extended period of time. AA told us that he found this frustrating and embarrassing. Receiving no response, JS eventually moved away. No formal report or complaint was made.

Female visitors and others

In the late 1960s, ZB was a girl aged under 16 years old. One day on her way to the local shops in a Leeds suburb, she noticed an unusual campervan parked nearby. Peering at the window, she was surprised to see JS sitting there and plucked up the courage to ask for his autograph. He gave her his phone number and said he would give her his autograph later.

Excited and flattered, after a few days she rang, and he answered, and she couldn't quite believe it. He told her to meet him at the Head Porter's office at the Infirmary, which she did. He offered to drive her home, and she accompanied him in his campervan which was parked in the hospital car park. On the journey home, he pulled over onto some wasteland and invited her to look in the back of the campervan. Not anticipating that anything harmful might occur, she followed him to the back of the campervan and he raped her. Afterwards he didn't speak other than to say on arrival at her home 'Ring me again.'

Her parents knew that she had met him and that he had given her his phone number. They believed his interest was innocent and he was just being friendly. She told them nothing about what had happened to her. Over the coming weeks, he befriended the parents and would regularly pop round for social visits.

JS met ZB on a number of occasions, always arranging to meet at the Head Porter's office at the Infirmary. Although not every encounter she had with him was sexual, she was raped by him on three occasions. ZB then missed a period. She was very scared about this development and told her mother that she had had sex with JS and about her pregnancy fears. Her mother took her to their family doctor, and then to see a consultant gynaecologist at the Infirmary.

ZB told JS about her situation and that she was going to see a doctor at the hospital. He coached her to say that she would harm herself if the doctor refused to end the pregnancy, making her repeat a statement over and over to him until he was confident she would say this to the consultant. When she and her mother saw the gynaecologist and explained the situation, she repeated this statement to him. He gave her two pink tablets (which were possibly progesterone) and two days later she had a vaginal bleed.

She had no further contact from JS. Apart from her parents knowing she had had sexual intercourse with JS, ZB did not tell anyone else about this experience. Her father was very distressed by what had happened to his daughter and sought advice and support from the GP. The memories of this experience continue to be a source of concern and upset for ZB.

In the late 1960s, ZA was a girl aged under 16 years old. Her older sister had been a patient in the Infirmary, and during this time had come in contact with JS as he often visited the wards. He met ZA's sister after she was discharged home and encouraged her to keep in touch.

Over the weeks and months he gradually became a friend of the family and a regular visitor to their home. On one occasion, the family were invited to meet him and his mother in Scarborough and the girls enjoyed a trip in his Rolls-Royce around the town. ZA's sister then got married and moved away from the family home. JS attended the wedding and even offered his Rolls-Royce to drive them to the Registry Office.

He continued to visit the family and, after a few months, bought a campervan which he showed to them. One evening he visited and suggested that he and ZA pop out to buy fish and chips for them all. In the campervan, he gave her permission to smoke a cigarette, and as she secretly smoked when not at home, she enjoyed this attention.

He parked a little way away from the chip shop in a relatively quiet spot. He kissed her and moved her onto the bed in the back of the campervan. He then raped her. Afterwards, he said 'Don't worry, next time it'll be better for you.'

ZA was a nervous, quiet girl and had never had a boyfriend before this. She recalled how she lacked the confidence to have challenged him directly. JS advised her to lie to her mother, saying there had been a queue at the chip shop and that was the reason for the delay in their return to the family home.

Over the ensuing weeks, he would visit them sporadically. When there was a longer gap between visits, ZA's mother, who was impressed by his celebrity profile, would ring and chat with him. On these occasions, he would ask after ZA and invite her to meet him at the Head Porter's office at the Infirmary, which she did. Sometimes, when he was taking ZA somewhere in one of his vehicles he would wear a balaclava to hide his hair so that he wouldn't be recognised.

He took her to a terraced house in Leeds which he said was his childhood home. In a sparsely furnished downstairs room containing a single bed, he had sexual intercourse with her, without her consent, on three further occasions over the period of a few months.

During this time period, ZA had started a relationship with a young man, and had become pregnant by him. After the birth of her baby, it was decided to give up the child for adoption. She recalls that the last sexual encounter with JS was five weeks after the birth and around the time she faced giving her child away. She recalls this was a very vulnerable time for her.

ZA didn't tell anyone about her experiences with JS, but she told us they have had a lasting impact on her life and relationships.

In the late 1960s, ZK was in her first job after leaving school. She had an administration role at a soft drinks factory in Leeds. JS was invited to conduct the official opening event for the factory, and she recalls how he 'made a beeline' for her at the event.

Sitting in one of the offices in view of the reception area, he insisted she sat on his knee, calling her his 'official cigar lighter'. He put his arm round her waist and pulled her towards him, rubbing the inside of her thighs. He would not let her go despite her requests to get away, and this continued for three to four hours.

He repeatedly suggested that she should meet him later at the Infirmary, telling her about his visits to Buckingham Palace and offering her dinner and trips in his Rolls-Royce. She recalls how he stared at her and that his demeanour scared her.

Over the next three months, he rang her workplace frequently to persuade her to meet with him. She became very anxious about these calls and said 'It got to the stage where I daren't answer the phone.' On one occasion, JS sent a car to her home to collect her and take her to the Infirmary. She hid in the house until the car drove away. The calls continued for three months, when because of the break-up of her parents' marriage she moved to live with her mother in a different part of the country.

She heard nothing further from JS after this time, but remains troubled by her experience with him even today.

In the late 1960s UU was a girl aged under 16 years old who was preparing for a newspaper competition for young people to write an article about a celebrity. It was suggested she try to meet JS and write her article on him.

Initially, she met with a man who she understood to be the Head Porter at his office and he gave her a very informed interview about JS, claiming that 'I'm like Jimmy Savile's brother here.' He also offered to arrange a meeting for her with Savile. UU wrote her article and it was highly commended in the competition. The Head Porter subsequently rang her home and spoke to her mother to arrange the meeting with JS. UU came back to the Head Porter's office and the man she had met previously greeted her and went to get JS. He then left JS and UU alone in the office.

Immediately they were alone, she described how JS's 'demeanour changed'. He forcibly kissed her, putting his tongue into her mouth, touched her breasts, penetrated her vagina with his fingers twice and forced her to masturbate him. This was her first sexual encounter and she described how her experience has had a profound and sustained impact upon her. She recalls JS saying 'You won't talk about this, nobody will believe you. I'm Jimmy Savile, I can get you.'

UU told her mother that she was bleeding following the incident and that she had been sexually assaulted, but felt her mother did not believe her. She did not disclose what happened to anyone else.

In the late 1960s ZG was a schoolgirl aged under 16 years. She and a female friend visited a mutual male friend who was a patient following a car accident. One day whilst they were visiting, JS walked past their friend's bed and spoke with them. He wanted to record their conversation for his radio programme *Savile's Travels*.

The relationship developed, and they would occasionally leave school early to meet with him in a local sandwich shop. He would take them into the hospital radio station and they would accompany him on his visits to wards in their school uniform. Over a matter of months, there were approximately 20 such visits. ZG does not recall, however, ever being challenged or questioned by hospital staff as they walked onto the wards following JS.

On one occasion they accompanied him to a children's ward where he told a young male patient who ZG believed to be aged 10 or 11 that the girls were going to rub him all over with surgical spirits. These encounters were recalled as friendly and he would talk with them about pop groups and other famous people. He also promised to take them to see *Top of the Pops* when they were 16 and invited them to a concert held by The Beach Boys at the Infirmary.

Whilst they were in his company, JS would often give the girls kisses and cuddles, but ZG did not feel this was anything untoward as she observed that he was tactile with lots of people. One day, however, they went to his house at Consort Terrace, and he opened the door wearing a tracksuit and let them in before returning to his bed. He asked them to make him a cup of tea. The girls were in separate rooms as one stayed in the kitchen and ZG went into his bedroom. He pulled her close, and gave her a prolonged kiss in a sexual manner and rubbed his hand up and down her body to the top of her leg. Then he stopped and sent her into the kitchen, instructing her friend to come to him. ZG believes he repeated his actions with her.

Nothing further happened on this occasion, but ZG recalls how the experience did not 'feel right', and they made sure they never returned to his house. They continued to follow him on his ward visits, and ZG recalls watching the moon landings on a portable television with JS in his campervan, where she also noticed he kept a bed.

When she became 16, ZG left school and, with her friend, began employed work. The visits to the hospital and contact with JS stopped when they left school. ZG recalls 'At the time we thought it was something special, we were special, and now we realise we weren't, we were just being groomed.'

In the early 1970s ZE, a girl under 16 years old, was undertaking a few days' work experience at the Infirmary as part of a school project. As she walked along a corridor with a couple of her school friends, she was stopped by JS, who was alone. He pinned her arms to her side as he grabbed her in a 'bear' hug and forcibly kissed her, putting his tongue into her mouth, an experience that she said lasted for some 30 seconds or so before he walked off. No conversation whatsoever took place. ZE was aware of other people in the corridor at the time but nobody intervened. She was shocked but did not disclose what had happened to any adult at the time.

In the early 1970s ZF, a teenager, was in the canteen at the Infirmary with two of her school friends. They were all on work experience at the hospital and were wearing school uniform. The three young women were approached by JS, who kissed them all. He then asked ZF to go home with him. ZF recounted the invitation to her mother, who worked at the hospital. She strongly dissuaded her from doing so or from having anything further to do with him.

Female staff

In the late 1960s, K was in her first job after leaving school. She worked in the post room at the Infirmary. She was busy one day, alone in the office, singing to herself, when JS came into the post room and grabbed her from behind and touched her breast. K told him to 'get off'.

He told her she had a beautiful voice and asked her to sing on the hospital radio. She declined. He asked again and she repeated her refusal, angry with him for touching her. That evening she told her mother, who advised her to keep away from him.

Some time later, near Christmas, she recalls being busy but alone in the post room. JS came in and placed his hands over her eyes. He gave her a packet of cigarillos and some sweets, and then pushed her against the wall, pressing himself up against her. She pushed him away and told him to back off.

On a third occasion, she was asked by her supervisor to give JS a 'wake up call'. He sometimes slept in his campervan in the car park, and K was asked to wake him with a cup of coffee. She knocked on the door and he opened it and grabbed her arm, trying to pull her into the campervan. At the same time, two porters entered the car park and asked if she was OK. JS immediately released her. K didn't report these incidents but soon left the Infirmary for another post.

In the early 1970s, B was a young woman who worked at the Infirmary in the administration offices. She recalls she was used to 'lewd remarks' and to frequently being touched by men whilst at work and at social gatherings.

She met JS on a couple of occasions and described his invasion of her personal space, and that he touched and stroked her hand, arm and back. At the time she was flattered at this attention from the celebrity. She was, she feels, more tolerant of his behaviour because of who he was. She was never alone with him and, whilst with hindsight she believes his behaviour was inappropriate, at the time she accepted it. She did not report her concerns to anyone at the time.

In the early 1970s MM was a secretary at the Infirmary. She recalls attending a Christmas party at the Medical Records Office one year, which JS also attended. He came over to dance with her and 'groped' her bottom. MM quickly moved away. She didn't inform anyone about this incident at the time.

In the early 1970s, S was a student nurse at the Infirmary. Leaving an evening shift a little later than normal, she was walking through the link corridor from the hospital to the nurses' home to get changed and go home. It was late and dark outside.

Alone in the corridor, she saw JS approaching her, wearing a kilt. She spoke briefly to acknowledge him, when he suddenly lifted his kilt exposing his erect penis. He made a lewd suggestion to her, and stood blocking her way. Terrified, she swore at him and ran to the nurses' home. She recalls she was 'shaking like a leaf'. As she was late leaving the ward, there was no one in the changing room in the nurses' home to talk to.

She recalls she didn't tell anyone as she felt she wouldn't be believed. Some weeks earlier, whilst on duty, she had attended to a male patient who had tried to grab her and had torn her uniform. When she reported this to the Matron (now deceased), even though she wanted to report it to the police, she was advised that, as they didn't want any scandal, that wouldn't be necessary. She felt her incident with JS would be similarly dealt with, and reported nothing further.

In the 1970s, KK was a medical secretary at the Infirmary. She came into contact with JS as she also did some work for the hospital radio, which at the time was run by the Head Porter. He asked if she would like to get involved in some fundraising activity in the hospital and she expressed an interest in doing so.

Through this she was introduced to JS by the Head Porter. On another occasion, she recalls being invited by JS to join him, the Head Porter and some other men to visit JS's flat in Roundhay Park when he was in the process of buying the property.

On the afternoon of the fundraising fair, which was held over a weekend, JS called in during the late afternoon and asked KK if she wanted a break. He offered her a lift in his Rolls-Royce saying that he wanted to pick something up from his mother's house. On reaching the property he invited her inside, and took her into a ground floor room KK described as 'sordid', with a linoleum floor and a bed in the corner. JS told her to sit on the bed. He pulled down his trousers and raped her. He then drove her back to the hospital in silence and never had any further contact with her.

In her words, KK felt 'so embarrassed and ashamed' that she didn't tell anyone about her ordeal at the time, and only told her fiancé, soon to be her husband, before they got married. She never saw JS again, and left the hospital three years later. As a result of this assault, KK has experienced significant emotional trauma throughout her adult life.

In the late 1970s FF was a student nurse at the Infirmary. She was aware that JS was often in the hospital, and that many of her nursing colleagues felt uncomfortable about him as he was 'touchy feely'.

One day on her way to x-ray, FF came across JS walking in a narrow corridor. He made some lewd remarks to her and touched her bottom. FF pushed him away and walked on away from him.

On returning to the ward, she told her colleagues. One said 'Oh no not again.' FF recalls the Ward Sister commenting on all the good things he did for the hospital. FF didn't report the incident formally, as she believed it would not be acted upon.

In the early 1980s, JJ was a nurse on a children's ward at the Infirmary. She recalls JS attending the ward for the promotion of a safety campaign, 'Play it Safe'. She described how he insisted that the promotional work for the campaign was to be prioritised over the ward routines, including delaying the lunchtime meals for the children who were patients.

One press photo (seen by the investigation team) from that day covered a donation made to the ward. While the picture was being taken JJ stood next to a child in a bed and JS stood alongside her. She described how he put his hand up inside her uniform to touch her bottom whilst this took place. She endeavoured to push his hand away and then moved away from him as soon as the photo was taken. She didn't tell anyone, however, about this behaviour.

In the early 1980s, F worked at the Infirmary in a clinical role. She recalls JS buying birthday cakes for staff in one of the departments as it was his birthday.

One of the young women, a ward clerk, returned a plate of leftover cakes to JS in his office. He was behind the desk. The woman thanked him for the cakes and turned to leave. She told F he leapt out of his seat saying 'I think they were worth more than that' and forcibly kissed her, putting his tongue in her mouth.

She left the room promptly and in a distressed state rushed to the bathroom and washed her mouth. Although upset, she recounted this to her work colleagues (including F), but didn't report it to anyone in authority.

In the late 1980s HH was a student who worked with cardiology services at the Infirmary. She was taking equipment to a department one day when she saw JS in the corridor.

She described how he approached her, and commented that he recognised the equipment she was carrying as a heart monitor. Standing in front of her, he took her hand and placed it on his chest, saying 'My heart's feeling a bit funny today, can you feel it?' He then asked her if he could

feel her 'heart'. His hand moved to touch her breast, but she moved away and avoided him doing this. She recalls there were lots of people milling around, but she didn't tell anyone about this encounter.

In the early 1990s, G was a doctor working in the Infirmary on a paediatric ward. She was on the ward on a Christmas Day when JS entered the ward accompanied by two other men that she didn't recognise. She walked towards JS to welcome him to the ward.

Suddenly he lunged forward and grabbed her hand and kissed her forcibly on the mouth, inserting his tongue. He then rubbed her breasts. The two other men had stayed near the ward entrance. Just as suddenly, JS then turned and left the ward immediately without speaking.

G was stunned and repulsed. She recalls being supported by the Ward Sister. The other nurses had remained at the 'nurses' station' all this time. When G asked them if they had seen what happened, one responded 'Why do you think we stayed here? That's what Jimmy Savile does to women.' G also spoke about the incident to her senior consultant who was empathetic. At no time did G or any of her colleagues think of making a formal report or complaint about the incident.

In the mid-1990s, R was a secretary at the Infirmary. She recalls two occasions when she was on her own with JS in a lift. On the first occasion, he commented that he could see through her blouse, and stood so close to her that she could feel his breath. This made her very uncomfortable and she fled the lift as soon as it came to a stop.

On the second occasion, 18 months later, he entered the lift and brushed her shoulder and breast with his hand. He spoke to her, but she recalls only being so shocked that she did not hear what he said. She left the lift as soon as the doors opened. She informed a colleague who advised her to avoid him in future. She felt inhibited from saying anything further because of his celebrity status.

In the mid-1990s, EE was a Ward Sister at the Infirmary. She remembers JS bringing a patient back from x-ray, pushing her in a wheelchair onto the ward. EE recalls how JS stopped to talk with some patients, and kept his hands on the woman's shoulders, moving them inappropriately close to her breasts. Although the patient didn't react, it made EE uncomfortable.

As he left the unit, EE asked JS if he would 'fix it for the nurses to have a pay rise'. He looked her up and down and made a lewd remark to her, suggesting that if she had sex with him he would see what he could do. EE rebuffed him firmly, and he left the ward. She asked her colleagues if they had heard what he said, and they confirmed they had. Initially they were surprised, then laughed about it. No further action was taken.

In the late 1990s, SS worked in the hospital on one of the reception desks in the Infirmary. This was a main reception desk, where keys were kept for various departments including the on-site residences for on-call staff. She recalls JS would often come up behind her, to see what she was doing, and to see what keys were around. He would often put his arms around her: this was unwelcome and she pulled away from him. She did not report his behaviour to anyone. She recalls JS 'hanging around' the reception desk on many occasions including millennium night.

In the late 1990s RR worked at the Infirmary as a receptionist mainly at one of the many entrances for patients. One day an elderly gentleman came in asking to see his brother. She went to his assistance and found the location of his relative.

It became clear the gentleman was JS, and he was very grateful for her assistance. He flamboyantly kissed her hand and then all the way up her bare arm to her shoulder. She found this attention unwelcome and 'creepy'. She didn't inform anyone of this incident, however.

In the mid-2000s, P was a junior doctor at the Infirmary. She admitted JS as a patient. P recalls his behaviour as 'bizarre'. He kissed her hand and up her arm and wanted her to sit on the bed. This made her feel uncomfortable. She did not report this to anyone.

In the early 2000s, D was in her late twenties and worked at the Infirmary in an administrative role. JS visited her department on the ground floor as part of a publicity campaign. He was elderly at the time and she offered to accompany him to his destination on the fourth floor.

She entered a lift with him. They were alone. D stood facing the lift door and JS stood behind her. He swept his hand up her legs and placed his hand on her genitals. D yelled out and stepped away.

JS laughed at her and left her in tears as he walked from the lift. Still upset, she told her colleagues who advised her to inform a senior person, a consultant, which she did. They dismissed her account as 'silly'. She felt betrayed by them at the time, but on reflection, believed they were embarrassed and didn't know what to do.

A few years later, at another fundraising event in the department, JS attended and D told us he groped her bottom. D recalls that other people were present but feels they did not take her report of the incident seriously.

W worked in a clinical department in the Infirmary. In the mid-2000s, she recalls a consultant bringing JS into the department. She thinks he was a patient at the time. He went round all the female staff, kissing their hands. 'It was just really creepy', and made her feel uncomfortable.

Whilst he was present the female staff were giggling and engaging with him. When he left the general feeling was 'I need to wash my hand now.' W believed that JS did many good things for the hospital, but her contact with him, although fleeting, was unpleasant and unwelcome.

Other hospitals

(We advised these other hospitals about their own investigations and contributed to the interview process, and so include these accounts for completeness.)

In the late 1960s VV, a teenager aged under 16 years, was admitted to Dewsbury Hospital for treatment of a skin condition. She was on an adult female ward, and one morning the patients were told that JS was visiting the department.

VV and another young female patient asked to meet him and, clutching pens and papers for autographs, they were escorted by a nurse off the ward to the reception to meet him.

Later that day, as part of his visit, JS came up to the ward, and sat on VV's bed with his back to her, but facing the other female patients, chatting away for an hour or so.

He then got up, and turned to face VV as she was sitting on the bed with her legs straight in front of her. He placed a fist either side of her legs and tried to put his leg over her to 'straddle her'. He then leant over and kissed her, forcing his tongue into her mouth. This lasted for 10 seconds and she found it terrifying. He then grinned at her and walked off.

One of the other patients exclaimed that what he had done wasn't right, but no one said anything directly to VV. She was embarrassed, 'red faced and tearful'. At visiting time, one of the patients told her mother that JS had kissed her, but VV said nothing else about the incident to anyone.

In the late 1980s, YY was a patient at High Royds Psychiatric Hospital in Leeds for a number of months. Plans were afoot for celebrating the centenary of the organisation, and staff and service users were told that a 'big star' would be coming to the celebration event. YY was involved in the preparations, making decorations with crepe paper. JS attended the event, arriving in his 'big white car'.

Part of the celebrations involved a fun run, where YY and others dressed in fancy dress. She recalls wearing a red leotard and tights. JS groped her bottom, and also one of the female nurses. YY told the nurse she wasn't happy about what he had done, but did not tell the Sister as she felt intimidated by her.

In the late 1980s, Q had a technical role at High Royds Psychiatric Hospital. As part of a fundraising event, a fun run, many staff attended in fancy dress.

Q recalls JS attending the event and 'being free with his hands'. He put 'his arm round the waists of female staff, cupped their breasts and put his hand up their skirts'. At the time, she recalls, they laughed it off, and told him to 'bugger off'. He was seen by Q and her colleagues as a 'dirty old man' and they avoided him for the rest of the day. No staff made any formal complaints.

In the late 1970s, V was a girl aged under 16 years old. She won a prize from her school to attend the opening event for Wheatfields Hospice in Leeds.

She recalls being innocent and 'young for her age'. Advised to dress smartly, but not to wear school uniform, she wore a dark skirt suit belonging to her mother. Because of a medical problem, she had been advised against wearing tights or tight clothes, so wore stockings under the suit.

V recalls being excited about going to the event, and looking forward to meeting 'the' JS. The seats for the various guests were arranged in a horseshoe shape in a large room, and she was seated near to the centre of the front row when he entered the room.

He approached her directly, asking her age and what she was doing there, and saying 'Squeeze up' as he wanted to sit right next to her. As he sat down, he stroked her leg and, on feeling the suspender belt under her skirt, stared at her before announcing 'Ooh lovely looking young lady, wearing stockings, goodness gracious me' to the room full of people.

V felt humiliated and embarrassed, 'like a rabbit in the headlights'. When she went home, she recounted what had happened to her mother, who was dismissive and advised her to 'grow up'. V did not tell anyone else.

High-risk encounters

In the late 1960s ZH was a student at Leeds University. A keen sportswoman, she was informed by a colleague that she could make a request to JS to find out whether some funding might be available for some of the sports activity she was involved in. She arranged to see him at a hospital, which she believes was the Infirmary as it was near to the University.

She recalls that JS was uninterested in the funding request, but appeared more interested in the news that she intended to attend a ball to be held at the University the following weekend.

Whilst at the ball, she noticed JS enter the room and walk around seemingly looking for someone. He was accompanied by two other men. On seeing ZH, he approached her and invited her to join him at a party that evening where, he claimed, there would be many famous people present. He suggested she left with him, and she did so. On reflection, ZH describes her response as 'young, stupid and flattered'.

He drove to a terraced house in Leeds and they entered the property. There was no one else present and ZH recalls feeling 'duped' at having believed that there was a genuine party to attend. The downstairs room contained a single bed and little else. The other men left her alone with JS, who repeatedly tried to touch her sexually. She recalls 'I spent the night fighting him off.' After some time, still wearing her ball gown, she fell asleep.

The next morning JS drove her back to the University in silence and she did not hear from him again. She told her friends, but took no further action as she felt foolish and blamed herself for the situation, and also felt that nothing had happened.

In the mid-1980s ZO was a young woman who worked on a local radio station. Each year they had a charity appeal, and this particular year the aim was to raise money for children to go to America. The grandmother of a young boy who was very ill and being treated in the Infirmary contacted her and explained he couldn't go to America, but the family were looking for help. Touched by their plight, ZO built a relationship with the family.

As Christmas approached, there was a party for the children. ZO invited the young boy, asking what he would like for Christmas, and he asked ZO if he could meet JS. She used her contacts at the radio station to obtain JS's phone number and rang him to tell him about this boy and to invite him to the party. JS attended and met the boy, and was told about his forthcoming surgery. JS asked to be kept informed and promised to send a Christmas card to the family.

In due course, the boy had his surgery, but was very ill afterwards and was treated in the intensive care unit at the Infirmary. ZO contacted the family and in conversation they said JS had never contacted them, or sent a card.

ZO rang JS and berated him for letting the boy down. He offered to visit him with ZO and suggested she came to his flat that evening and they would travel to the hospital together. Strongly advised by her producer not to go to his flat alone, ZO went along accompanied by her father. On arrival, she used the intercom to alert JS, who instructed her to come up in the lift which would open at his flat. Her father did not speak at this point, so JS was not aware he was present.

As the lift door opened to his flat, ZO and her father met JS. He was completely naked apart from a pair of 'see-through' running shorts. Her father greeted him, and JS, clearly shocked at his unanticipated presence, disappeared quickly to get dressed. They then went to the hospital as planned and JS was very professional and attentive to the boy and his family.

On reflection, ZO felt his intentions in the flat were clear, and that had she not been accompanied by her father, she would have been placed at a high risk of sexual assault by JS. ZO feels he had little or no interest in the welfare of the child. Because of the security arrangement at the flat, she feels she would not have known how to leave quickly, and therefore potentially was not in control of the situation.

She informed her colleagues about the incident but no further action was taken.

Part two

The accounts from victims who came forward to be interviewed as part of this investigation reveal the extent of Savile's abuse in the Infirmary. We were particularly struck by four patterns or consistent features in some of the accounts given:

1 There were three cases of Savile working with others to organise the abuse.

2 There were eight cases of Savile going to considerable lengths to plan in detail abusive encounters.

3 Whilst the majority of cases of abuse reported to us were opportunistic in nature, many were not covert or hidden from the public gaze. Forty-three took place in hospital corridors, in ward areas or in other locations where access to the public or to staff was unrestricted.

4 In seven cases of abuse of children and young people, we were told how Savile used intimidation or humiliation to ensure they remained silent.

We illustrate these patterns below using examples chosen to demonstrate the diversity and extent of his abuse.

Involvement of others

In three of the accounts given to us there was evidence that Savile's ability to abuse was assisted or facilitated by other people. Although the victims concerned were not able to recollect specific names of the other people, their perception was that, at the time, these individuals were employees of the Infirmary.

All three accounts date back to the late 1960s and early 1970s. A number of further enquiries have been made in an attempt to identify these individuals, but this has not been possible. Because of the length of time since the assaults, even if Savile's associates were indeed employees at the time, we have found no evidence that they remain in the Infirmary's employment today. Further, our enquiries confirm that the longest serving current members of the staff groups at the Infirmary referred to in the following examples commenced their employment after these events took place (source: Leeds Teaching Hospitals NHS Trust workforce information, 2013).

Example 1

UU was a teenager aged under 16 years, and an aspiring journalist (see page 123). In the late 1960s she entered a national competition to write an article about a celebrity. She wanted to interview Savile and had been advised by the local newspaper newsroom to make her approach via the Head Porter at the Infirmary. Acting on that advice she went to the hospital,

knocked on the door of the Head Porter's office and explained her request. A man whom she assumed to be the Head Porter answered the door, and advised her that he would conduct the interview on behalf of Savile. He explained that he was in a position to do that as:

> "I'm like Jimmy Savile's brother here."

When the interview took place, the man was able to substantiate his claim of being close to Savile when he provided detailed answers to her many questions. At the end of the interview he asked her if she would like to meet Savile, an opportunity that she readily accepted:

> "He said, I can arrange it you know. I can arrange it. He's got access… He's got access to other famous people you might be able to do articles about, and I was completely star-struck."

Arrangements were subsequently made for her to return to the hospital to meet with Savile. Once again, she went to the Head Porter's office and met the same man as before. After inviting her into his office he left the room. He returned a short time later accompanied by Savile, who was, initially, very friendly. However, in the words of the victim:

> "The Head Porter said, I'll leave you to it, shut the door, and then he changed. His demeanour changed… he wasn't the Jimmy Savile that you saw on the telly, that you know, you saw at charity events. He was, he just wasn't that sort of man anymore… He changed within, I would have said, seconds. His eyes were cold and dead, and he moved his hand, you know, he started that then. I mean, literally, as soon as the door had shut."

Savile then subjected the victim to a serious sexual assault (see page 123).

> "I don't know how long it was; it felt like a really really long time… I think I was just very very shocked that this was happening... when I pushed sort of had a grip, he had a grip on me. His mouth was back on mine… I was like an object… whatever I said or did made absolutely no difference. He was like, his eyes were dead and cold, that's the thing I remember completely."

UU recalled that during her first visit to the Head Porter's office, it had been extremely busy with callers, a regular flow of people. However, during her attack by Savile, in the same office and during working hours for most staff, no one had called:

> "When I was there before, people coming in and out the whole time. I don't quite understand why people weren't coming in and out that time."

Whilst we cannot be certain that another person conspired with Savile to ensure that he was not disturbed whilst in the office with UU, the fact that there were no visitors to the office during the hours of the working day is, at least, unusual.

From the evidence provided by this victim we do not believe the person she perceived to be the Head Porter was the person who fulfilled the role at that time (Charles Hullighan, now deceased). However, we have been unable to determine the identity of this individual.

Example 2

Savile was assisted by others to perpetrate his abusive behaviour in the case of WW who, as a young teenager in the early 1970s, was a patient on an adult ward when she was first approached by Savile (see page 113). He took her to a local newsagent's shop and arranged for magazines and sweets to be brought to the ward for her. Savile was not asked to pay for the items:

> "There were magazines and all down the shelves on the right hand side there were sweets, there were magazines, there were papers, and he just got the whole lot and arranged to have them delivered to the ward. It was just quite bizarre really."

A day or two later a man she recognised as a porter (as she had previously seen him about the ward with patients) called into the ward and approached her as she rested on her bed, and advised her that Savile wanted to see her. She left the ward with him, and he led her to a remote part of the hospital, without engaging her in any conversation:

> "I remember going down some stairs, a lot of stairs, and I remember going along a corridor, a long, long corridor with huge pipes down the right hand side as you are walking down. We seemed to be walking down further."

The porter knocked on and then opened an office door. As WW entered the small room, which just contained two desks, she saw Savile leaning against a wall:

> "He pulled me to him… he started kissing me, started with the tongue in the mouth… his left hand went on to my right thigh, just under my dress, and his, his right hand went onto my left breast."

Savile then went on to subject the victim to a serious sexual assault, only speaking to her once when he asked her if she was on the pill. Her response that she was not appears to have influenced how he continued with his attack.

Following the attack, Savile knocked on the door from the inside. The door was immediately opened and another man stood outside the room and motioned for her to follow him. This second man was not familiar to WW and was not wearing the usual porter's type of coat. She never saw this man again.

At no point was there any conversation between Savile and either of the two men who accompanied WW from, and back to, the ward. When asked if she believed that the three men were working together, she replied:

> "No doubt at all. They must have been… obviously it wasn't the first time that was done, it was seamless. It was through 'knock knock' and in, and then 'knock knock' and out."

There can be little doubt that these two other men helped Savile. Further, there was no challenge from staff as WW was taken from the ward.

It has not been possible to ascertain the identity of either of the two men involved.

Example 3

KK was an employee at the Infirmary in the early 1970s (see page 125). She also volunteered to work on the hospital radio station. The Head Porter, who at this time was Charles Hullighan, managed the hospital radio station. After recruiting her, he spent an increasing amount of time with her, always managing the radio control console when she was helping out at the radio station.

He subsequently invited KK down to his office to discuss his suggestion that she become involved in a charity fundraising event at the hospital, and when she called down to the office she was introduced to Savile.

Savile invited KK to accompany him and some other associates, all of whom were men, on a visit to his future flat in Roundhay when he was viewing it prior to purchase. KK was the only woman in the group, and recalls:

> "The feeling was that I was being appraised, you know, sort of looked at… I couldn't really think of any good reason why I should be there, you know, or asked there. You know, they kept sort of looking at you and talking, and I felt very much out of place."

In the period following that visit she attended the fundraising event at the Infirmary that Hullighan had proposed she be involved in. When Savile arrived he asked her if she wanted to have a break, proposing that this could include a visit to his mother's home in Leeds where he claimed he had something to collect. They travelled in his Rolls-Royce to the property. Savile took her inside and invited her to sit down on a bed located in a downstairs room.

He then raped her on the bed. KK recalled being 'frozen in shock' at what was happening. Afterwards he calmly made himself a cup of tea before taking her back to the hospital in his car in total silence. When asked to describe Savile's attitude following the attack, KK said:

> "Well, I've done that, end of story. Cold. He just didn't seem to care."

We cannot be sure Hullighan knew of any intention by Savile to rape KK, but what is clear from the evidence is that he played the central role in their introduction. He also encouraged KK to become involved in the weekend fundraising event from which Savile took her to his mother's house and raped her.

KK was asked if she believed that Hullighan was involved in preparing her to become a victim of Savile. As the person who lived through the experience and as the only living witness to the events that occurred, she replied:

> "Yes, I do now. Yes. No doubt."

Planned encounters

Eight encounters involved considerable levels of preparation and organisation by Savile. These cases demonstrate an intent that was unforeseen by the subsequent victims or their families. Some cases demonstrated his ability to establish a trusting relationship with both the victims and their families over many weeks and months prior to an assault. In modern parlance, such relationships could be described as 'grooming'. Whilst clearly an opportunistic abuser, these cases illustrate that Savile was sometimes willing to wait for his victim, however long it took. Two examples are given below.

Example 1

M was a child under 10 years of age and lived outside the Leeds area (see page 111). Her family received an offer from Savile to transport her to the Infirmary to undergo her treatment. Savile arrived at M's home in a car so small that it could not accommodate her parents. They had to make their own travel arrangements to Leeds whilst Savile travelled alone with their daughter. The car had a seating arrangement which meant that any passengers had to sit alongside the driver, on a bench seat.

M suffered abuse, of both a physical and an emotional nature, at the hospital, prior to the arrival of her parents. M recalls:

> "He sat me there, and said that he was going to make me pretty. He actually said that it was him that was paying to make me pretty and that when I grew up I'd be pretty…
>
> He kissed my neck again. It wasn't like if your daughter falls or any of your family's children fall, you pick them up and say 'come here and let me kiss it better'. It wasn't like that. It was a horrible slimy kiss with him there."

The pattern of the sexual abuse was repeated several months later when M required further treatment and the same travel arrangements were made. On this occasion Savile also sexually abused M during the journey to the hospital. These repeated attacks traumatised M to such an extent that she attempted to prevent further abuse by deliberately and seriously injuring herself, requiring hospital treatment locally.

Unfortunately, whilst the self-harm saved M from further abuse, it also meant that the specialist medical treatment did not continue.

Example 2

ZA was a young teenage girl aged under 16 years who first met Savile when he befriended her older sister, who was a patient at the Infirmary (see page 121). He went on to develop a relationship with their parents that extended to social visits.

On one occasion, having called at the family home in his new campervan, Savile proposed a visit to the local fish and chip shop and asked ZA to accompany him. En route, Savile parked on a side road away from the parade of shops and invited her into the back of the vehicle where he raped her:

> “He didn’t push me onto the bed or anything like that. It was kind of manoeuvred; very sort of manipulatively back onto the bed.”

The relationship with the family had been going on for two years at this point and it continued for some months afterwards. During that period Savile had sexual intercourse with her without her consent on three further occasions at a terraced house in Leeds. He would contact her and ask her to meet him at the Head Porter’s office at the Infirmary. He would then take her in his car to the house where the encounters took place on a single bed in a ground floor room. This location is very similarly described by three other victims and a further witness:

> “I remember standing in front of the fireplace and him pulling, you know, I might’ve been sat in a chair or something, pulling me up and holding me and manoeuvring me back to the bed.”

His cultivation of a relationship with the victim’s parents and older sibling, including special treats, demonstrates the lengths he would go to over a prolonged period of time which, in this case, approached three years.

Opportunistic abuse in public areas

The majority of Savile’s victims experienced opportunistic abuse or inappropriate behaviour. These incidents primarily involved female staff (16 out of 19 cases) but also included both male (10) and female (13) patients, and four other victims across a broad range of venues and circumstances.

It is likely that Savile knew the Infirmary very well and evidence suggests that he frequented areas and departments where it was relatively easy for him to have access to vulnerable patients, such as cubicles in the A&E Department. However, he also abused many (at least 35)

of his victims in busy public spaces such as corridors, wards and departments, where there would invariably be many people passing by. In a further eight cases, abuse took place in a public area, but Savile took steps to conceal his actions. Such encounters took place in lifts, where he ensured he was alone with the victim, or on wards where he would pull the curtains around the victim's bed. The majority of cases took place in busy public areas, and we can infer from this brazen behaviour that he had little concern about the possibility of being challenged or sanctioned. This is underlined further by the number of assaults Savile commited.

Example 1

In the early 1980s Savile attended a children's ward for a publicity event. He had his photograph (seen by the investigation team) taken for a press article with a nurse, JJ, and a child who was a patient on the ward (see page 126). What appeared to be a happy, positive event was compromised for JJ, who had to endure Savile's attempts to indecently assault her whilst the photograph was being taken in the middle of a busy children's ward:

> "All the time we were posing for this picture being taken he had his hand up my skirt… I am desperately saying 'Get out, get out!'… I kept his hand down and everything and I just got away from him as soon as I could."

When asked how she felt following Savile's unwanted attention, JJ simply replied:

> "Violated."

Example 2

When GG was a young woman in the late 1960s she was a patient in the Infirmary (see page 115). She described two encounters with Savile. The youngest patient on a female ward, she described his behaviour when visiting the ward. He walked round the ward, kissing the hands of all the female patients. When he arrived at her bedside:

> "He wouldn't leave me until I kissed him, and it wasn't that he wanted a kiss on my hand like he did with all the other patients. I had to give him a kiss on the lips… He was stroking my arm… touching my leg under the covers… He said I had to give him a kiss and it had to be on the lips… I was literally the only person that he kissed. Everybody else it was a quick kiss on the hand and then go off, but he was with me about 15, 20 minutes… it wasn't a peck and he didn't use his tongue but it wasn't like a quick peck on the lips."

GG recalled the nurses on the ward at the time looked disapprovingly at Savile as he walked around the ward kissing the patients. She does not recall anyone intervening as they watched his behaviour with her.

A few days later GG encountered Savile in the corridor as he was pushing a patient in a wheelchair in the company of a fellow hospital porter. On seeing her, he immediately left the patient he had been attending to and blocked GG's way so that she was unable to pass him in the corridor:

> "He literally was squeezing and putting his arms up and down my back… yes, literally like a bear hug… and I think he kissed me again then and, to this day, if I see that corridor, I get panic attacks."

Example 3

J was a child of less than 10 years of age in the late 1960s when she was abused by Savile in a café across the road from the Infirmary (see page 111). In this case, over a period of several weeks he had befriended her mother as she brought her daughter into clinics for treatment.

Savile invited them for lunch at the café, where he sat alongside the child with her mother opposite. When J's mother left her alone, briefly, to go to the toilet, he took his opportunity to sexually abuse the young child, putting his hand under her clothes. The victim described her feelings, even as a young child, of fear and panic as she was being abused:

> "All that I was aware of was looking for my mum and I was panicking and frightened. I didn't like what he did. I knew it wasn't right but I didn't know it was wrong. I was frightened. I just remember feeling sheer panic and looking for my mum."

Intimidation and humiliation

In seven cases concerning children and young people, we heard how Savile would intimidate or humiliate them verbally after the assault. His intimidation and threatening behaviour were not confined to his child victims, however. He also attempted to humiliate or intimidate three adult patients. Further, we heard accounts from one of the very senior managers (chapter nine) describing Savile making menacing comments to him, threatening his position in the organisation and reminding him of his (Savile's) power and influence.

Example 1

U was a young teenager aged under 16 years who was an in-patient in the late 1990s (see page 114). Savile assaulted her in her bed on the ward. Earlier that day he had been pushing U in a wheelchair along a hospital corridor. In response to a challenge from her, he became angry and abandoned her in the corridor, leaving a passing nurse to return her to the ward.

Later that day, Savile came to see her on the ward and assaulted her. U recalls:

> “He came up and he was stood on my right-hand side of the bed and he came quite close to my face very very quickly so that when I tried to shout or make a noise or do anything, nothing came out…
>
> He just stopped [the abuse] and let go. He did say ‘you are all slags anyway’ or something along those lines. He used the word ‘slag’ in my face.”

Example 2

NN was a young boy aged under 16 years admitted via the A&E Department in the late 1960s (see page 118).

In his capacity as a porter, Savile took him to have an x-ray, and sexually assaulted him both in the corridor and as he lay on the trolley outside the x-ray room. Immediately after the assault, when the victim called out to his mother who was nearby, Savile claimed to be readjusting the blanket covering the boy’s knees. NN recalled:

> “[Savile said] ‘I’m just readjusting the blanket ’cos I thought it were falling off. Right I’ve got to go’ and as he said that, his eyes just looked at me, really evil looking eyes… then he gave me that evil looking stare… and then he shot off.”

Example 3

ZK was a young girl aged under 16 years in her first job (see page 122). When he attended the official opening of the factory where she worked in the late 1960s, Savile forced her to sit on his knee, where he sexually assaulted her. She recalls feeling scared as she couldn’t get away from him:

> “I wanted to get away but it was like he just had this grip on me. He just kept giving me this look, do you know what I mean?… It’s just like you freeze, don’t you, when you’re scared.”

When the victim was asked if she was frightened of him, she replied:

> “Yes. Because of some of the things he was coming out with, ‘You’re going to have to come down to the LGI and you can help me go around the wards… I’ll send the car for you… and I’ll take you for a bit of dinner after’.”

Concluding remarks

For a 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. Many of them had gone through life thinking they were the only person this had happened to. Abusive encounters with Savile, even after many years, had blighted many of their lives and, in some cases where there had been disclosure to close family, their families' lives as well.

A consistent theme of the investigation has been the enduring effect that Savile's abusive behaviour has had on many of his victims. Again and again we heard compelling accounts of the contemporary impact of memories of abusive experiences from decades ago.

We therefore conclude this chapter with the words of some of the victims as they described these feelings to us. In media discussions during the last year about the abuse perpetrated by Savile and some other celebrities, many commentators have described them as cases of 'historical' abuse. The following comments illustrate that, for many of the victims, living with what happened years ago is a daily, enduring and painful reality. Part of their history, but also a part of their lives today.

> "He gave me a complex that I was ugly. He gave me a complex that I was never going to be anybody in my life and he also gave me a complex that it was fine for him to do what he was doing… He doesn't stop winning. He doesn't stop winning at any point. You live with it. You live with the fact… Every day now, it's worse now. I'm just happy he's dead, but it's worse now because I just feel like he's laughing now. I just feel he's laughing at us all."
>
> Source: Victim M, female child, 1970s

> "I certainly didn't trust the idea of people, even if they were strangers, they could still affect you and certainly it continued to have a lasting effect in the way I felt about things sexually; people coming near you, strangers coming near you. I know at the beginning especially it was really bad but it got better over the years… I remember at the time that it affected me a lot and it went on affecting me just watching television, or seeing him on television."
>
> Source: Victim QQ, female adult, 1970s

> "Oh I hate it [the feeling of hair touching his face]. I just, I don't know what it is. I mean, if you brought [my wife] in here and, and, and asked her she'd tell you straightaway. I hate, I just hate it. It just freaks me out… And I think in early stages of relationships as well, it took me a long time to know somebody, you know, before any physical relationship could happen. It took me a long time and just not a nice experience, I tell you."
>
> Source: Victim ZC, male child, 1960s

> “I was walking up there [corridor] alone. It was completely deserted and Jimmy was walking down towards me in a kilt… he lifted up his kilt. He had an engorged penis and he stood blocking my way… I was absolutely terrified… and I ran into the nurses' home.
>
> He has affected me all my life by doing that, believe it or not.”
>
> Source: Victim S, staff member, 1960s

> “Even now I can't bear it; we have to turn the television off when there are any reports on or anything. It just makes me want to be sick.”
>
> Source: Victim KK, staff member, 1970s

> “I suppose you bury it deep within you, and sometimes it will have surfaced over the years when you see things on TV, 'Oh, he's doing all this wonderful work and all this he is doing for charity', and I'm thinking 'You bastard, there is more to you than people know.'”
>
> Source: Victim ZB, female teenager, 1960s

> “Well it's like it never goes away; it's always there every time you see a picture of him or see something in the newspaper. I just used to go sick when I saw his face… when it came to light and they were saying for people to come forward, I said to my husband 'do you think I should get in touch with somebody?'… and then I picked the phone up and phoned the police and told them.”
>
> Source: Victim ZK, female teenager, 1960s

8 Individual responses

8 Individual responses

Chapter summary:

- Within and outside the Infirmary, Savile had a reputation of being sexually attracted to teenage girls.
- A small number of clinical staff told us rumours existed about his potential risk to female patients.
- Patients and staff reported witnessing Savile's inappropriate access to patients, and inappropriate behaviour in public areas of the Infirmary.
- Of his 60 victims, nine made disclosures to staff about their abusive encounter with Savile; six were patients, and three were themselves staff members.
- One of his teenage victims believed she was pregnant as a result of Savile's abuse. Her clinical management is presented in a case study below.

Introduction

One of the persistent questions raised by the investigation has been 'Did anyone know about Savile's abusive behaviour in the Infirmary during these years?' We have looked in depth at this matter and have found that during the 1960s, 1970s and 1980s among certain groups of staff, including nurses and doctors, general rumours and gossip about aspects of his behaviour were common within the Infirmary. Much of this focused on his eccentricity and celebrity rather than anything specific concerning abuse, but there was also an awareness of his fondness for the company of teenage girls.

We were told that hospitals are often places where gossip and rumour thrive, and the gossip about Savile over the years was widespread among staff in wards and departments to the extent that it created a 'background noise' that was neither challenged nor scrutinised (source: witness statements N11; N116; N204; N239). We heard from current and former staff that these rumours did not just reflect the general feeling that he was a disruptive influence on the wards, but also that he was a sexual nuisance to female staff in particular.

A smaller number of staff (source: witness statements N11; N208; N112) also told us of occasions from the 1970s to 1990s when there was a belief among some staff that female patients were not to be left alone with him.

We also heard accounts from staff and former staff who observed or experienced behaviour by Savile that they deemed inappropriate at the time it took place, and heard descriptions of how people responded to these events.

Five adult victims and four child patient victims informed members of staff themselves, or via their parents, about their abusive encounters with Savile. We examined the responses to these disclosures, and also considered the reasons why so many victims remained silent about their abuse. We were also made aware of one patient's experience (Victim ZB) where some senior clinicians were informed about the consequences of Savile's sexual abuse, and describe this and their actions in detail.

Savile's reputation: patients and children and young people

We heard mixed views about Savile and his reputation in the Infirmary. A small but significant minority of former staff told us about the positive perception of his work for the hospital in increasing its profile, raising funds and boosting morale among patients and some staff. We also heard comments that were in no sense positive about his reputation in the Infirmary, in particular concerns of many former and current staff about his behaviour towards women, the awareness among some of his sexual attraction towards young teenage girls and, from a small number of clinical staff, concerns about potential risks that he posed to patients.

In chapter four we discussed some of the positive views about his reputation, and also what was reportedly widely known about his attitude and behaviour towards female staff. Here, given what we have learnt about the abuse of his victims, we consider his reputation in dealing with patients, and towards children and young people.

Dealing with patients

The majority of current and former staff (clinicians, managers and support staff) who were interviewed were consistent in their opinions that they had no inkling that Savile posed any risk to patients. This was in spite of his reputation with young girls and the hospital gossip about being a nuisance with female staff.

We then heard contradictory accounts from three clinical staff witnesses, two of whom were based in the Accident and Emergency (A&E) Department, who gave examples of Savile posing a risk to the safety and welfare of young patients. These comments date from the late 1970s to early 1990s.

> "The other thing we had was single sex wards in those days and on the female wards basically occasionally we would have kids 14, 15, 16 who would go to the adult wards… whenever he came in with a young girl he would be pretty much escorted to the bed. It was just generally recognised on the unit that as a nurse you never wanted to be on the unit on your own with him and you never left a young female patient with him on their own. That was not written down anywhere it was just something like hospital hearsay.
>
> If there were five patients in the department that needed portering, he would always make a beeline for the lady – always whatever age and particularly if it was a young girl. Always, and I think everyone recognised that."
>
> Source: witness statement N11; employee, 1970s to 2000s, referring to the 1990s

> “Mr Savile has returned a patient from x-ray and he stopped in the unit to talk to the other patients. I just remember he had his hands over the woman's shoulders and his hands were just too close to her boobs which made me feel really uncomfortable… he wheeled the woman to her bedspace and he was chatting to one of the nurses. I could see how his arms were leaning over her. He didn't actually touch her boobs… if I had been a patient I would have been uncomfortable… the nurses saw the patient into the bed…”
>
> Source: Victim EE; employee, 1990s

In the mid-1980s we heard that a young female patient was admitted to A&E following an overdose. There had been some difficulty in obtaining a bed on a children's ward, but one had been found on a female surgical ward and she was waiting to be transferred. She was looked after by a student nurse who, after washing her, left her momentarily to get her a change of nightdress. Savile took the patient from the department without permission and disappeared with her for 20 minutes before returning with her, having unsuccessfully tried to take her to a children's ward.

> “I was really scared of getting into trouble for losing her… and I was frantic because I didn't know where she had gone. And then I found that Savile had taken her up to the Clarendon Wing [where the children's wards were]… and I was really upset because she wasn't supposed to go there. Eventually he brought her back and practically dumped her and I think either myself or another student nurse took her to the ward where they had been expecting her.”
>
> Source: witness statement N208; student nurse, 1980s, talking about the late 1980s

Presented together, these accounts do raise concerns about the welfare of patients who found themselves in close proximity to Savile. We need to recognise that they were individual accounts from staff who did not work together and, as far as they were concerned, what they saw was an isolated incident where no actual harm took place. These witnesses did not raise the alarm at the time, although the student nurse did inform her supervisor when her young patient went missing, and to her great relief was returned some minutes later.

These comments are important in offering a perspective on his freedoms in the hospital, against a background noise or 'hospital hearsay' of potential risk to patients. Whilst they are from a small number of witnesses, they are of significance in helping us to understand a little more of what was known about his behaviour, what was tolerated and what was believed by a handful of people about the risks he posed to patients.

Intimidation

A number of his victims spoke about Savile as a menacing presence, intimidating them after an assault to dissuade any disclosure (chapter seven). We also heard how this side of his character was expressed to people in senior leadership roles, including the Chief Executive, whether in an attempt to assert authority, as a threat, or as mere bravado.

> “I've met some fearful guys in my time and he [Savile] was up there. He was up there with the best… Perhaps he was trying to be the alpha male. I don't know… But he, he actually specifically made remarks about, erm, shadowy figures who could get – who could deal with people if he wanted people dealt with… I don't know whether shadowy figures were hoodlums or whether they were prime ministers. I've no idea… But he said it… ”
>
> Source: witness statement N157; Stuart Ingham, Chief Executive, 1988 to 1998

One former clinician told us how Savile would visit the A&E Department at nights following his wrestling bouts in the 1960s and offered to use intimidation by 'having a word' with any recalcitrant or awkward patients to assist the staff in keeping order in the department:

> “Because it was in the days when he was wrestling, and he used to come into casualty when we were on night duty… on nights, Friday, Saturday night when Casualty or the Receiving Room was busy, Jimmy used to come in and say, you know, ask if we would have any problems with any difficult patients and, we'd either say yes or no, and if we said yes, he'd go down and have a quiet talk to them and things would be quiet, and we could get on with the work without too many traumas… he was very effective, because he had this sort of reputation as being a wrestler. You know, he'd been on telly, so not many of the incumbents of the Infirmary Receiving Room would argue with him. ”
>
> Source: witness statement N245; speaking of his experience as a junior doctor at the Infirmary in the late 1960s

Certainly this sinister side of Savile was one that he sometimes promoted, intimating to others either that he was personally capable of inflicting physical harm or that he was so well connected that he could harm an individual or their family in terms of their career and future well-being. Through hospital 'gossip', awareness of this particular aspect of his personality may have contributed to the general reluctance of people to challenge Savile or to place any constraints on his activity in the hospital.

Children and young people

Rumours about Savile and his sexual attraction towards young teenage girls persisted in Leeds and elsewhere for most of his adult life (Bellamy, 2012). Similar themes were explored in some of his later TV and press interviews (source: Andrew Neil interview, 1995; *Have I Got News for You*, 1999; Louis Theroux documentary, 2000). Since his death, in the wake of the ITV *Exposure* documentary and from our investigation, these rumours have been substantiated by witness and victim accounts.

In the 1960s and early 1970s, we were told that he would regularly come into the porters' office near to the A&E Department at Martin Wing on his way from the Mecca Dancehall in the small hours, often accompanied by teenage girls. He would introduce the girls to the porters and then leave them to chat whilst he went round the department greeting patients.

> “He turned up once with three young girls all at the same time. It was here in this hospital. He nicknamed them and I'm sure you're not going to know this, traffic lights. Each one had different coloured hair, like traffic lights. But they were only young. When I say young, 13, 14, something like that… I didn't get the idea that anything wrong was there. He wasn't trying to hide being with them because he brought them into a public place. I think they were more enamoured by him, somebody being a celebrity.”

Source: witness statement N111; employee, late 1960s to 2000s, talking about the early 1980s

> “We were young blokes, you know at the end of the day! Celebrity brought us in two chicks… you know two smart looking girls. And as I say they looked old enough… Nobody questioned that. Nobody questioned 'cos it was two dolly birds to talk to.”

Source: witness statement N76; employee, 1980s to present, talking about the early 1980s

Because of his openness in bringing the girls into the hospital, and the apparent willingness of the girls to accompany him, at that time on the whole the porters were not suspicious of anything untoward. It would appear that porters and others, whilst observing his contacts with young girls, made no judgements about them. The notion that these girls were under age, or possibly uncomprehending of his intentions did not seem to cross people's minds. Neither was there any connection made to the possibility of inappropriate access or contact with young teenagers who were patients.

One witness recalled an incident to us from the early 1990s (when he was a young member of staff). He realised that Savile's interest in young girls had a sinister edge, and described his reaction to this discovery. Up to this point, the witness thought Savile was 'a decent bloke'. Savile was chatting to the porters in their office near the A&E Department and had with him an envelope containing what looked like professional photographs of young teenage girls. These had been sent to him by their parents, asking Savile to help their daughters get on in showbusiness:

> “And then one night he came in and he had his cigar and his gold chain and he had an A4 envelope and he opened it up and he had some pictures in. They weren't of young girls, but it was of girls [later confirmed as between 13 and 16 years old], and he basically said, 'the parents send these to me, but I'll be shagging these'… they must have sent them in for auditions or something, I don't know, 'can you do something to get my child on the way'… I was shocked, I still am if I'm honest… He [Savile] were just boasting and being his normal self but in a sick way; it were just like not nice”

Source: witness statement N289; employee, 1980s to present, referring to early 1990s

The witness said that the others present did not comment on Savile's remarks, and at the time he also said nothing. He felt both shocked and embarrassed and didn't know what to do or say, and so nothing further was said about the incident. It did prey on his mind, though.

> "I can imagine her parents paying a lot of money way back then for that picture, and I don't even know that he's done what he's said he's done, or wanted to do, but the thought of him saying that, and out loud, yeah it did stick with me. And it stuck with me for a long time."
>
> Source: witness statement N289; employee from mid 1980s to present, talking about the early 1990s

Other witnesses commented on what had been known or heard about Savile's interest in young teenagers. He was described as a 'pervert' by some of his male victims, and this word was also used by some of his former colleagues, albeit in junior positions at the time.

> "We must have had probably a hundred staff, full time and part time. It was mentioned from many people. People who had said, you know, he's a pervert, he's into young kids."
>
> Source: witness statement N140; employee, 1970s

> "'He likes them young, really young. Do you get my meaning?' I went 'Yes', and I thought, 'no'."
>
> Source: Victim L; patient 1970s, recalling a conversation about Savile with an employee at the Mecca Dancehall in the late 1960s

> "I don't know how Savile had come up in conversation and I remember her saying 'Oh, Jimmy likes them young and plump'."
>
> Source: Victim ZZ; patient, 1960s, recalling a conversation about Savile

We heard from witnesses who worked in the offices of local media organisations that they also heard rumours in their places of work about Savile and teenage girls.

> "There were the rumours [about young girls] they have always gone on, but I truly didn't believe they were true. In fact before I was defending him, like the lads in the newsroom would say, 'oh, watch yourself' it's hard to think but it was like a joke. It is unbelievable."
>
> Source: witness statement N82; employee, local media, 1990s to 2011

> "I mean they'd heard rumours. I think, and it was from what I understood Jimmy Savile liked under-age girls, twelve-year-olds and little girls. That's what I'd heard… It was just one of those things that everybody said 'you want to watch him'."
>
> Source: witness statement N279; employee, local media, 1980s to present

From our review of witness statements, it is apparent that Savile's known preference for young girls was not questioned or acted upon. It is difficult to ascertain why this was the case. From the witness accounts we heard, time and again people did not make the connection that his interest in teenage girls was out of the ordinary. The girls he brought in to meet the porters in the A&E Department were young and attractive and, according to witness accounts, seemed happy to be in his company. The connection that teenage girls who were patients in the hospital may have been at risk from Savile was not made, and so his behaviour, which was not hidden to any particular degree, continued unchallenged and unremarked upon.

Publicly, he consistently claimed never to like children, even to hate them (source: Bellamy, 2012; Interview with Anthony Clare, 1991; Interview with Louis Theroux, 2000). Since his death, commentators have cited these interviews as illustrations of Savile's way of deflecting scrutiny of controversial topics. He displayed similar responses to questions about why he had never married, about his sexuality and as to why young girls were apparently attracted to him. He explained this was because of his proximity to pop stars and nothing to do with him at all (Bellamy, 2012).

Despite all these rumours, and the gossip about Savile, and despite what we know now, at the time any concerns there might have been about his behaviour or potential risk towards children or young people were not publically substantiated. This background noise remained in the background, and did not reach senior management and so was not investigated.

Accounts where staff witnessed inappropriate access to patients

Savile visited wards and departments across the Infirmary. We have been informed of a number of occasions when he was given access to patients that we believe was wholly inappropriate for someone who was in effect an honorary member of staff. The examples below give an indication of how accepted his presence was, and how unchallenged. They also show how, repeatedly, the safeguarding of confidentiality, dignity and well-being of patients was compromised. These examples date from the 1960s to 1990s and are presented chronologically.

Example 1

Savile spent a great deal of time in the A&E Department. During the late 1960s, one morning each week a clinic took place in the department for children who had endured mild-to-moderate burns. At the clinic the children received a new type of skin treatment that was being developed. Treatment required application to the skin and the covering of the affected area with thin gauze. Apart from this 'dressing', the children were usually naked in the clinic as they played and were assessed by the nurses or doctors. We heard that Savile regularly attended this clinic:

> “And Jimmy would be there constantly, so there would be all these children, with bare bodies… yes, he used to come to that clinic on a regular basis… I mean in the 1960s the sort of attitude to children with no clothes on was slightly different [from today]… The parents would be with them, because they brought them up in an ambulance with them, and he was accepted, it was okay… he would just be talking and making them laugh.”
>
> Source: witness statement N244; former nurse, late 1950s to 1990s

Example 2

We heard that Savile attended clinical ward rounds, accompanying the entourage of doctors and nurses as they visited each patient on a ward and shared clinical reports and information. Even 50 years ago, it would have been known that the information discussed would be sensitive and, in many cases, confidential. Yet his presence was not remarked upon, but accepted.

C was in her forties and had a spinal injury (see page 116). She was on flat bed rest on a ward and had been told she probably would not walk again. The doctors and nurses came round to see her and the other patients as part of the ward round. Savile was with them.

> “It was the second day I was in and Jimmy Savile came round. He was not on his own, he had nurses and doctors with him… he asked what I had done and then he said to me… ‘what you need is a man… I shall come back to see you at three o’clock in the morning’. I wasn’t offended by the remark, I laughed about it… he was a popular figure at the time. You thought it was a bit of an honour for him to really visit you and speak to you.”
>
> Source: Victim C (now deceased); 1970s

Example 3

AA was a young man in his twenties and had had surgery on his knee (see page 120). He awoke to find Savile bouncing on the end of his bed trying to wake him up.

> “After I had the operation, I remember being laid in the bed with the curtains drawn three quarters of the way down so you could see out of the end of the bed. I woke up to somebody bouncing on the end of the bed – literally banging up and down, up and down… nobody escorted him. He was by himself and when I woke up he was sat at the end of the bed.”
>
> Source: Victim AA; 1980s

Once the patient was awake, Savile repeatedly called a nurse on the ward to give AA a bed bath, which he didn't want. The nurse politely responded to Savile's banter but didn't challenge him, or the fact that he was disturbing a post-operative patient, with all the potential risks of pain, infection or other harm.

Example 4

CC's teenage daughter was very ill following neurosurgery which took place in the early 1990s (see page 113). CC and her mother were keeping a constant vigil at CC's daughter's bedside and were exhausted. Savile approached them and offered to sit with CC's daughter whilst they went home to get some rest. The next day the nurses confirmed he had stayed all night. It is extremely unusual for a male adult who was neither a clinical professional nor a relative/partner to be permitted to sit with a young female patient unsupervised overnight.

> "So I came home on the bus praising him for being so brilliant, staying with her all night. When I went back the next morning and I asked the nurses did he stay, and they said 'oh yes, he was with her all night' but then she had a room of her own, a side ward. A couple of days after, she had to go for a scan, and he came to take her, but she wouldn't go with him, she didn't want to go… Just taking it from there with what we have heard, I can guarantee what happened that night."

Accounts where staff witnessed inappropriate behaviour towards others

In the previous chapter we described how at least 43 of Savile's victims were subject to his abusive or inappropriate behaviour in public spaces in the hospital. Inappropriate behaviour perpetrated by Savile was also witnessed in scenarios outside the clinical area.

Example 1

In the early 1970s, Savile was approached in the Infirmary by the mother of a young boy who asked him for an autograph, and he charged her £2:

> "I had one dealing with him before that when in the early 1970s… I was coming up from theatre and he was in the lift and there was me, a porter… and a young mother with a little child, and he went 'mam, mam, its Jimmy Savile, Jim'll Fix It' and she asked him for his autograph and he says, 'yeah you can have my autograph, love that'll be two pound', and he put the two pound in his pocket."
>
> Source: witness statement N188; employee, 1990s to present, recounting a time when he was a young patient in the 1970s

Example 2

Visiting a ward in the 1990s, one of the nurses asked him to 'fix it' for them to have a pay rise. There were a few staff around and this was a light-hearted exchange, until Savile responded, as described below.

> "I just said to him, 'Jimmy could you fix it for us to get a pay rise' and he looked me up and down and said 'if you go round the corner and lie on your back with your legs open, I will see what I can do for you'. Then I looked at him and said, 'look do me a favour, don't hold your breath waiting'… he started laughing and said 'you didn't know I was like that did you?' And that was it. He walked off the unit."
>
> Source: Victim EE; 1990s

Example 3

At the opening of the Jubilee Wing of the Infirmary in 1998, Savile was in attendance, chatting to people as they milled about the reception area. A woman and her teenage children, a boy and a girl, came in and Savile posed with them for a photograph. A member of staff noticed him putting a hand on the boy's shoulders and the other arm round the waist of the girl, who appeared to be uncomfortable with this conduct.

> "He put his hand on the little lad's shoulder and smiled at the camera and put his arm round the waist of the little girl and she pulled away but he pulled her right in, and I just, more out of humour said, 'get off you perv!' Oh whoo the manager called to me 'you can't call him that'."
>
> Source: witness statement N110; employee, 1980s to present

Accounts where Savile was challenged

Not everyone was deferential and obsequious to Savile, although this type of behaviour was more commonly reported to us. A number of witnesses observed him being challenged by staff. Most examples relate to ward sisters confronting him when he appeared on their ward to walk round and chat to patients.

> "I heard he'd been up on ward 22 and Sister XXX had gone to lunch, and she came back and found him sat on a bed, and very politely she asked him to leave. And she rang Charlie Hullighan who was the Head Porter at the front door and told him that that man was not ever to go on her ward again."
>
> Source: witness statement N261; employee, 1960s

> "I saw straightaway it was Jimmy Savile… he started marching up and a voice went – which was Sister's – 'Where do you think you're going?' He said 'Oh, I just came to see if you needed anybody taking down to theatre or anything. I saw you were busy so I thought I'd just say hello.' She said 'You know quite well' (and I remember her saying this) 'if we need a porter we send for a porter or phone for a porter', whatever. He said 'I know but I just happened to be passing.' She said 'I don't care if you're passing or not, I'm busy. Now, will you go? We don't need anybody.' He said 'I might as well say hello.' She said 'Not until I have a nurse to go round with you.' He said 'No need for that.' She said 'Yes, there is, but I need to finish telling them about the patients'… He said 'Oh, no, I won't disturb you any more', and went out"
>
> Source: Victim L; 1970s

Responses to the incidents of abuse

It is important that we understand the reasons why so many of Savile's victims remained silent following their ordeal. Research into the responses of victims of child sexual abuse indicates a number of common responses (Allnock and Miller, 2013). Similar themes have emerged from the accounts of his victims at the Infirmary:

- a feeling that they were the only one this had happened to, so felt they had brought it on themselves;
- thinking that they would not be believed because of Savile's celebrity and fame;
- feeling so humiliated and embarrassed that they did not want to relive it by telling anyone;
- a belief that they would not be taken seriously;
- a belief that no one would act to support them, again because of Savile's fame;
- feeling intimidated by the staff and their attitude;
- being intimidated by Savile through verbal or physical threats;
- feeling that they were in some way to blame; and
- a belief that it was not important enough to report to anyone.

> "There was nobody to tell when I went into the nurses' home; no sign of the Home Sister and besides which I don't think anybody would have believed me. That's the reason why I didn't go and report it… He was bringing thousands of pounds into the hospital. Who was going to take any notice of me?"
>
> Source: Victim S; employee, 1960s

"I just assumed it was just me he was doing it to… have I done something in my life that's he's only done it to me or am I dreaming it or is there something wrong with me… and he was a famous person, you think, 'is it me that he's chosen?' you think you've been chosen by him. He used to get that across. It was across that he was going to make me better and that he was paying for me to be pretty. It's a hard thing to tell your dad… You think you're going to get into trouble for lying or something, don't you?"

Source: Victim M; child patient, 1970s

"Even I knew that in a court of law it would have been me against him. At that time I thought I was the first one, the only one."

Source: Victim N; adult patient, 1970s

"I was too embarrassed, too scared. Never said nowt, me mam still doesn't know… I just looked at him, he looked at me and his eyes were evil, the way he looked at me."

Source: Victim NN; child patient, 1960s

"I was immobile, there was nothing that I could do, I'd even got so that crying, down when you're lying flat is quite difficult… I knew that I couldn't tell. Because I wouldn't have been believed… It could have been my fault because I was wearing a hospital gown so I wasn't fully covered. I only had the gown on, I didn't have underwear on… they might have felt that I led him on or something."

Source: Victim TT; child patient, 1970s

"I have asked myself this question an awful lot over the last few months [what prevented you from telling anyone?] and I have come to several different conclusions. I think one was that I was quite shy and introverted at the time and I did not want to make a fuss. I did not want to be the centre of attention. That would have been a nightmare for me. Another reason was that he seemed to be held in such high esteem by everybody… And I thought they're not going to believe me. I can't imagine my voice would be heard or if it was it would be 'oh that's a silly hysterical little girl'…"

Source: Victim ZD; adult patient, 1970s

Disclosure to staff: patients

In total, only nine of Savile's victims, four children and five adults, told us that they informed members of staff about their experience. We will examine these disclosures and subsequent actions. Three of the children and two of the adults were patients at the time of their abusive encounter with Savile and did report what happened to members of staff, either directly or via their parents. These particular incidents took place between the mid-1960s and mid-1970s. The fourth account also dates back to the late 1960s, and is presented as a case study on page 160.

Example 1

ZC was under 10 years old (see page 117). He was sexually assaulted by Savile whilst on a trolley waiting to have an x-ray on a broken arm. He was in a great deal of pain and quite distressed. Following the assault, a nurse entered the room.

> "She had a dark uniform on and when he was still stood back of me there and I, I said to her then. I said 'that man's touched me' and he says, you know, making out like, he says 'I was only calming him. I were only patting him on his head', he says, you know, 'he were upset' and then he went… She didn't query and he jumped in straightaway, like, 'you were upset'…"
>
> Source: Victim ZC; child patient, 1960s

ZC has no recollection of the nurse discussing this further with him after Savile had left him with her, only that she accompanied him into the x-ray room.

Example 2

QQ was a young female patient, immobile in a back plaster cast (see page 115). She was nursed in a side ward, and was informed by one of the nurses that Savile was going to visit their ward that particular day. Unaccompanied, he entered her side room:

> "He then moved over and before I could even imagine what he was doing, he started to kiss me and then put his hand down the front under the sheet and started to fondle my breasts. I couldn't do anything except close my mouth… I felt very dirty. I did tell the sister and the answer was 'oh but that's just Jimmy Savile; that's his way'. And because of what they said I didn't want to tell anyone else and I never did."
>
> Source: Victim QQ; patient, 1970s

QQ did not speak further to anyone about the incident.

Example 3

T was aged under 16 and was recovering after abdominal surgery (see page 112). Savile came onto the ward and asked to see her scar, so she lifted her nightdress to show him. He played with a stethoscope, pretending to listen to her stomach, and kissed her abdomen. Her grandmother was nearby and told him to 'get off my grand-daughter'. He apologised and left.

> “I think my grandma must have gone home and told her [mother] because when they came in the evening my mum went straight to the Sister. [Asked, did the Sister say anything to you as a result of that?] No, nothing was ever spoken of it.”
>
> Source: Victim T; child patient, 1970s

T was unsure if anyone spoke with Savile following the complaint from her mother to the Ward Sister. She didn't see him on the ward for the remainder of her stay.

Example 4

H was a young female patient who, having had surgery on her spine, was immobile and on bed rest (see page 116). From her bed she could see into another bay of four beds, and saw Savile approach and then sexually assault another female patient. She tried to call a nurse to report what she had seen, but for a while after this there were none available. Later that day when a nurse came to her to do her observations, H reported what she had seen.

> “Eventually a nurse came to do my obs and I pointed to where he was and I told her what happened and she went like that and shrugged her shoulders and off she went. Before she was walking off, I said if he comes anywhere near me I will scream the place down, and that was it.”
>
> Source: Victim H; patient, 1970s

H was not aware of any subsequent action taken in response to her report to the nurse.

Example 5

WW was a young teenage patient and had been informed by a porter attending the ward that Savile wanted to see her (see page 113). Accompanying the porter, she was escorted to a room where Savile was waiting and where he sexually assaulted her. A second man collected her and escorted her part of the way back to the ward. On her return she tried to tell the nurses:

> “I went back upstairs and went back to the ward and there were three nurses there, at like, a nurses station. I remember there were three because I remember thinking 'do I get one of them to one side and say? Or do I say it to all of them?' And I said, you know you'll never guess what happened, and they looked and I said 'Jimmy Savile' and I never even got as far as anything else because they just laughed. They just laughed.”
>
> Source: Victim WW; child patient, 1970s

WW did not tell anyone else about her experience following this reaction by the nurses.

All these incidents took place at least 40 years ago. Recollections of details such as the name of wards, specific dates of admission and names of staff have been extremely difficult to confirm.

We have pursued every avenue available to us in light of what was disclosed with the above cases, but have been unable to identify the specific staff concerned, or ascertain whether any further action was taken in response to the disclosures made.

Disclosure from victims: staff

Three members of staff disclosed to senior colleagues what happened to them. These incidents date from the mid-1970s to 2000s, and are presented in chronological order.

Example 1

FF was a student nurse who had come across Savile in a narrow corridor on the way to the X-ray Department (see page 126). He made lewd remarks to her and touched her bottom. FF pushed him away and returned to the ward. She informed her colleagues including the Ward Sister, who responded 'Oh no not again' and then went on to remind her to 'look at all the things he does for the hospital'.

> "Whoever was in charge at the time, it was just regarded as something that happens… because other people who had other incidents with him had a similar response. They didn't get anywhere and they knew that if they did try and pursue it, it wouldn't happen. With regards to the bosses it was very much them and us. You didn't feel particularly at ease talking to them."
>
> Source: Victim FF; staff, 1970s

Example 2

G was a doctor working on a children's ward in the 1990s (see page 127). Savile appeared unannounced on the ward and she walked over to welcome him. He lunged at her, kissing her, forcing his tongue into her mouth, and grabbed her breast. He then left the ward.

> "The Sister came over to me and said 'are you all right?' and I said 'no' and I told her what happened… I can remember the nurses saying 'why do you think we stayed behind here?' [meaning the nurses' desk]. It was almost an acknowledgement that that was the way he behaved and it was known by the nursing staff, the female staff, that you keep away from that man… I do remember the consultant came on [the ward] and I remember telling him as in not 'I am reporting it to XXX', but telling him as in 'you'll never guess what happened to me'… again it was very sympathetic… not I need to escalate it up and talk about it. It was very supportive and that was the culture at the time."
>
> Source: Victim G; staff, 1990s

Example 3

D was an administrator for a charity based in the Infirmary (see page 128). In the early 2000s Savile was involved in some publicity for them and attended the department one day. She welcomed him and accompanied him in the lift to the correct location. In the lift he sexually assaulted her, which left her very upset and tearful.

> “I went to speak to some of the secretaries… it was just ‘you need to report this to the consultants’, ‘you need to talk to someone senior’. I tried talking to someone senior and it was dismissed as being silly… ‘don’t worry about it, it’s just silliness’ and that sort of thing. I think with hindsight they didn’t know where to put themselves. I certainly didn’t know where to put myself.”
>
> Source: Victim D; staff, 2000s

D had a second incident with Savile some years later, and was similarly dealt with by her colleagues.

Commentary – victims who reported incidents of abuse

It would be unsafe to extrapolate significant findings from this small number of reported cases of abuse. The accounts from the two adult patients indicate that among the nurses concerned there was a degree of passivity and a reluctance to raise any concerns about Savile’s behaviour towards patients under their care.

These incidents happened over 40 years ago and the passage of time and the lack of contemporaneous documentary evidence mean we have been unable to identify the nurses to whom the reports were made. However, their priority should have been the protection of their patients and, in these cases, it appears that this did not happen.

Different levels of tolerance towards the sexual harassment of female staff mean we have seen variations in responses to and from different generations of victims as part of this investigation. The comments from example 1 above, a student nurse in the 1970s, are telling. The power imbalance between Savile and his victims is evident, with the majority being reluctant to report their ordeal to anyone, even trusted individuals or professionals. This was the case for both staff and patients. In FF’s case, the prevailing and strictly hierarchical nature of nursing meant that, having disclosed what happened to the Ward Sister, it was for her (the Sister) to decide on any action, and that was an end to it. Her response made it clear that no further action would be taken, and that it had happened before. In her acceptance that such harassment was to be tolerated, the Ward Sister did not fulfil her responsibilities to her staff. This was disappointing as at the time, even though there was greater tolerance of sexual harassment at work, the sisters were reputed to have a strong commitment to the pastoral care and moral well-being of the students (Anning, 1966).

The other accounts are more recent, occurring in the 1990s and early 2000s. This time, in the case of example 2 above, the nurses on the ward were aware of the risks of Savile’s behaviour. Their objectives were avoidance of Savile and self-preservation. G commented in response to her experience with Savile that she expected and received personal support from the Sister and the nurses, and did not consider formally reporting it to any higher authorities. She did talk with her consultant, but again there was no suggestion of taking any complaint further, as it was just not part of the culture at the time. Over 20 years on from this experience, we have tried to identify the nurses on the ward at the time, but this has not been possible.

> "I remember us discussing it and it being a very matter of fact 'that's what Jimmy Savile does to women'… When I say it wasn't a big deal, it was not kind of, 'oh my goodness, we must go and report it… it was kind of 'well that's what that man is like and you keep away from him'… so there was an acknowledgement that that was what he did."
>
> Source: Victim G, 1990s

In the case of D, she did expect her consultant (who was her line manager) to act, certainly to be supportive, but instead her complaint was dismissed. Her analysis that people possibly didn't know how to react may be correct. However, when this assault took place (2000s), the Trust had a policy that covered bullying, harassment and violence and aggression, and this should have been followed. National guidance from the time sets out clear stages of action from informal reporting, record keeping, formal complaint and investigation (NHS Employers, 2006). Based on these accounts, a gap clearly exists between the existence of the guidance and the practice of managing and supporting staff correctly. The consultant concerned no longer works for the Trust and, at the request of D, has not been contacted by the investigation team.

Case study – The response of senior clinicians to a specific account of abuse

Here, we present evidence based on the account of a young teenage victim from the 1960s, when she was aged under 16 years. It describes the clinical management of her suspected pregnancy. The two clinicians who dealt with her were both aware that the identity of the potential father was Savile. This account is based on the victim's statement and on letters sent between the two doctors.

Thinking she was pregnant following a rape by Savile, ZB, the teenage girl, was seen by her GP and referred to a consultant gynaecologist at the Infirmary with a request for a termination of the pregnancy. We were informed by the victim that the GP and the consultant were told the identity of the 'father' by the victim's mother, who accompanied her to both consultations.

> "I was frightened I might be pregnant, and of course I told my mum. We were a close family and I had no reason to be terrified of telling her, we were really close… and we obviously went to the GP. After visiting the GP my mother said, you'll have to tell him [meaning Savile], he needs to know."

Prior to the visit to the hospital, ZB informed Savile about the situation. He coached her to threaten suicide should her request for a termination at the hospital be refused, making her repeat the same phrase over and over.

> "I told Savile that I was going and he said, well when you go you must say to him, 'if I am pregnant and you don't do anything about it, I will put my head in the gas oven'. He says 'don't forget, you must say that to him', and he had me repeating it."

ZB and her mother visited the consultant (now deceased) at the Public Dispensary at the Infirmary. ZB recalls he remained seated behind his desk throughout the consultation and also did not examine her or conduct a pregnancy test. She felt he was not really listening to her until she repeated the phrase Savile had advised. He looked up and commented on what she said as being unusual.

> "And he said 'how would you feel about it if you were pregnant?' and I said, that is when I said the words Savile has told me to say… and he looked up at me and said 'that's a strange thing to say, can you tell me again what you have just said' and I repeated it… He got up and left the room and he came back with a little paper cup with two pink tablets in and a glass of water and he said 'take those'. I haven't a clue what they were, they could have been anything, and I took them. 'I don't think you'll need to worry'."

She took the tablets, which we believe (based on expert clinical opinion from Professor Aidan Halligan, former Deputy Chief Medical Officer, Department of Health; appendix five) were progesterone, and within 48 hours had a heavy vaginal blood loss. She went back to the consultant a week later for a check-up and it was confirmed that she was not pregnant.

The consultant wrote to the GP saying that ZB was difficult to examine (although she does not recall being examined) but that he had given her 'some tablets' to correct the situation. Details of the specific medication administered and its dosage are not included in the letter (source: clinicians' letters witnessed by investigation team; written in the late 1960s).

He made reference to the behaviour of Savile, as the letter states:

> "I understand that ZB's parents will be having a word with the gentleman concerned. It seems to be essential and I hope it will scare him off from doing the same again."

Following the introduction of the Abortion Act in 1967, the regulations concerning legal termination of pregnancy were clearly stated (a copy of the Act is included in appendix seven). At the time, methods of termination were largely surgical. Accepted practice for the medical termination of pregnancy came much later with the advent of the 'morning after pill' in 2001. In discussion with Professor Aidan Halligan, who practised fetal medicine from the mid-1990s, it was confirmed that, whilst the administration of progesterone tablets was not a legally acceptable form of termination at that time, in early pregnancy administration of these drugs 'could have been used for that purpose'.

In this case, however, it was never clear that ZB was even pregnant. At no time did either doctor examine her or conduct a pregnancy test. This appeared to be a pre-emptive referral to the gynaecologist without validating the pregnancy in order to resolve the 'situation'. We are advised that the physical risks of giving this medication to a non-pregnant girl were minimal, in that its purpose was to bring on the prevent fertilisation through inhibiting ovulation. However, by not confirming the pregnancy, there was no way of calculating accurately the gestational age of the fetus. If ZB had been more than 9–10 weeks pregnant, the progesterone tablets may not have caused a termination, but could have harmed the development of the growing fetus.

At no time did either doctor acknowledge the risk of psychological damage to the young patient in front of them, or consider her well-being as a child who had been raped by an adult – celebrity or not; nor did they consider referring the case to the police, or to social services, or even provide sexual health and contraceptive advice and support to her to prevent this from happening again.

The impact on her parents was also poorly managed. In the case of her father, he subsequently visited the GP extremely distressed at what had happened to his daughter.

> “My dad went to see the GP on his own, because he was absolutely distraught over it. He just didn’t know what to do, and the GP said to my father, ‘If I was you I would go to Jimmy Savile’s house and write on the wall in red paint ‘Jimmy Savile is a bastard”. Of course he didn’t do anything of the sort.”

This case study illustrates a number of weaknesses in the standards of care delivered by both doctors at the time of the events in the late 1960s. If such practice happened today, they would also have fallen foul of contemporary safeguarding children legislation, which is much more robust than was the case at the time of these events. However, even in the late 1960s, it is our view that they should have done something more to support ZB and her parents, and to alert senior management in the hospital, or the police or social services to Savile. We consider the general role of senior management more closely in the next chapter.

Extensive enquiries have confirmed that the consultant is deceased and we have been unable to locate information about the GP.

Conclusions

With the benefit of hindsight we can all reflect on what we now know happened, and on Savile’s audacious conduct in his harassment and abuse of patients, staff and teenage girls. He did not particularly hide his behaviour, certainly not his pestering of female staff or his contacts with young teenage girls.

We should not minimise the privilege that hindsight offers us. It is one thing to observe behaviour that can best be described as eccentric or odd, and then to make an assumption that oddness is an indicator of sexual offending. From our perspective today, we can appreciate the signs and indications of risk and increasing audacity in his behaviour over the years. From the evidence gathered, we can make the connections that were not made by the managers and senior clinicians in the past. Savile’s eccentricities were common knowledge among many within the Infirmary and outside the hospital but, at the time, it could be argued that that was part of his celebrity ‘brand’, and what made him a unique star. The shift from perceptions about his odd behaviour to judgements about sex offending was far too great and extraordinary for colleagues, patients and co-workers to make.

> “He was iconic. He was renowned for his charity work. He was renowned to be a friend, a good friend of the hospital, and you know, there are many people we all know whose demeanour we think ‘gosh, that’s a bit odd’, but we would never translate that into some kind of serial sex offender, abuser of women and other people, patients… you would never have imagined it. It is such a leap from eccentricity, creepiness on the one hand to being a serial offender and abuser on the other. It beggars belief.”
>
> Source: witness statement N218; Sir Neil McKay, former Chief Executive, 2002 to 2006

On the other hand, from the accounts we have heard, much of what he was doing was more than odd – it was unacceptable and inappropriate, even by the standards of the day. Further, we heard that much of it took place in public areas of the hospital, and some was witnessed by staff, visitors and patients.

We heard many accounts from former staff, patients and people associated with the Infirmary that indicated a strong and consistent background noise of gossip, whispers and rumours about not only his disruptive impact on wards, but also his association with young teenage girls.

In considering the question posed in the first paragraph of this chapter – ‘Did anyone know about Savile’s abusive behaviour in the Infirmary?’ – some people knew some things related to a very small number of specific incidents of abuse. This answer needs some further consideration:

- Victim accounts suggest that three people assisted Savile in the organisation of his abuse during the 1960s. It is possible, but not definite, that these individuals were employees at the time. It has not been possible to identify them further. However, our enquiries on the length of service of current porters confirm that none were working at the Infirmary at the time these abusive encounters took place.
- A small number of unconnected nurses and doctors heard disclosures from victims (staff or patients) over a timeframe of decades. Connections between the few disclosures were not made by these individuals, or by anyone more senior, as they were not escalated further for management attention, and Savile continued undisturbed by any interference or additional controls.
- A slightly larger number of staff in clinical and support roles recalled occasions where they observed Savile’s behaviour and felt it was inappropriate. Some felt discomfort at the time, but also felt inhibited from taking any action, reporting their concern, or challenging him because of his popularity and celebrity profile, and their perception that he was favoured by senior management.
- Other staff commented to us that at the time they did not consider his behaviour inappropriate, but with the benefit of hindsight, and with their new knowledge through the media of the scale of Savile’s abuse, they now feel that what they saw was certainly inappropriate and may have been abusive.

We have heard repeatedly how the culture in the Infirmary during the 1960s to 1980s was formal, hierarchical and structured in rigid professional lines of accountability. Generally, the staff who witnessed or who heard disclosures from staff about Savile were closer to the ‘front line’ of the clinical areas, and remote from the management structure. So if anything was spoken about Savile more widely, it was in the form of gossip, nuance and rumour, and not

formally actioned. The case study of ZB, and the disclosures heard by the consultant and GP about Savile's abuse and its consequences, illustrate that even senior clinicians did not escalate this to anyone in management, but focused on the clinical treatment of the patient exclusively.

From what was known about his disruption to clinical areas, and his behaviour as a sexual nuisance to female staff, it is hard to accept that this was not seen as potentially harmful, reported to more senior staff, or challenged more rigorously. The culture of the organisation at the time and attitudes to what was deemed appropriate to report to more senior staff will have had a major influence on behaviours. We heard from both patient and staff victims a strongly held belief that they would not be taken seriously if they reported their encounters with Savile, and that even if they did, and were believed, no action would be taken because of their perception that senior people in the Infirmary were of the opinion that he did so much good for the organisation and that this should not be compromised.

We believe that the scale of his offending was not widely known or understood at all at any level in the organisation, at any time over his 50-year association with the Infirmary. Many warning signs given out by Savile were not seen, and even if they were, it would appear that the systems in the hospital made it almost impossible for concerns to be raised to a level where action could take place or the bigger picture could be seen (chapter nine).

Former senior managers repeatedly told us they heard nothing negative about Savile, and saw him as a force for good in his charitable acts for the hospital despite their reported personal feelings about him, when many told us that he made them feel uncomfortable and uneasy (source: witness statements N185; N213; N227; N88; N220; N218; N157; N214; N154; N202). This matter is examined further in chapter nine.

In a large, hierarchical organisation, because of the nature of the Chief Executive's role, it was strongly suggested that they would not be party to gossip and rumour from the 'front line', but that if something serious was of concern, systems should be in place to ensure that concerns would be reported to them.

> "You're not party to scuttlebutt, you know, you cannot get away from the fact that the Chief Exec's the Chief Exec, so I think there may well have been discussion and stuff going on at a level in the organisation where people were talking about or to others about Savile, but it didn't get to my level. Because if it got to my level, then it would have been an official issue."
>
> Source: witness statement N201; Maggie Boyle, Chief Executive, 2007 to 2013

This assumption is reliant on the systems for reporting being as robust as they can be, and on the culture being one that welcomes and nurtures staff and patients to feel empowered to raise concerns. A former Chairman commented on this:

> “I think that people are responsible for organisations where they are in leadership roles, and, you know, you can only deal with what you know. But organisations also have a duty to have systems that enable them to find out, and that enables people to come forward where there are concerns… And whatever system you set up there will be, there will be gaps in it, and you often only find those gaps when you analyse what went wrong. And I mean the best systems analyse it before it goes wrong… if it's true that individual people were assaulted by him [Savile] and reported it to staff, and those staff didn't take it further, then, you know, there's something, something wrong with the systems in an organisation where they couldn't do that.”
>
> Source: witness statement N309; Bill Kilgallon, Chairman, 1998 to 2001

Those who receive such reports of concerns need to be confident to know what to do with the disclosures, and then act swiftly and responsibly, driven by a guiding principle to safeguard the welfare of patients and staff. Repeatedly, in the accounts from victims – staff and patients – this was not the case.

For someone like Savile, the Infirmary at Leeds in the 1960s and 1970s was an ideal setting in which to indulge his unacceptable, and at times criminal, sexual activity. At the same time he was able to enhance his celebrity and charitable fundraising reputation, a combination which allowed him further and sustained access to vulnerable people. By the 1980s and 1990s, he was regarded by many as 'part of the furniture' and his presence was seen to be of little significance to any of those in authority. This gave him something akin to invisibility in the hospital, which enabled his abusive behaviour to continue unseen for years.

It is our opinion that the individual professional responses to Savile's behaviour when it was reported by victims or observed by staff were inadequate. Where health professionals had disclosures made to them, there was the added failure of not adhering to appropriate professional standards which over the years had become more explicit and robust as Codes of Professional Conduct (UKCC, 1983).

For the victims who disclosed to staff what happened to them, not being believed, or being belittled, even laughed at, served only to compound their feelings of hurt and betrayal. With hindsight, some victims have reflected that the staff they disclosed their abuse to just did not know what to do in response. This may be true, but it is unacceptable and, certainly in a hierarchical structure, the first response to such disclosure would have been to tell someone in a more senior position. Even where the staff were unsure as to the veracity of the reported incident, it should have similarly been reported upwards and by not doing so, those staff who were told of Savile's abusive behaviour failed in their responsibilities. We do not suggest that such staff members were uncaring, or would have failed to act if they had known the full extent of Savile's conduct.

9 Corporate responses

9 Corporate responses

Chapter summary:

- Connections were not made regarding people's personal perceptions of Savile and his presence in and potential risk to the Infirmary.
- Concerns about Savile were not escalated to the Board of Governors, or more latterly the Chief Executives of the Trust Boards.
- Internal scrutiny was ineffective regarding Savile's association with the Infirmary over a 50-year period.
- Safeguarding controls for the protection of children as patients were found wanting up until the 1990s.

Role and purpose of NHS boards

The role and purpose of NHS boards has evolved over the period from the inception of the NHS in 1948 to the present day. Over the last two decades NHS boards have seen increased local representation, clinical professional representation, public accountability and scrutiny, together with the introduction of systems and business practice in the running of NHS organisations. The culmination of this is a unitary NHS board which comprises executive and non-executive directors, all collectively and corporately accountable for organisational performance, with a shared corporate responsibility for collective decision-making and managing risk (NHS Leadership Academy, 2013).

The NHS Leadership Academy (2013) defines the role and purpose of current NHS boards as follows:

- to formulate strategy;
- to ensure accountability; and
- to shape culture.

The purpose of NHS boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their healthcare is in safe hands (NHS Leadership Academy, 2013). Wells (2006) defines an effective board as one that depends on having the right information at the right time, pitched at the right level and presented clearly to enable effective scrutiny and challenge.

Over the last five decades Leeds General Infirmary, in line with the rest of the NHS, has undergone a series of significant changes. 1991 saw the Infirmary become a self-governing hospital trust (SGHT). SGHTs have the advantages of increased autonomy, greater control over their own destiny and increased financial and investment freedoms (*Working for Patients*, Department of Health, 1989).

The Infirmary has seen successive changes amongst senior management, particularly in recent years, as the pace of change has accelerated and the focus on the delivery of financial and operational targets has increased. Recently, there has been a renewed focus on proactive

assurance of the safety and quality of patient care, particularly in light of a number of recent hospital scandals. This was mandated in the recommendations of the inquiry into events at Mid Staffordshire NHS Foundation Trust (Francis, 2013).

The profile and level of corporate responsibility associated with safeguarding services for adults and children have increased over recent years, with trust boards required to provide significant assurance in this area, and ensure that the standards embodied in safeguarding legislation are met. Since 2004, NHS trust boards have been required to have an executive director with an explicit lead for safeguarding, who is responsible for ensuring that safeguarding systems and processes are in place and are being followed (HM Government, 2004). In Leeds, this responsibility sits with the Chief Nurse (Department of Health, 2000a).

The role of NHS trust boards is complex in the need to balance multiple priorities against the ever increasing demands on hospital services. The Board at Leeds Teaching Hospitals NHS Trust faces a range of complex issues given that it oversees one of the largest trusts in the UK.

We have observed that the recent appointment of a new Chief Executive and new directors has led to a refreshed focus on organisational development and performance, building on the work of previous management teams.

Prior to 1974 Savile fostered close relationships with the Board of Governors and we believe this set the tone for his ongoing relationship with the organisation. Amongst clinical and support staff, he was perceived to have the support of senior management. This was not a view always shared by senior managers themselves. We have endeavoured to speak to as many current and former directors (executive and non-executive) as possible. We have interviewed all of those at the top of the organisation between 1974 and 2013 (see figure 3.1 on page 34). Five former chairmen and 24 other senior managers have also been interviewed. This chapter seeks to examine the role of hospital management and the successive boards of the Trust in connection with Savile.

To govern effectively, the Board needs to provide strong leadership and be robust, enquiring and willing to challenge in exercising its duty. In considering this a number of consistent issues struck us as significant in relation to Savile's association with the senior management of the Infirmary. These are:

- leadership curiosity;
- leadership insight and empathy;
- the connection between senior management and the rest of the organisation;
- systems of internal control;
- the safeguarding and protection of patients;
- systems for reporting concerns and complaints; and
- reputation management.

We examine each of these issues in turn.

Leadership curiosity

Throughout the course of the investigation, we have been concerned by the lack of curiosity and insight demonstrated by senior managers over the years relating to Savile's ongoing association with the Infirmary. Many, but not all, viewed him as an inheritance from the decisions made by previous administrations. It is worth remembering that Savile's presence was set in the context of having his own office in the organisation from 1992 to 2011, raising circa £3.5 million for hospital-related causes, being a publicity magnet for the hospital, having

unrestricted access to all areas on a 24-hour basis and utilising the Infirmary as a base for his fan mail. It is also the case that his presence at the Infirmary, whether as a volunteer or fundraiser, fluctuated significantly over the years; for a period of time in the 1980s, for example, it would appear that he focused his attentions on Stoke Mandeville Hospital rather than the Infirmary.

Even so, based on the evidence we found, there was a consistent lack of discussion or debate about his involvement with the organisation by those in leadership positions, for which we cannot find a credible explanation. This is not associated with perceptions of 'oddness' or a failure to connect personal characteristics with risk to staff or patients, but rather a failure to question his role, informal or otherwise, at the Infirmary. We find this to be remarkable given that, out of the six ex-chief executives (or equivalent) we interviewed, four of them had implicit knowledge of his significant fundraising activities for the Infirmary and on this basis alone, we would have expected them to have had a degree of engagement with him.

> "If I'm honest about it, I was probably aware that he had been associated with, I thought it was Jimmy's [St James's Hospital] not the Infirmary, but probably just a personality, so having seen him on television or something and knowing that he did some portering."
>
> Source: witness statement N201; Maggie Boyle, Chief Executive, 2007 to 2013

> "I was always aware of his association with Leeds hospitals. Apart from anything else I have lived in Yorkshire for years and years, since the mid-80s. I was aware of an association. I can't even remember the first time that he was mentioned when I was there… In fact, even during the whole of my four years, I can barely remember any reference to him at all. There would have been the odd comment here or there, but nothing about his behaviour or anything like that, other than an association."
>
> Source: witness statement N128; Sir Neil McKay, Chief Executive, 2002 to 2006

> "Whatever contact he had certainly wasn't with me or any member of the senior management team that were working with me at that time. It may have been that he had more contact with people who had been previously involved at the Infirmary, I don't know… well, I mean, I was running a massive organisation… I had no interest in Jimmy Savile… You may know more about that than I did in terms of incidents and dates. They certainly weren't brought to my attention at the time."
>
> Source: witness statement N156; David Johnson (now deceased), Chief Executive, 1998 to 2001

> “I've got no recollection of any Board discussion or even any sort of private discussions about him… I think from my perspective he was, you know, he wasn't somebody on the radar at all, when I was Chairman, I don't suppose I was really aware of him doing very much, in the hospital.”

Source: witness statement N309; Bill Kilgallon, Chairman, 1998 to 2001

> “Erm, I've met him probably three times… I mean, I'm guessing. I can't remember. It might have been four; it might have been two… But I would guess three times. He wasn't a – he wasn't a figure, he wasn't in our lives… In any way whatsoever.”

Source: witness statement N157; Stuart Ingham, Chief Executive, 1988 to 1998

It is a reasonable assumption that chief executives and chairs of NHS organisations should have a good level of knowledge about regular celebrity volunteers and major fundraisers, such as Savile. We were concerned that, from those we interviewed, successive managers and management teams were either unaware of Savile's presence at the Infirmary or alternatively knew but failed to question his presence and what his purpose was for being there from the mid-1970s onwards. The impression given is of no particular individual being in control of and responsible for Savile's presence in the hospital, to the extent that his presence there was acknowledged at all.

> “We just took it at face value really… sort of a volunteer. But after a little time I thought 'What on earth did he come for – it must be some sort of self-promotion'.”

Source: witness statement N214; Betty Vigrass (prev Champney), Director of Nurse Education, 1974 to 1977, then Chief Nurse until 1984

> “I certainly was aware of the fact that Jimmy Savile was at the LGI but it was not part of any, you know, briefing … These are the people you need to get to know about… No, there was no – it wasn't part of a formal sort of induction process.”

Source: witness statement N227; Richard Oswald, District Administrator, 1976 to 1984, then District General Manager until 1988

> “If you are working in a hospital, the people who do well adopt the core values of that organisation both explicit and unexpressed and you wouldn't automatically expect somebody who poses, and clearly is proven to be a benefactor of that organisation, to be using it as a cover for criminality. There will be a very low index of suspicion about such people… from the people who are in control.”

Source: witness statement N185; Margaret Bark, Medical Director, 1993 to 1997

Some of the former chief executives who were responsible for the hospital between 1974 and 2011 told us they were unaware of the extent of Savile's association with their organisation. This is at odds with his local media profile and the expectation that chief executives should be aware of matters concerning their organisation as reported in the press. That is not to say that none of these chief executives were aware of any press reports concerning their organisation and Savile. However, the frequency with which the two subjects received press attention might conceivably have prompted greater curiosity at the top of the organisation regarding Savile's role within it.

The following table sets out the number of local newspaper articles we have found relating to Savile and the Infirmary during the tenure of each chief executive (appendix four presents a broad summary of relevant press cuttings).

Table 9.1: Media articles in local press against chief executive tenure

Chief Executive (or equivalent)	Dates in post	Range of media dates	Number of articles in the period in local press	Source
Arnold Tunstall	1957–1977	1968–1973	33	*Yorkshire Post* archive
Brian Edwards	1974–1976	1974–1975	6	*Yorkshire Post* archive
Richard Oswald	1977–1988	1977–1984	20	*Yorkshire Post* archive
Stuart Ingham	1988–1998	1988–1997	15	*Yorkshire Post* archive
David Johnson	1998–2001	1998–2000	7	*Yorkshire Post* archive
Sir Neil McKay	2002–2006	2002–2006	11	*Yorkshire Post* archive
Maggie Boyle	2007–2013	2008–2010	6	*Yorkshire Post* archive

Leadership insight and empathy

In hindsight, there appears to have been a lack of empathy or failure by some senior managers to consider what might have been the effect of Savile's presence on junior members of staff and patients. A number of current and former senior figures we interviewed were concerned about Savile's behaviour towards them, describing him as 'creepy' and 'odd', but that is not to say that such characteristics displayed by someone famously 'out of the ordinary' should have alerted senior managers to Savile's actual conduct.

> "Yes, as I said earlier, he [Savile] was an odd fish, not the sort of person you'd want to spend a lot of time with, if only because he was just bizarre."
>
> Source: witness statement N227; Richard Oswald, District Administrator, 1976 to 1984, then District General Manager to 1988

> "The scale and the gravity of the situation comes as a surprise to me, although he was a man who you wouldn't want your daughter to meet on a late night. That is not correct, there was something about him. I am sure everybody says consistently there was something about him. As I say, you don't have long blonde hair and a big cigar and gold everywhere and all the things he had and be normal, do you?"
>
> Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973 to 1979, junior doctor to 1987, then consultant, Medical Director, 2009 to 2013, talking about the Infirmary in the 1970s

> “What was my perception? I wasn't particularly surprised I don't think. I always thought he [Savile] was a bit of a weirdo, frankly. I never saw him as anything more sinister. I just thought he was a bit kind of like weird.”
>
> Source: witness statement N77; Karl Milner, Director of External Affairs and Communications, 2010 to 2014

We found absolutely no evidence to suggest that those in leadership positions we interviewed knew Savile was sexually assaulting patients and staff. However, we did hear that on occasions they found his behaviour inappropriate for a hospital setting. This discomfort felt amongst some staff at the top of the organisation did not prompt them to appreciate the potential impact Savile may have had on junior members of staff or even on patients for whom they were responsible.

> “I know that the assistant matrons didn't like him, because whenever he met one he wanted to kiss their hands and things like that and I think some of them told him to get lost. This was hearsay… although I believed it to be true”
>
> Source: witness statement N214; Betty Vigrass (prev Champney), Director of Nurse Education, 1974 to 1977, then Chief Nurse until 1984

> “I do remember – I think there was one occasion when there was some sort of reception going on in the boardroom at the LGI sort of round the corner on the left, and for some unknown reason Jimmy Savile just invited himself in and started pushing himself around.”
>
> Source: witness statement N227; Richard Oswald, District Administrator, 1976 to 1984, then District General Manager to 1988

> “He wasn't a person I particularly liked – He was a man who I always thought was after Jimmy Savile – And, and he was a great kind of – I don't mean kissy-kissy, but if I used to walk along the corridor he'd, if he was, say, on his own he'd be, he'd be fine, but if he'd got people with him, he'd be shouting 'Stand back, here comes the matron', and all that kind of, you know, nonsense. And I remember once he was kind of, he was a great one at kissing your hand, and I said, 'I don't like that', and he never tried it again.”
>
> Source: witness statement N202; senior manager, late 1970s to late 1980s

> "I can't ever recall seeing him in the hospital. I was… aware of the fact that he was around sometimes… I recall that when he was around, people used to get fed up because he was quite disruptive and slowed things down; always chit chatting to people and you know, just behaving like Jimmy Savile did and when staff were trying to get on with their work. I think ward sisters were probably a bit fed up with it. It would just be passing remarks from a manager or a ward sister. I mean it wasn't a big deal.
>
> I think people just accepted that he was odd… And they accommodated him really I suppose."
>
> Source: witness statement N154; Liz Jenks, nursing manager from mid-1980s and Chief Nurse, 1991 to 1998

> "I could well imagine him putting the frighteners on some people… Both victims… and managers. And staff nurses and porters."
>
> Source: witness statement N157; Stuart Ingham, Chief Executive, 1988 to 1998

> "I suppose I thought what many people did. I always thought he was a bit odd, eccentric, not my cup of tea by any means and therefore I thought 'this is awful', but am I entirely surprised? Well perhaps I'm not. I mean he was sleazy, cheesy, wasn't he?… because he was iconic you just thought that was part of his persona, it was eccentricity… the more you learn about the police enquiries, the more you hear about the kind of investigation you are doing… the more you move from thinking 'Am I surprised?' to being totally appalled."
>
> Source: witness statement N218; Sir Neil McKay, Chief Executive, 2002 to 2006

We have found no evidence that the senior managers we interviewed made the connection between what they were observing, their own personal feelings about Savile, and his presence within the organisation to prompt action. It appeared that they did not connect their own feelings about him as an individual with any potential wider risk to the Infirmary, its staff or patients. With the benefit of hindsight, action they could have taken includes a pooling of information through executive discussion; confirmation and assurance about the application of internal controls on him; seeking feedback from staff and patients; and questioning his presence and access at the hospital instead of accepting it as unremarkable due to his status as a volunteer, a fundraiser or a national celebrity of long standing.

The connection between senior management and the rest of the organisation

The lack of curiosity about Savile from those at the top of the organisation appears to have been symptomatic of a broader disconnect between senior managers and the rest of the organisation.

Today, the Trust has seven hospital sites (see chapter one). Since the creation of Leeds Teaching Hospitals NHS Trust in 1998, the Trust headquarters and executive offices have been based at the St James's site in the east of the city. Some of the senior managers of the Trust we interviewed attributed their lack of knowledge about Savile's activities to their base being at St James's:

> "I never actually physically based myself at the Infirmary. I was always physically based at St James's."
>
> Source: witness statement N156; David Johnson, Chief Executive, 1998 to 2001

> "I was based at Jimmy's… I was less likely to hear (albeit in informal settings, such as overheard conversations in the canteen/corridors) the LGI gossip and noise because I was at Jimmy's."
>
> Source: witness statement N251; Rachael Allsop, Deputy Director of Human Resources, 2000 to 2004, Director of Human Resources, 2004 to 2009

> "[Asked if he had heard that staff at the Infirmary had been advised not to be on their own with Savile] I think part of the reason might be was because we were based at Jimmy's, not at LGI. Had we been at LGI at the old, kind of admin suite at the heart of the hospital then it is possible we would have heard more and more routinely, but hand on heart I can't remember that kind of background sort of hum of warnings about Savile and his behaviour."
>
> Source: witness statement N128; Sir Neil McKay, Chief Executive, 2002 to 2006

> "I knew he had interactions with the organisation and that he came into the organisation but I personally never saw him, or I don't recall seeing him in either of those two time frames [1999 to 2001 and 2006 to 2012]. And I guess Trust headquarters was over at Jimmy's and if he was still doing the same thing he would just have gone on the ward and off again and actually, there's no real reason why I would've known if that's continued to be his pattern of working."
>
> Source: witness statement N239; Ruth Holt, Assistant Chief Nurse, 1999 to 2001, Chief Nurse, 2006 to 2012

In contrast to the majority of views expressed, we heard how one chairman who had a particular leadership style routinely walked around the Infirmary:

> "In my time, my experience, my contact with Savile was principally in my walkabouts round the LGI. I came across him when he was doing portering duties and I also came across him generally in the areas of the elder people in the geriatric wards… I don't think the non-executives would [walk around the Infirmary] because they came and went into the office area. They very rarely went into the hospital itself. So I don't think any of them would ever have had any contact whatsoever, or occasion to have contact."
>
> Source: witness statement N308; David Hall, Chairman, 1995 to 1998

We heard from one former executive director that, being at the top of the organisation, she did not have the networks with people lower down the hierarchy who may have been party to gossip about Savile and may (or indeed may not) have then learnt of it:

> "One gets this sort of thing from talking to the cleaners, student nurses, junior doctors and so on. I came into the LGI at the top of my career so I didn't have such contacts… Because of the nature of my role and experience at the LGI I do not think it likely that I would ever have heard about any adverse rumours about Savile."
>
> Source: witness statement N185; Margaret Bark, Medical Director, 1993 to 1997

Whether or not senior managers were based at the Infirmary or at St James's should be immaterial as, certainly in the case of executive directors, their corporate responsibility extends to the whole Trust. It is reasonable to assume that they should have known what was happening at each site, regardless of where their offices were based, but something, or someone, would have needed to prompt that knowledge, not mere geographical presence alone. However, they could have been more aware of the extent of Savile's access within the hospital, his role as a volunteer and his possession of an office after the merger of the two Leeds trusts in 1998. In any event, some senior managers remained based at the Infirmary post-merger.

The current Chief Executive of the Trust has recognised the need to build on work from previous administrations to improve the visibility of the leadership across the organisation, and we understand that this is one strand of the Trust's new organisational development programme. We have seen evidence of this increased visibility since October 2013, through the Trust Chief Executive's weekly update to all staff and continuing programme of informal visits and board meetings as undertaken by earlier senior management teams across all hospital sites. He and the Chairman have an office on both the Infirmary and St James's sites, and there are hot-desking and meeting facilities at the Infirmary for executive directors.

Systems of internal control

A recurring theme throughout the investigation has been the way in which internal controls in respect of support services in place at the Infirmary were insufficient to restrict or call into question Savile's access to the hospital, and its patients and staff (chapter six).

In considering this, we examined internal controls in the following areas:

- allocation of Savile's offices at the hospital;
- the portering, security and mortuary services;
- access to the hospital at night; and
- access to the hospital for celebrities and other sanctioned visitors.

Savile's profile in the organisation was enhanced by his charity and celebrity work. In 1992, he made a funding contribution of circa £165,000 from his charitable trust towards the development of the Leeds Institute for Minimally Invasive Therapy (LIMIT) suite and it is perceived by some witnesses that this afforded him the opportunity to ensure that an office for his use was incorporated into the plans (source: witness statements N78 and N88). This was the first of three offices Savile occupied during his time in the organisation and was without question the best appointed. The LIMIT suite was closed down in 2006 and his office was moved to the front entrance off Great George Street. Whilst not as salubrious as the premises in the LIMIT suite, it was well furnished and was well positioned within the hospital. The third and final office given to Savile in 2009 was tucked away at the back of the disused nurses' home and was humble in comparison to the previous accommodation he had been allocated. Given his age and increasing infirmity, it appears that he may have spent less time in this last office.

The significance of Savile having an office within the hospital is an issue which the investigation has explored in some detail (chapter six). We have found no reference to any formal decision to allocate him an office at the Infirmary; it appears that there was never any debate at board or senior committee level to explain this decision.

In observing the corporate structure of the board, it is reasonable to suggest that the allocation of an office to a known celebrity might fall under the remit of the Director of Facilities; however, the following comment does not support this assertion in respect of the early 1990s:

> "The interesting thing about that is that he did have an office… Why the decision was taken at the time that Jimmy should have an office I don't know. That was outside my brief at the time."
>
> Source: witness statement N178; Stephen Farey, former Director of Facilities during construction of LIMIT suite

With the exception of former Chief Executive Maggie Boyle, who recalls a discussion about allocating Savile a replacement office in 2009, former senior managers we spoke to could not recall any management discussion about reallocating him an office:

> "You see my biggest regret is that I didn't pursue that [Savile having an office]… and ask why he'd had it.."
>
> Source: witness statement N152; Maureen Naughton CBE, Chief Nurse, 1998 to 2006

> “So the question was raised, and I don't know by whom, as to what we should do about Jimmy Savile's office and I took the view that even if he had donated to the LIMIT Suite that didn't entitle him to an office and I wasn't very sympathetic to that! I thought that that was, that people don't normally expect, in my experience, that if you donate charitably you get something like an office. And I thought at the time it was a bit typical of Jimmy Savile and that sort of 'give with one hand but take with the other'; that sort of personality and perhaps a little bit typical of some aspects of the LGI that it sometimes seemed to lack clarity about these sorts of relationships. So I was unsympathetic to it and, yes, that's where that rested.”
>
> Source: witness statement N220; Hugo Mascie-Taylor, medical student in Leeds, 1969 to 1974, junior doctor 1975 to 1986 in Leeds and elsewhere, consultant, St James's Hospital, Leeds, 1986, Medical Director, 1998 to 2008

> “I absolutely don't recall it but that, that if it was a formal discussion at the Board it would have been minuted so you can find that out. But I don't recall it, no. I had no idea he'd been given another office!”
>
> Source: witness statement N220; Hugo Mascie-Taylor, medical student in Leeds, 1969 to 1974, junior doctor 1975 to 1986 in Leeds and elsewhere, consultant, St James's Hospital, Leeds, 1986, Medical Director, 1998 to 2008

> “You could ask yourself with the benefit of hindsight why we thought it was appropriate to offer him another one [an office] and it was just because he had been here for such a while that I think we had stopped asking the question.”
>
> Source: witness statement N201; Maggie Boyle, Chief Executive, 2007 to 2013

> “I've no idea [why he was given an office]. When I came he had had an association with the organisation for some time. I was aware that in the early days of that, which would have been the 70s or 80s, I think he had occasionally come in almost as a publicity type thing and acted as a 'porter'… then I understand he had been involved in fundraising for the organisation, and as part of that the organisation had considered it appropriate, for whatever reason, to allocate him an office so that he was able to be on site.”
>
> Source: witness statement N201; Maggie Boyle, Chief Executive, 2007 to 2013

From the evidence we reviewed, it seems that the opportunity to consider the appropriateness of Savile having further offices in the Infirmary was never taken at any board or senior management meeting. Having analysed relevant committee minutes, we have found no official record of any decision taking place about him having another office base once his first office in the LIMIT suite was closed down in 2006. We recognise that, faced with an existing situation (Savile occupying an office), there may have been an assumption, if the matter had been considered at all, that Savile would be provided with alternative office accommodation. We do not actively criticise any individual senior manager for a failure to block the provision of a new

office, or for failing to evict him from it. However, the failure to consider that issue over a period of 19 years suggests that the Trust as an organisation gave insufficient scrutiny to matters not directly concerned with the day-to-day running of a large teaching hospital trust.

We heard how Savile cultivated relationships with the support staff at the hospital, including porters, security staff and, during the 1970s to mid-1990s, the Chief Mortician. We also heard that controls in these services were lacking until the late 1980s/early 1990s in the case of the mortuary, and early 2000s for portering and security staff (chapter six).

Since 2001, portering, together with security services, has undergone a process of significant professionalisation and modernisation. The portering service has a strategic plan in place relating to ongoing and future improvements. The security service across the Trust has benefited from £3.5 million of investment in order to develop a state-of-the-art security system across all the Trust premises.

We heard that the process of recruiting and training porters and security staff is very different from the weak processes described to us in the 1970s, 1980s and 1990s:

> “Once a position's accepted a porter or security officer will spend perhaps a week-long induction at our training school before they're allowed out to clinical areas and to handle patients. That's backed up by annual appraisal, a PDP [personal development plan]. I think the last, the percentage for last year was something in the region of between 85 and 90% of portering and security staff will have received an appraisal and PDP. And then that's followed up by an annual refresher for what we determine to be mandatory or key training aspects.”
>
> Source: witness statement N89; employee since mid-1990s

The responsible director receives regular updates about support services across the hospital:

> “My Director is a member of the Board… so each month we have quite a robust performance meeting. The kind of things I would talk about would be around portering performance, response times, number of tasks in month, all those kind of things so at a very basic level we're having that conversation with somebody on the Board to say… portering now in terms of response times is much better than it used to be… we've got a Security Director on the Board already… that's unusual for most trusts.”
>
> Source: witness statement N89; employee since mid-1990s

The mortuary too has undergone a process of modernisation since the late 1980s/early 1990s, including the introduction of standard operating procedures.

We understand that for historical reasons, there are separate human resources (HR) processes in place for the estates and facilities department of the Trust (which is responsible for portering, security and the transportation of patients' bodies to the mortuary). We have been told that the processes are parallel and the rationale relates to the fact that support services include many staff on short-term contracts, compared with main Trust services. However, we are concerned that separate processes may make it difficult for the Board to receive an overall assurance that

recruitment and employment practices are operating in a consistent and robust manner. Consideration should be given to establishing a unified HR process across the organisation which fulfils the recruitment and employment requirements for all Trust employees.

We heard how Savile was a frequent and often unwelcome presence in the hospital on the ward areas during the night, when there are fewer staff on duty to care for patients. He was seen by the nursing staff as a regular source of irritation whilst they were on duty.

Today, we are advised that the Trust has systems and processes in place to ensure that staff working through the night are supported and protected. There is a minimum of two qualified nurses on each ward through the night and the hospital has senior clinical and operational management in place overnight on each of the hospital sites. These processes, consistent with standard practice in hospital settings, should help to reduce the risk of people being able to wander around the hospital unchallenged at night.

> "I get their [clinical site managers] status report every morning that tells me what's gone on at night and if two or three patients have absconded or if they've had a particular problem with a relative, everything is communicated so the management team in the day time can helicopter in and do stuff. I would expect 'Jimmy Savile was here overnight' to be on that sort of a report…
>
> I think that, I'm absolutely certain that if he pulled up in the canteen in the middle of the night now and somebody had just said, 'Oh, Jimmy Savile's always in the canteen,' there would be some formal communication about appropriateness. I think it's a very, very different world, isn't it?"
>
> Source: witness statement N94; employed mid-1980s to present, talking about their time as a nurse in the mid-1980s compared with current practice

We considered how Savile's access to the Infirmary was aided by his celebrity status earlier in the report. Savile was not and is not the only celebrity to be associated with the hospital:

> "We have celebrities come and visit our wards all the time – the football team or whatever. That is in a bit more of a controlled way in that they say they are going to come around Christmas time or whatever and we let them on the ward. It is generally into the Children's Hospital because they love seeing the local football or rugby team."
>
> Source: witness statement N88; Peter Belfield, medical student in Leeds, 1973 to 1979, junior doctor to 1987, then consultant, Medical Director, 2009 to 2013

Numerous TV and radio personalities regularly visit the hospital for a variety of reasons. Similarly, over the course of the investigation, there have been media production crews on site, including those making 'fly on the wall' documentaries, those filming dramas, and others reporting the news. Some recent programmes filmed at the Infirmary include *Unsafe Sex in the City* (BBC Three, 2013) and *One Born Every Minute* (Channel 4).

Following the revelations about Savile in October 2012, the Trust's Internal Audit service reviewed relevant corporate policies and made a number of recommendations (see chapter ten). The recommendations included developing specific guidance by the end of April 2013 about the supervision of people who could be viewed as being sanctioned or approved by the Trust and who may have access to Trust premises (source: LTHT Internal Audit service report 2012/29).

Witness interviews have revealed that, until November 2013, there were no policies or procedures governing access to hospital premises by celebrities and media crews, ie those who could be seen as 'sanctioned visitors'. In light of this, it was not possible for the Board to receive any assurance in this area. This was confirmed by a former Director:

> "I think probably the policies are in place… If you are asking me to put my hand on my heart and say that every single bit of this hospital follows those policies, I can't give you that assurance…
>
> There are criteria; is it written down is quite an interesting question. No, it's not – it's in my head so the first thing is that it doesn't jeopardise the care and safety of the wards, etc, it's not going to get in the way. The second thing is, is it big enough for Leeds and those are the two criteria that I use in my head…
>
> Yes, documentaries are one-off, they are ad hoc and they do come to me to make the final decision on them. Do I have a written criterion for doing that? No, I don't."
>
> Source: witness statement N77; Karl Milner, Director of External Affairs and Communications, 2010 to 2014

The long-standing absence of documented criteria and procedures relating to production companies' access to Trust premises suggests that internal scrutiny and board assurance in this area has been lacking. We are concerned that, in the absence of documented criteria and procedures, unauthorised individuals may have been able to access Trust premises, including patient care areas, without adequate levels of supervision.

It is not possible to directly link the absence of internal controls as described above and in chapter six with Savile's abuse at the Infirmary. However, had appropriate internal controls been in place with regard to access to hospital premises, staff and patients, they would have helped senior managers to reduce the potential risks associated with his unrestricted presence at the Infirmary.

The safeguarding and protection of patients

A safe environment ensures every employee meets certain standards in relation to safe practice and has an understanding of safeguarding. These standards include:

- the systems, checks and balances at the corporate level, for example employment checks, and board assurance; and
- standards of delivery of direct patient care.

We looked at the systems and controls in place to safeguard patients, and have found evidence that there were inadequacies in a number of these during the time that Savile was associated with the Infirmary. This includes training, supervision and appraisals for support services staff, which are examined in chapter six, and pre-employment checks and safe standards of care, which we consider now.

We heard how Savile's role at the Infirmary was officially sanctioned in 1968 but were also informed that he was present as a volunteer before this date. It is unrealistic to have expected Savile to have undergone the same standard of employment checks as are in place today as they simply did not exist and, arguably, he might have passed those checks if he had undergone them. However, we found no evidence to suggest that Savile underwent any assessment relating to his suitability as a volunteer porter at any time during his association with the Infirmary.

> "Well, he was, he was a well-established character by the time I arrived… and he was a part of the furniture… he was to all intents and purposes an, an honorary member of staff… I remember asking myself did we; did anybody do any checks on Savile? I mean, I think the answer is that – no."
>
> Source: witness statement N80; Brian Edwards, District Administrator, 1974 to 1976

The absence of formal checks in the early part of Savile's association with the Infirmary can be partly explained by custom and practice at that time.

Savile's victims included children who were patients and visitors at the Infirmary. Those children and young people should reasonably have expected to be safe whilst in hospital. We have found evidence that suggested practice at the hospital between the 1960s and the 1990s was compromising their safety. An overview of the history of safeguarding in respect of children and young people is included in chapter three.

In Leeds during the 1960s and 1970s and into the 1980s, it was common practice to put up additional beds for patients on wards to meet demand, placing increased pressure on stretched resources, particularly nurse staffing. This activity potentially compromised nurses' ability to properly care for and safeguard patients. This would mean an extra row of beds being placed in the middle of a Nightingale ward or five beds in a bay designed for four. This practice, endorsed by many consultants, was the subject of much heated debate over the years between consultants, administrators and the nurses:

> "I mean, the big preoccupation of the day was the hospital was too busy… there were extra beds going up down the middle of the wards… it was a very, very excessively busy hospital at the time."
>
> Source: witness statement N80; Brian Edwards, District Administrator, 1974 to 1976

> "The consultants were not an easy lot. Well, I got in problems with them because they would insist on putting up extra beds in wards."
>
> Source: witness statement N214; Betty Vigrass (prev Champney), Director of Nurse Education, 1974 to 1977, then Chief Nurse until 1984

We were told that the District Administrator and the Matron met with consultants in the 1970s to discuss this matter, insisting that the practice of putting extra beds on wards had to stop as patient safety was being put at risk. Pressures on beds continued into the 1980s.

Staff shortages were a regular challenge, and there were rarely any extra staff available to care for these additional patients, so ward staff just had to do their best. The Infirmary came close to losing its accreditation for nursing education because of the pressures caused by this approach to bed management at this time. This would have been catastrophic for a teaching hospital of its reputation and profile:

> “The Chairman reported the decision of the Approvals/Applications Committee of the English National Board that in the light of the submissions from this Authority, use of the medical and surgical wards at the General Infirmary at Leeds for nurse training had been approved for a further three years… While relieved that the immediate threat to nurse training and services to patients had been removed, members recognised that a commitment to and evidence of steady progress in implementing the planned improvements to admission arrangements and nursing ratios would be required.”
>
> Source: minutes of Leeds Western Health Authority, 20 December 1983

A further consequence of placing additional beds onto wards was that, on occasion, children who were patients were placed on adult wards:

> “[Asked, were you on a children’s ward] No, I wasn’t. I was in an adult’s ward. I remember that. Definitely.”
>
> Source: statement by Victim E; early 1970s, aged under 16

> “No it wasn’t [a children’s ward] there were women and there were elderly patients in the room… I was in when I was 13.”
>
> Source: statement by Victim U; late 1990s, aged under 16

This placing of children amongst adults (albeit of the same gender) meant that if Savile had access to a general ward, it was likely to include children. Guidance from the Department of Health and Social Security to the NHS in 1969 asked hospital authorities to ensure by 1971 that children were not accommodated on adult wards (source: circular H.M. (69)4). In August 1971, the hospital’s working party on facilities for children commented as follows:

> “Children under 12 and others ‘below the age of puberty’ should all go to children’s wards unless there is some compelling reason to the contrary. Older children should be accommodated according to their physical and mental development rather than their age.”
>
> Source: Working party for hospital facilities for children, Leeds General Infirmary, 5 August 1971

In April 1971, the Paediatric Committee of the Faculty of Leeds General Infirmary agreed that children should no longer be admitted to adult wards (source: minutes of the Paediatric Committee of the Faculty of the General Infirmary, 9 June 1971). This did not happen, however, although there is no evidence to suggest that the Infirmary alone was slow to implement the required segregation.

Incidences of children placed on adult wards were being formally reported on by the hospital management team as late as 1985 (source: hospital management team minutes, 30 July 1985). Accounts of victims interviewed as part of the investigation show that children were still being admitted onto adult wards as late as the end of the 1990s (source: statement by Victim U) and five of Savile's victims were children on adult wards.

Adult wards do not provide an appropriate environment for children who are patients. Unlike adult wards, children's wards are staffed by registered children's nurses who have access to paediatricians, the staff to patient ratio is usually greater than on an adult ward, and the physical environment is designed with children in mind.

A practice that did not protect children and young people and which should have ceased in 1971 continued for a further 28 years.

The practice of putting additional beds on wards, after some earlier attempts, was finally stopped in 1988 (source: witness statement N154).

Examination of historical documents relating to child health at Leeds General Infirmary revealed that there were other issues relating to safeguarding children which were acknowledged but not addressed. We have found records to show that between September 1993 and October 1995 the Leeds General Infirmary Child Health Committee met seven times. From the documents reviewed, child protection issues were discussed briefly at only one of these meetings (source: United Leeds Teaching Hospitals NHS Trust, minutes of the Child Health Committee, 27 October 1995, 27 June 1995, 23 March 1995, 16 January 1995, 18 November 1994, 29 October 1993, 20 September 1993). This scant attention is surprising, given that the issue of protecting children in a hospital setting was high profile at that time, after the conviction of nurse Beverley Allitt in May 1993 for murdering children in hospital in Grantham, which created a heightened sensitivity with regards to children in hospital.

Criminal Records Bureau (CRB) checks were mandatory for all staff working with vulnerable groups from 2002. CRB checks were replaced by Disclosure and Barring Service (DBS) checks in 2012. The rationale behind these checks is to help protect vulnerable people from harm.

Whilst the requirement to have CRB or DBS checks in place postdates the period when Savile was most active at the Infirmary, we have considered them as part of the investigation to assess whether current policy and practice at the Trust in this regard is fit for purpose. CRB checks were introduced in 2002, when Savile was still a regular presence with his own office and unrestricted access to areas including wards. The approach of the Trust when CRB checks were introduced was to apply these to new staff only. Therefore, Savile was never CRB checked by the Trust. This was in line with guidance at the time (source: NHS Employers website).

The Trust, in parallel with our investigation and following its own Internal Audit report on the matters raised by Savile's activities at the Infirmary (see chapter ten), identified DBS checks of staff as a matter for urgent action.

An internal HR report to the Trust senior management team in March 2013 outlined that there were 3,219 employees who required an enhanced DBS check with no record of one in place, 974 employees who required a standard check with no record of one in place, and 240 employees who required a basic check with no record of one in place. An internal update to the

Trust's senior management team in August 2013 gave the number of employees requiring an enhanced check but with no record of one as 3,624. This was later revised to include 910 estates and facilities staff, meaning that the total number of Trust employees who required an enhanced DBS check but where there was no record of one being in place was actually 4,534. The Trust Board has been made aware of our concern regarding outstanding DBS checks and is in the process of urgently addressing this matter. As of 22 May 2014, the number of employees requiring an enhanced DBS check but with no record of one was 672 (source: data provided to the investigation by LTHT). At the same date, 256 out of 332 volunteers identified as requiring an enhanced DBS check had one in place. We would urge the Trust to ensure that current DBS checks are in place as a matter of urgency for all employees, volunteers and contractors who require one.

The Trust has invested heavily in developing and monitoring systems to measure and improve support services, including portering and security, in recent years. We heard about the Computer Aided Radio Personnel System (CARPS), installed in the Infirmary in 2002, which monitors and records the time each porter takes to complete specific tasks. Using this data, the Trust management team has developed key performance indicators (KPIs) and can identify when porters are not reaching these. Similarly, in 2009 the Trust introduced an electronic system that monitors members of the security team to verify that they have completed their rounds of the hospital, and is planning to update this system in 2014.

Whilst safeguarding is a core element of induction training for all porters and security staff, we heard that it is not an element of their performance appraisal, which is instead based around KPIs that focus on efficiency and timekeeping:

> "They [weekly reports on porters' performance] cover basically virtually everything – the time it takes to allocate a job, time porters are en route, time porters take to accept it, time porters are on jobs, because they've got like set targets, five minutes to be allocated, a minute to accept, seven minutes Jimmy's, six minutes en route at LGI, and 17 minutes on jobs or patient requests. We are basically measuring that… [asked what happens if someone isn't meeting the targets] every member of staff's sat down and they go through the performance letter… [asked if the performance letters and meetings include aspects of safeguarding and customer satisfaction] No, they don't."
>
> Source: witness statement N182; employed mid-1980s to present, talking about current practice

> "It's more the, as I say, they have a series of performance but that performance monitoring is more about we know where they all are at any one time; we know generally how long it should take them to respond to a call. We know how long the average call response should take so it's very much more their performance of moving patients from A to B more than anything specific dedicated to the safeguarding."
>
> Source: witness statement N243; Darryn Kerr, Director of Estates and Facilities, 2006 to present

Whilst these steps to improve performance are to be welcomed, we are concerned that the focus is on quantitative measures rather than qualitative measures that might be a better indicator of how well support services contribute to the safeguarding of patients.

The Board has ultimate responsibility for safeguarding standards in the hospital. Prior to 2004, when the current national policy on safeguarding was published, responsibility still rested with the Board, although the language used to describe it was different (for example, 'child protection'). Today, the Trust Executive Director Lead for Safeguarding is the Chief Nurse. Responsibility for employment checks rests with the HR Director.

Systems for reporting concerns and complaints

During the course of the investigation we interviewed 46 past and current senior managers and clinicians who had been responsible for the Infirmary, its staff and its patients.

Of those interviewed, most believed and expected that any concerns about Savile's behaviour would have been escalated by staff to the top of the organisation. Two chief executives were unsure that this would have happened. This passive belief on the part of management in the systems to raise concerns, together with accounts that junior staff did not feel able or were unwilling to escalate concerns (see chapter eight), meant that issues regarding Savile were not acted upon:

> "So you would go out on to the ward, and depending on the character of the Sister really dictated what the placement would be like. And so in some wards it was very, very rigid and you wouldn't even dare speak to Sister, and you would only speak – in fact you might only speak to the person that is in the – I was in Year 1 first, and the people above you, you might talk to them, and they might talk to the Third Year, so it was quite – very hierarchical."
>
> Source: witness statement N283; employed from early 1980s to mid-1990s, talking about being a student nurse in the early 1980s

This view was endorsed when we interviewed Dr Jane Brooks, an expert on nursing matters:

> "In actual fact, the system would have not allowed people to speak out, so students may not have been believed or would not have been listened to. Students probably wouldn't have been able to because if they'd gone to –. If I was –, if you were a, you know, second-year and you saw something and you went to a third-year, the third-year would say 'Oh God, don't tell anybody."
>
> Source: witness statement N255; Dr Jane Brooks, Director of UK Centre for the History of Nursing and Midwifery

The Brunel management system (see chapter three), with its perceived rigidity around communications, was introduced into the Infirmary in the early 1990s and may have reinforced the hierarchies that were present in the hospital up to the time of the merger in 1998. It is our view that an unintentional side effect of this could have been to make it harder for junior members of staff to escalate concerns.

We know that individual members of staff witnessed some of Savile's inappropriate and offending behaviour. Similarly nine victims told us that Savile's behaviour towards them was reported to members of staff who appeared to do nothing about it. Staff who heard these disclosures did not escalate the concerns or respond effectively, even in more recent times.

In trying to absorb the facts of Savile's abuse of patients and staff, former and current senior managers and Trust Board members we have spoken to have been adamant that, had they been aware of concerns and complaints about Savile's behaviour, they would have acted on them:

> "I am convinced that they [the ward sisters] would have told us."
>
> Source: witness statement N202; senior manager, late 1970s to late 1980s

> "If I had become aware of any of the allegations or incidents, offences, that we now know of, of course I would [have raised them]."
>
> Source: witness statement N156; David Johnson, Chief Executive, 1998 to 2001

> "It is like any complaints process. You hope that a majority of them will be dealt with at source, as it were. However, if something was so serious, along the lines that you are investigating with Savile, I would have expected it to have been elevated through the system."
>
> Source: witness statement N218; Sir Neil McKay, Chief Executive, 2002 to 2006

> "That would be the kind of organisation that I would want to be running. So if it was the situation that people did witness things and didn't act, then that's not what I would expect from people in positions of authority within this organisation."
>
> Source: witness statement N201; Maggie Boyle, Chief Executive, 2007 to 2013

We can illustrate that in contemporary times, where there have been allegations of sexual impropriety against a member of staff, and these matters have been brought to the attention of executive directors, they have been responsive and thorough in their investigation of the matter and have taken decisive action. The case of consultant OG (below) illustrates how in the last 15 years the clinical executive directors of the Trust have displayed courage in doing the right thing to protect patients.

Case study – Allegations of sexual impropriety

In the last 15 years, Leeds Teaching Hospitals NHS Trust has dealt with a case of allegations against a male consultant of sexual impropriety with female patients. This example demonstrates how, in a relatively contemporary timescale, the organisation responded to the concerns raised by staff and acted to protect patients. This case gives an indication of speed and rigour in the Board's response to the events once senior managers were made aware of the concerns. This case has nothing to do with Savile, but is an indication of how the Trust would respond to allegations of sexual harm to patients now.

Mr OG was a Consultant in Obstetrics and Gynaecology in Leeds from 1980. A patient complaint in the mid-1990s resulted in him being advised to have a chaperone present when performing examinations on female patients.

A further complaint in 1999 concerned his private practice, and was investigated by the Trust Medical Director, although the patient refused to make a formal complaint. OG was again advised to have a chaperone present, and to undergo professional peer supervision.

In 2000, the Medical Director was advised of another complaint from a private patient concerning OG and her permission to provide a statement to the Trust was being sought when a further complaint was received. This patient was contacted and was willing to provide a statement to the Chief Nurse. The matter was immediately referred to the police.

OG was suspended in 2000. The police, the Trust and the private healthcare provider worked together to agree the appropriate process for an investigation. A helpline was set up for patients, and was well publicised. Hundreds of calls came in and those patients who had concerns about their treatment were referred to the police.

OG was charged with 31 offences and found guilty on two charges of indecent assault on private patients. He received two 18-month suspended sentences and was referred to the General Medical Council and removed from the register. The Trust summarily dismissed him for gross misconduct in 2002.

Even though the events concerned his private practice and not NHS care, immediate steps were taken by the Medical Director, HR Director and Chief Nurse to protect patients. The Trust subsequently developed thorough guidelines for the use of chaperones. Any such incidents where impropriety is alleged are investigated as serious incidents and the matters are referred to the police (source: Trust briefing paper, 2013).

The former Medical Director informed us that the concern that triggered the above actions came from another gynaecologist who spoke with him informally, asking what he should do:

> "My view was that if what was alleged had indeed occurred then that would be a criminal offence and so it was not a professional matter, primarily, nor was it an employment matter, primarily… it was a ***prima facie*** criminal matter and therefore I should involve the police at a very senior level."

Source: Hugo Mascie-Taylor, medical student in Leeds, 1969 to 1974, junior doctor 1975 to 1986 in Leeds and elsewhere, consultant, St James's Hospital, Leeds, 1986, Medical Director, 1998 to 2008

He also spoke of the tensions with other clinicians within the Trust and in other trusts who disagreed with his approach, and the need to be confident and steadfast in his decision:

> "There were a number of people in Leeds who thought that what I'd done was the right thing and there were a number of people in Leeds who thought I'd done completely the wrong thing. And neither group held back in explaining to me why I should accept their point of view. I had quite a torrid two or three weeks but my line to all of them was that… ultimately this was a matter which was my responsibility, not theirs… I have to say there were other doctors from other places ringing me up and expressing their view; largely that I'd done the wrong thing, including much to my irritation and embarrassment a Medical Director from another hospital…"

Source: Hugo Mascie-Taylor, medical student in Leeds, 1969 to 1974, junior doctor 1975 to 1986 in Leeds and elsewhere, consultant, St James's Hospital, Leeds, 1986, Medical Director, 1998 to 2008

In the case of Savile, we have found no evidence that concerns were escalated to senior managers. A number of explanations were offered for this:

> "It was just regarded as something that happens… because other people who had other incidents had a similar response. They didn't get anywhere and they knew that if they did try and pursue it, it wouldn't happen. With regard to the bosses, it was very much a 'them and us'. You didn't feel particularly at ease talking to them… I mean the hierarchy of the nursing staff; the sister, the nursing officers, right up to the Director of Nursing at the time."

Source: statement by Victim FF; mid-1970s, talking about her time as an employee in the 1970s

> "I guess again, with him being famous you feel less inclined to complain about things. I probably mentioned it to the nursing staff, as in, 'gosh, he's just done this', but I don't think I mentioned it to the consultant… I think he probably would have just said 'oh, that's just Jimmy'… I don't think he'd have acted on it personally."

Source: statement by Victim P; mid-2000s, talking about her time as an employees

We heard that concerns were not reported as people perceived that they would not be believed or have their concerns acted on because of beliefs about Savile's celebrity and fundraising, or that they had no faith in the system to raise concerns.

Concerns about complaints relating to Savile not reaching the top of the organisation again suggest that there has been a long-standing disconnect between those with corporate responsibility for the Infirmary and what happens at ward level.

The ability of staff to raise concerns within their organisations without fear of reprisal (universally known as 'whistleblowing') has been enshrined in law since 1999 and the enactment of the Public Interest Disclosure Act of 1998, .

In the wake of the Public Inquiry into Mid Staffordshire NHS Foundation Trust (Francis, 2013), momentum to support employees to raise concerns has gathered pace. This inquiry highlighted the effects for both patients and staff of concerns not being raised and dealt with effectively by management.

The Trust has a whistleblowing policy in place. We have been informed by the Trust that it has only been used twice since 2010. The whistleblowing policy in place at the start of our investigation did not explain how staff could raise concerns that they may not consider to be 'whistleblowing', a term which can be emotionally loaded following high-profile cases where people are perceived to have lost their jobs as a result of blowing the whistle. Consideration therefore needs to be given to how staff can be supported to raise any concerns and how the Board then responds to these. This has begun in the Trust through the commissioning of an independent specialist to review the policies and processes in place to support staff in raising concerns (source: minutes of Leeds Teaching Hospitals NHS Trust Board meeting, 26 September 2013).

We have observed further progress in this area since autumn 2013, with the Chief Executive's weekly e-mail to all staff encouraging people to raise concerns (source: 'Start the Week' e-mail to LTHT staff), and the Trust's endorsement of, and participation in, the *Nursing Times* Speak Out Safely campaign (source: *Nursing Times* website, February 2014).

The recent personal message from the Secretary of State Jeremy Hunt to all NHS trusts (Hunt J (2013) Letter to all NHS trusts re defensive culture in the NHS), encouraging individuals to raise concerns and emphasising that doctors and nurses have a professional duty to do so, provides a further impetus for action within the organisation.

Although a small number of victims made verbal reports of Savile's abuse at the Infirmary, we found no evidence that anyone made a formal written complaint about him.

Until 1985 with the introduction of the Hospital Complaints Procedure Act, there was no consistent approach to the handling of complaints from patients. Each hospital had its own system (Hospital Complaints Procedure Act, 1985).

Documentary evidence collected in relation to the Infirmary identified minutes from the District Management Health Board in September 1987 (source: minutes of the meeting of West Leeds Health Authority, 15 September 1987) where it states that the monthly analysis of complaints had been expanded to incorporate complaints with regard to communications (between staff and patients) and staff attitudes. This suggests that complaints from patients began to be taken progressively more seriously, and began to form part of a suite of measures on quality and safety.

The NHS Complaints Procedure was established in response to *Being Heard*, the report of the Review Committee chaired by Professor Alan Wilson (Wilson, 1994). The review had been set up to consider how patient complaints were dealt with in the face of criticism about current processes. It aimed to simplify the complaints process for patients. Hospital boards were asked to compare their own systems for dealing with complaints with the recommendations of the review and implement changes as required (Mayberry, 2002).

In 1994, in response to the *Being Heard* report (Wilson, 1994), the Board considered a comparison of its complaints policies and processes with those in the review. In the accompanying board paper, their own assessment indicates weaknesses in internal systems in a number of relevant areas:

> "
> - a lack of written material explaining how to complain;
> - less than comprehensive staff training;
> - lack of tie in between complaints and quality monitoring processes;
> - lack of support for vulnerable people making complaints;
> - staff not empowered to initiate appropriate action to remedy complaints; and
> - a lack of impartiality when reviewing complaints "
>
> Source: minutes of United Leeds Teaching Hospitals NHS Trust Board meeting, 19 July 1994

Examination of contemporary board and committee documents has revealed that, in line with other NHS trusts, the Trust Board currently receives regular reports on patient complaints as part of its assurance around the quality of care and services.

In light of this investigation we feel it would be timely for the Board to assure itself of the rigour of its complaints processes. The publication of the review of NHS hospitals' complaints systems, *Putting Patients back in the Picture* (Clwyd and Hart, 2013), identifies four key areas and associated recommendations which we would urge the organisation to embrace. These key areas are: improving the quality of care; improving the way complaints are handled; greater perceived and actual independence in the complaints process; and whistleblowing.

As illustrated above, there are a number of routes through which concerns can reach the top of the organisation, for example through staff escalating issues, whistleblowing and patient complaints. However and whatever the reason for their failure to be informed, the senior managers we spoke to had been unaware of concerns about Savile. Even in more recent times, there was a sustained misplaced faith amongst senior managers that staff concerns would be escalated to them. If a more active management stance had been taken, for example greater visibility of leadership and proactively seeking information from staff and patients, they might have been more questioning about the effectiveness of the systems to raise concerns.

Reputation management

When the revelations about Savile came to light following the ITV *Exposure* programme in October 2012, they immediately provoked significant media interest in the Trust, resulting in unprecedented attention on the organisation as described by a former director:

> "The media was on to it and it was a frenzy, an absolute frenzy. I have never known anything like it, anything like it. It was a case study in medievalism – it was just unbelievable and that was a hard week."
>
> Source: witness statement N77; Karl Milner, Director of External Affairs and Communications, 2010 to 2014

We understand that the scale of demand (within the Trust) from the numerous media agencies created a significant and unanticipated pressure on those in leadership positions, resulting in a number of urgent crisis meetings. Some days passed before the Trust implemented a systematic approach to managing media and patient contacts as a result of the revelations.

Whilst planning for the unknown is always difficult, with hindsight the Trust and its Board would have benefited from having plans and procedures in place to help to manage these unprecedented and unexpected events.

We believe it would be prudent for the Trust to develop a strategic plan for issues where public confidence in the organisation may be at stake in the light of unprecedented events. Such a plan would enable the organisation to speak with one voice whilst informing and assuring the Board, stakeholders and the public of a professional response. The development of the plan would also enable an honest assessment to be made of the capacity and capability available within the organisation to deal effectively with the crisis, allowing external expertise to be drafted in where necessary.

In recent years there are examples of NHS organisations that have lost public confidence and whose reputations have been significantly tarnished by extensive negative media coverage following high-profile controversies. Whilst it is difficult to plan for such events, it is suggested that having a strategic plan in place will minimise the uncertainty regarding roles and responsibilities and primary actions to take should such an event occur.

Conclusion

From our interviews with those who had been in leadership positions at the Infirmary, we have no doubt that had Savile's offending been explicitly raised with them, they would have done something about it. However, we feel that opportunities to identify and challenge Savile's role, his access and his privileges were missed throughout the whole of the period he was associated with the Infirmary.

The chief executives, chairmen and senior managers we interviewed were largely unaware of Savile's day-to-day presence at the hospital, considered him part of the furniture, and therefore did not stop to think about why he was there and what he might be doing. Others have remarked that Savile's visits to the Infirmary were so infrequent that the management team did not in fact even see Savile as part of the furniture. They were focused on other matters that

were considered the priority of the day, such as bed pressures, financial pressures and waiting lists. These are all significant concerns, and should be taken into account in any assessment of the performance of the leadership in the Trust.

It is our view that there should also have been more attention paid to issues concerning the safety of patients and staff, including in the non-clinical context. There should have been stronger management of the risks presented by weaknesses in the internal systems of control, such as those described earlier in this chapter and in chapter six.

On the whole, and particularly in the last 30 years of Savile's life, those senior managers who knew he continued to visit ward areas and/or occupied office space did not challenge or question his reasons for being in the hospital. They were passive in their consideration of him. Despite the discomfort felt by some senior managers about him as an individual, he was not seen as a potential risk to the organisation. Had they been more proactive in their governance and internal scrutiny, and then asked why someone whose appearance and behaviour seemed at odds with a hospital setting was at the Infirmary, they might well have acted differently. This could have included discussion at executive level about his role and purpose in the organisation and a re-examination of the controls around his access and privileges. It would be speculation to say whether such interventions would have stopped him abusing people at the Infirmary; however, they might have reduced the risk of this happening.

10 Policy critique

10 Policy critique

Chapter summary:

- Implementation of the Trust's Internal Audit service's recommendations to improve policies in light of the allegations about Savile was slow.
- There are inconsistencies in the presentation and scope of policies.
- Policies could be strengthened by seeking the views of a wider set of stakeholders.
- The Trust should identify and adopt best practice from other organisations.
- The Trust is currently reviewing all its corporate policies.

Introduction

The terms of reference for the investigation included reviewing the Trust's current relevant policies and practices to assess their fitness for purpose (appendix one). This extended to ensuring safeguards were in place to prevent any recurrence of matters of concern identified by the investigation and identifying matters that required immediate attention.

During the early years of Savile's association with the Leeds General Infirmary (the 1960s and 1970s), the hospital, in line with other NHS organisations, was required to comply with national circulars and management letters issued by the government department with responsibility for the health service at that time, ie the Ministry of Health (until 1968) and the Department of Health and Social Security (from 1968). We reviewed minutes of Board of Governors' meetings for this earlier period which illustrated that they formally received such circulars and referred them to the relevant committee at the hospital. A summary of the circulars that the Board of Governors considered to be relevant to this investigation is included in appendix eight. Whilst it is impossible to confirm compliance with this national guidance, given the passage of time, the fact that there appears to have been a contemporaneous process in place to receive and disseminate it is of relevance.

In this chapter, we describe the process undertaken to assess the Trust's current policies, explain how common themes emerged from the assessment, consider the safeguards that are in place today and go on to make recommendations as to how the policies could be strengthened.

In autumn 2013, the current Trust Board began a programme of work to review all of its corporate policies and assurance systems. Whilst our assessment of Trust policies pre-dates this programme of work, we have advised the Trust on the areas we feel need attention and would urge the Board to consider the points we make in this chapter as it continues to strengthen its assurance systems.

First, we describe the initial steps taken by the Trust during October and November 2012 to review its corporate policies covering employment checks, safeguarding, reporting concerns and the investigation of reported incidents. The review was carried out by the Trust's Internal Audit team and made 13 formal recommendations for improvement.

Trust Internal Audit report

In response to the revelations about Savile, the Trust's Internal Audit team reviewed corporate policies that were relevant to the allegations known at that time. We understand that the report was undertaken in response to a specific request from the then Trust Chief Executive, Maggie Boyle, and was classed as Internal Audit 'consultancy' work, rather than 'assurance' work (source: internal e-mail from Trust Head of Internal Audit, 15 February 2013). We understand that Internal Audit does not assume any management responsibility for its consultancy work (source: LTHT Internal Audit Charter, July 2013). The Trust Clinical Governance Committee reviewed Internal Audit's diagnostic report on 29 November 2012.

Three months later, Internal Audit circulated the same report to Trust policy leads, who were expected to take responsibility for ensuring compliance with the recommendations in February 2013. We were not made aware of the reasons for the delay in circulation. Internal Audit made 13 specific recommendations (source: LTHT Internal Audit Report No. 2012/29). The recommendations cover the following areas:

- bringing policies into line with current legislation, official guidance or best practice;
- clarifying and complying with the requirement for Disclosure and Barring Service (DBS) re-checks;
- developing a volunteering policy, to include mandatory employment checks and training;
- developing guidance for sanctioned visitors;
- raising concerns about inappropriate behaviour towards patients;
- publicising the availability of the Patient Advocacy and Liaison Service; and
- enhancing processes for developing and managing Trust policies.

In March 2013, we requested a report through Internal Audit on the Trust's progress in implementing the recommendations; this was four months after the initial report. At that time, we found that only two of the 13 recommendations made had been fully implemented by their due date. In the case of the specific recommendation to clarify the requirement for three-yearly DBS re-checks, the implementation date had been deferred by more than a year.

Despite these delays in implementing the recommendations, at the Trust Board meeting on 29 November 2012 Maggie Boyle, the then Chief Executive, included the following assurance regarding Trust policies in her monthly written report to the Board:

> "Work around the Jimmy Savile investigation continues. Our top priority is to ensure that our current approach to safeguarding of vulnerable adults and children is robust. We have reviewed relevant policies and updated them ensuring that these are rigorously followed by our own staff and by the many charitable and voluntary organisations who are part of our day to day hospital life."
>
> Source: Chief Executive's report to the Board, 29 November 2012

The minutes of the Board meeting held on 20 December 2012 record the following:

> “Miss Boyle reassured Board Members that the Trust had ensured that its current practices and processes were fit for purpose and that any unacceptable activities of the type being alleged would be detected and prevented quickly.”
>
> Source: minutes of the Leeds Teaching Hospitals NHS Trust Board meeting, 20 December 2012

We are concerned that, as the Internal Audit recommendations were not circulated to Trust policy leads until February 2013, and given the delay in implementing them, the Board was not in a position to receive assurance that the relevant safeguarding policies had been updated, were fit for purpose and were being rigorously adhered to at its meetings in November and December 2012. The Internal Audit report had concluded, in a first draft circulated on 15 November 2012, that policies relating to both children and vulnerable adults were under review and subject to receiving third party guidance. That process had not been completed at the time of the 29 November 2012 Board report, or the Board meeting on 20 December 2012. This could indicate a gap in current assurance processes at the Trust and we escalated this risk to the Trust Board in January 2014.

Current assurance

In selecting which policies to assess to demonstrate current assurance, we took as our starting point the policies that had been identified as relevant by the Trust Internal Audit team in October 2012, and supplemented these with intelligence that emerged through witness interviews. This meant that, in total, 14 policy areas were analysed and reviewed as part of the investigation.

These were:

- recruitment and selection;
- safeguarding children;
- volunteering;
- conduct and discipline;
- whistleblowing;
- violence and aggression;
- sanctioned visitors;
- safeguarding adults;
- complaints and concerns;
- dignity at work;
- information governance;
- security;
- standards of business conduct; and
- retention of documents.

Between the start of the investigation and 28 November 2013, the Trust did not have a policy for sanctioned visitors that set clear boundaries regarding the role of celebrities, VIPs and media contractors in the Trust; nor did it have a policy for volunteers working at any of the hospital sites until November 2013. We were also told that the Trust did not have its own specific policy on the retention of documents; instead, it relied on national guidance in this area.

The policies, where they existed, were considered against the following criteria:

- stakeholder engagement when a policy is being developed or reviewed;
- the scope of the policy;
- clarity;
- policy and practice; and
- monitoring of compliance.

Where possible, we compared the Trust's policies with those of NHS trusts that were rated highly by regulatory bodies such as Monitor and the Care Quality Commission, and those of other organisations with expertise in particular areas, eg charitable organisations' policies on the use of volunteers.

We also considered the recommendations made by the Trust's Internal Audit team in its review of policies at the end of 2012, and the Trust's response to these.

Whilst we considered each of the 14 policy areas identified as relevant individually, a number of common themes emerged which require particular attention. These themes are discussed below.

Stakeholder engagement and seeking best practice

With the exception of the safeguarding adults policy and the safeguarding children policy, which are pan-Leeds policies developed in partnership with other health and social care organisations in the city, the Trust appeared to be insular in its policy development. We found little evidence that its policies had been developed in consultation with patients, patient representative groups or external organisations with expertise in a particular area. Consultation with Trust staff appeared in the main to have been restricted to formal staff representatives such as the Trust Negotiation and Consultation Committee.

The following table sets out who was consulted in the development of each policy, as described in the policy documents.

Policy	Who was consulted in its development?
Recruitment and selection	Trade union representatives
Safeguarding children	Pan-Leeds policy
Conduct and discipline	Staff side representatives
Whistleblowing	Whistleblowing Policy Review Group (including staff side and management representatives)
Violence and aggression	Key stakeholders (staff, directors, senior managers, Health and Safety Department, Risk Management Department, Security Department, unions, Emergency Department, high-rate reporting areas, training development, police, Leeds City Council, Security Management Service), divisional line management structure, Operational Management Group
Safeguarding adults	Pan-Leeds policy
Complaints and concerns	Senior managers and staff with direct involvement, West Yorkshire health and social care organisations, voluntary and user groups
Dignity at work	Staff side representatives, Trust Negotiation and Consultation Committee
Information governance	Staff side representatives
Security	Director of Estates and Facilities, Head of Facilities (Operational), Deputy Head of Facilities, Head of Health and Safety, Risk Management Department, Estates and Facilities Business Manager, Trust Security Advisor, local security management specialists
Standards of business conduct	No consultation process

We believe that the policies could be strengthened by seeking the views of a wider set of stakeholders, not least to identify and adopt best practice from other organisations. Similarly, involving staff (including volunteers) and patients in the development of policies could help to ensure that policies are relevant and better understood by those they support and who are required to comply with them.

Scope of application

All the policy areas assessed defined the scope of the application of the policy – ie to whom it applies – differently. In some, the groups affected were defined and named, while in others only 'all Trust staff' were specified. Volunteers, non-executive directors and contractors were not mentioned. We are concerned that, by default, some individuals and groups of staff will therefore be excluded from the conditions in the policies, and this could potentially present a risk for patients and staff in the implementation of the policies.

The following table sets out the scope of each policy, as described in the Trust documents.

Policy	Scope of application
Recruitment and selection	All Trust staff
Safeguarding children	Not specified
Conduct and discipline	All staff, managers, staff side representatives
Whistleblowing	All Trust staff, executive directors, senior managers in corporate functions, senior operational managers
Violence and aggression	All Trust staff, executive directors, senior managers in corporate functions, senior operational managers
Safeguarding adults	All staff who have direct contact with adult patients
Complaints and concerns	Chief Executive, executive directors, senior managers in corporate and operational areas, other NHS and social care organisations, local involvement and community organisations
Dignity at work	All staff
Information governance	All staff and third party contractors
Security	Trust-wide
Standards of business conduct	All staff

It is our view that the Trust should consider the nature and purpose of its broader community, including volunteers and non-executive directors, and ensure that its corporate policies apply to this whole community. This will be important in the Trust achieving its aspirations to become a Foundation Trust and working with its Council of Governors and wider membership.

Clarity

We understand that the Trust has developed a template for its policies, and we welcome this standardisation of approach. However, when we reviewed the policies, we found that they differed in style, length and whether and where they included detail on legal obligations and technical guidance. Many of the policies were lengthy and in some cases the inclusion of legal and technical details in the main body of the policy document made them difficult to read. Examples of some policies we have seen from other NHS organisations resolve this by having short and succinct policies that very clearly set out the salient points in plain language, using annexes for legal and technical details. We therefore urge the Trust to learn from best practice elsewhere and to work towards clear, succinct and understandable policies that can easily be communicated and implemented by its staff and stakeholders.

Policy and practice

For the Board to receive assurance that its policies are being adhered to, it needs to have knowledge of any gaps between policy and practice. There were a variety of mechanisms in place for monitoring the compliance with and effectiveness of the policies we reviewed. Many of these rely on reports of when procedures within policies have been invoked, for example the Trust complaints and concerns policy and its dignity at work policy. There appears to be very little assessment of why procedures may not have been used, and little analysis around this. It is important that the Trust understands why policies may not be being used as part of its assessment of effectiveness, and we would urge the Board to consider how analysis of policy use could be included in its assurance.

Monitoring compliance

Arrangements for monitoring compliance with policies are by their very nature complex, with reporting to the Board carried out via its relevant sub-committees. For example, the policy areas we considered in our review were each monitored by one or more of the following 12 committees/sub-committees/groups within the Trust:

- Workforce Committee;
- Audit Committee;
- Senior Management Team;
- Health and Safety Committee;
- Patient Experience Sub-Committee;
- Risk Management Group;
- Equality and Diversity Group;
- Information Governance Sub-Committee;
- Patient Safety Group;
- Safeguarding Adults at Risk Steering Group;
- Child Protection Steering Group; and
- Quality Committee.

It is also worth noting that the Trust must also know about, apply and comply with the multi-agency procedures of the Leeds Safeguarding Children and Safeguarding Adults Boards. In addition to monitoring its own compliance, it must report in accordance with the requirements of each of the Safeguarding Boards.

Within this complex corporate structure, with its separate reporting mechanisms, there is the possibility that the 'big picture' could be unintentionally obscured. It is our view that there is a danger that the Board is missing an opportunity to make the connections between the various policy areas. Consideration should be given to one part of the corporate infrastructure taking on the role of making these connections, giving regard to their relevance to patient-centred care, and providing assurance to the Board on this point. We understand that the Trust is looking to address this in its current programme to review all policies.

We believe that the role of Internal Audit in monitoring compliance with corporate policies should be reviewed. Prior to the investigation team being appointed, Internal Audit had already examined corporate policies that were pertinent to Savile's activity at the hospital and had made 13 recommendations for improvement. Most of these were due to have been implemented by the end of March 2013; however, we found that only two had been fully implemented by their due date.

Under normal circumstances, Internal Audit routinely reports twice a year to the Chief Executive on progress with implementing its recommendations. We feel that, where its recommendations are linked to the safeguarding of patients and staff, there is inherent risk in waiting until the next routine cycle of reporting to check if the recommendations have been implemented. We therefore ask the Board to urgently consider exceptional reporting being mandatory where Internal Audit recommendations have a direct correlation with patient and staff safety.

Safeguards in place today

In chapter nine we considered the systems and controls that were in place to safeguard patients during the time that Savile was associated with the Infirmary. Since the allegations about him emerged, and in parallel with this investigation, the Trust has reviewed a number of measures to ensure the safety of its patients and staff.

In September 2013, the Trust began a programme to complete enhanced DBS checks for 4,534 staff who required one but for whom there was no record of a check. As of 22 May 2014, this number had reduced to 672 (see chapter nine).

Safeguarding of children and vulnerable adults is led on behalf of the Trust Board by the Chief Nurse, who is a member of the Leeds city-wide Safeguarding Boards for Children and Adults.

During the course of this investigation, the Trust has developed both a sanctioned visitor policy and a volunteer policy. We understand that it is also working with the Leeds Teaching Hospitals Charitable Trust to develop a revised code of business conduct. These should be considered alongside its other policies as they are developed in line with our recommendations.

Conclusion

Given the passage of time, it is impossible to assess how well the Infirmary complied with national guidance during the early period of Savile's association with the hospital (the 1960s, 1970s and to some extent the 1980s). We found that during the 1990s and 2000s, when it is reasonable to have expected policies covering harassment to be in place at the Infirmary, staff who were victims of Savile did not feel able to report their concerns.

When allegations about Savile came to light in October 2012, the then Trust Chief Executive was timely and proactive in commissioning an internal review of the Trust's relevant policies. However, subsequent implementation of the recommendations of this internal review has been slow.

The Trust has commissioned a further review of all its corporate policies and we welcome this. We would urge the Trust to consider not only the content of its policies, but also its consultation processes, the presentation of policies, the confidence of staff and volunteers in using the policies, and its compliance as part of this wider review.

11 Recommendations

11 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.

1 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.

2 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).

3 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).

4 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).

5 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).

6 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).

7 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).

8 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.

9 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).

10 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).

11 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).

12 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).

13 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.

14 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).

15 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).

16 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.

17 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.

18 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).

19 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).

20 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).

21 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).

22 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).

23 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).

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

25 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).

26 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).

27 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).

28 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.

29 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).

30 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).

31 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).

12 Conclusion

12 Conclusion

Leeds is a wonderful city with a great vibrancy and spirit. It has been transformed over the last 50 years in terms of its socio-economic and cultural features and will undoubtedly continue to be one of the major centres for business, retail and economic growth in the UK.

Leeds General Infirmary, as part of Leeds Teaching Hospitals NHS Trust, has a long and rich history of over 200 years of innovation and excellence in research, teaching and clinical care services. It remains a major teaching hospital, which attracts quality staff and provides high-quality modern services to patients and their families from Leeds and the wider West and North Yorkshire areas. Some of its specialist services serve patients and families from across the country.

The revelations about Jimmy Savile's behaviour in the hospital have cast a major shadow over both the hospital itself and, by association, the city of Leeds. For some, there is a sense of betrayal that a celebrity so closely linked with the city could have done such harm to so many children, young people and adults over so many years.

There are still a significant number of people across the city and elsewhere who do not or cannot quite believe what happened. For them, the accounts of abuse and intimidation do not correspond with the public persona or the private man, the Jimmy Savile they thought they knew. Others are reflecting on whether they should have seen more, listened more, done more. Still others are looking for someone to blame. Responses such as these are perfectly natural when faced with abuse on this scale but, as the perpetrator is dead, these responses will not help in taking things forward.

Over successive decades, many of the people in positions of authority in Leeds General Infirmary did not know or act on what some staff in the wards and departments knew and talked about. The systems for reporting concerns were ineffective, and yet there was a misplaced belief in them by the senior management. Savile was a nuisance, a disruptive influence on clinical services and a persistent sexual predator towards young female staff. In addition, he had unprecedented access right across the organisation in his role as 'volunteer porter' and unsupervised access as a 'celebrity'.

Because of the very small number of patients and staff in the hospital who raised concerns or reported incidents, the actual scale of his offending was neither anticipated nor acknowledged at any level in the organisation. People in the Infirmary did not think the unthinkable: that patients and, in particular, children were at risk from him. These risks were therefore not acted upon, challenged (other than on rare occasions by courageous individuals) or stopped.

At the same time, Savile was seen by many as a force for good, liked by some patients and happy to use his celebrity to influence people in positions of power. He secured maximum press coverage for himself and, by association, for new services and fundraising. Sustained over 50 years, this charitable persona was perceived to offer benefits to the hospital, allowing it to obtain good press coverage, and on the face of things was good for morale. It was in Savile's interests to maintain a high and powerful celebrity profile, to be the centre of attention and to be associated with 'good deeds'. This served to deflect any attention from the rumours about his behaviour that were discussed in wider society and among people in the media for years.

In the wake of recent scandals such as that at Stafford Hospital, much has been spoken and debated about compassion. In public debates, through the press and through other media channels, hospital staff, including clinical professionals, have faced a barrage of criticism for a perceived loss of compassion towards patients.

However, compassion is not just within the remit of health professionals. It is everyone's responsibility. Compassion in this context requires a willingness to listen and to see the perspective of others, whoever they might be, when they report concerns about inappropriate or abusive behaviour. It may mean being willing to question the 'norm' when this is no longer appropriate. This is the case even if the message is uncomfortable or relates to someone in a position of power or influence, as was the case with Savile.

Within healthcare, there is an additional responsibility: to ensure that the central priority is always the safety and dignity of patients. This may mean being less amenable and deferential to the demands of the celebrity or VIP visitor, and more assertive regarding the paramountcy of patients' needs.

If there is any legacy from what we have learnt from the behaviour of Savile through this and other investigations, then it should be that – both within and outwith the NHS – we all pay more attention to what is going on around us, and become more courageous in challenging behaviour that is unacceptable or that concerns us in some way. Pretending not to see cannot be an option. Acting with compassion requires a shared commitment to protect and safeguard the most vulnerable, to take responsibility to raise concerns, and to expect and demand action by those in authority.

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Appendices

Appendix one: Terms of reference

Investigation into matters relating to Jimmy Savile

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

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

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

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

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

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

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

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

   a where the incident(s) occurred;

   b who was involved;

   c what occurred;

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

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

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

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

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

10 Identify recommendations for further action.

5 December 2012

Appendix two: Investigation Team biographies

Susan Proctor, Chair (Independent)

Dr Susan Proctor is a Director of SR Proctor Consulting Ltd, and former Diocesan Secretary for the Diocese of Ripon and Leeds. Until 2010 she worked in the NHS for over 25 years in a variety of nursing, midwifery and management posts, culminating in the position of Chief Nurse/ Director of Patient Care & Partnerships for NHS Yorkshire and Humber. In this position she had responsibility for clinical governance, professional standards and commissioning independent inquiries into serious adverse incidents of care delivery and overseeing the implementation of their recommendations. An experienced Board Director, she is also a Non-Executive Director at Harrogate and District Foundation Trust, Chair of the LEAF Multi Academy Trust in Leeds, a member of the Council of the University of Leeds, and a Visiting Professor at Leeds Metropolitan University.

Ray Galloway, Director of Investigation (Independent)

Ray retired from the police service in January 2013, having served as a Senior Investigating Officer with both Merseyside Police and North Yorkshire Police, during a career that spanned 30 years and included a wide variety of investigative roles.

Ray has extensive experience of dealing with major investigations, including serious and organised crime and sensitive investigations in healthcare settings. He was also a member of the Association of Chief Police Officers National Rape Working Group, which identified and embraced best practice in terms of investigating sexual offences.

Rebecca Chaloner, Director of Governance (Independent)

Rebecca has a public sector career spanning three decades, working nationally, regionally and locally. She has a wealth of experience having held a number of senior national positions in the health sector. Rebecca has been a senior civil servant at the Department of Health since 2008.

An experienced change management practitioner, Rebecca's appointments span a range of national programmes, including NHS Direct, the Department of Health's social enterprise unit, and the establishment of NHS England.

Rebecca is a Trustee of Pace, a national charity that works alongside parents and carers of children who are being sexually exploited.

Senior Investigation Advisor Claire Jones (Independent)

Claire is a Director of Kuredu Business Consultancy. She has worked in the NHS for 29 years. She has a range of nursing experience, plus a range of managerial positions working within the NHS at local, regional and national level.

Claire has worked as a National Associate Director for the NHS Modernisation Agency, Head of Urgent Care for West Yorkshire and more recently as Deputy Director of Performance at North of England Strategic Health Authority.

Senior Investigation Advisor David Thompson (Independent)

David was formerly the Deputy Chief Nurse for the North of England. He is a senior nursing professional with 37 years of experience in the NHS, working for the past 15 years at a strategic level. Previous to this he worked in a number of acute hospitals in Yorkshire. David is a RGN, BSc (Hons) Nursing and holds an MBA.

Appendix three: Schedule of documents and materials

Administration	
United Leeds Hospitals	
Board/Committee minutes	**Dates**
Board of Governors	1963–1974
Finance and General Purposes Committee	1959–1974
Nursing Committee	1960–1974
Infirmary House Committee	1960–1974
Establishment Committee	1960–1974
Sub-Committees	1960–1974
Priorities Committee	1965–1973
Annual reports	1960–1973
Leeds Western Health Authority (LWHA)	
Board/Management Group minutes	**Dates**
LWHA Board meetings	1982–1990
LWHA District Management Group	1985–1989
LWHA District Management Board	1986–1990
LWHA Trust Fund Advisory Panel	1984–1989
Leeds Area Health Authority	
Leeds Area Health Authority – Joint Liaison Committee minutes	1970–1975
United Leeds Teaching Hospitals	
Board minutes	April 1991 – March 1998
St James and Seacroft University Hospitals NHS Trust	
Board minutes	1990 – March 1998
Leeds Teaching Hospitals NHS Trust	
Board minutes	April 1998 – 2013
Leeds General Infirmary	
Paediatric Committee minutes	1969–1995
Accommodation Sub-Committee minutes	1974–1976
Hospital Management Team minutes	1985
Leeds General Infirmary Child Health Committee	1989–1995

General administration and correspondence	
United Leeds Hospitals – Board of Governors' miscellaneous correspondence	1965–1972
United Leeds Hospitals – Secretary to the Board's correspondence	1960–1973
United Leeds Hospitals – correspondence of the Chairman of the Board	1970–1974
Office equipment sub-committee – correspondence and minutes	1973–1975
Finance	
United Leeds Hospitals – various annual balance sheets	1960–1974
United Leeds Hospitals – various cash books and account books	1971–1975
United Leeds Hospitals – receipt book register	1960–1970
United Leeds Hospitals – receipt books	1960–1966
United Leeds Hospitals – Secretary to the Board of Governors' correspondence re miscellaneous donations, bequests, fundraising	1971–1974
Leeds Teaching Hospitals – Special Trustees' minutes and letters	1974–1979
Leeds General Infirmary – Special Trustees' minutes and correspondence	1988–1994
Leeds Teaching Hospitals Special Trustees' Account Ledger	Various
Minutes of the Special Trustees Vol. 1	2001–2003
Minutes of the Special Trustees Vol. 2	2004–2006
Minutes of the Special Trustees Vol. 3	2006–2008
Minutes of the Special Trustees Vol. 4	2009–2011
Leeds Teaching Hospitals Trust – Special Trustees' Attendance Registers	Various
Handwritten Accounts Ledger	Various
Other	
Various Health Service Circulars (HSCs) and Executive Letters	1960–1991
Leeds Teaching Hospitals NHS Trust complaints files	April 2002 – June 2003
Leeds Teaching Hospitals NHS Trust electronic complaints files	June 2003 – June 2013
Dan Mason Nursing Research Committee (1962) *The Work, Responsibilities and Status of the Enrolled Nurse: Report of the Dan Mason Nursing Research Committee of the National Florence Nightingale Memorial Committee*	1960
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Leeds Regional Hospital Board (31 March 1974) *Leeds Regional Hospital Board: Review of Policy and Objectives 1971/2 and 1973/4*	1971
Leeds General Infirmary booklet: *Information for Patients*	1965
United Leeds Teaching Hospitals NHS Trust security handbook for staff: *Hospital Watch*	1993
Various photographs of Savile pictured in and around the LGI	Various
Staff newsletters and publications	Various
United Leeds Teaching Hospitals – press and publicity cuttings (various)	Jan 1994 – Jan 1999
United Leeds Teaching Hospitals – press releases	1993–1997
Assorted Archive Letters	Various

Appendix four: Press articles inventory

Date	*Yorkshire Evening Post* ref.	Headline
1974	29	The track suit tycoon
1983	136	Cash and gifts for hospitals
01/02/1968	55	It's the medicine as before from 'Doctor' Savile
03/06/1968	142	Jimmy leads hospital clean-up volunteers
30/07/1968	74	Now DJ means Daredevil Jim
07/08/1968	36	JS donates stamps providing new stereo turntables at LGI
30/10/1968	164	Schoolchildren back Jimmy on his marathon run
05/12/1968	162	LGI buys JS Birthday present
02/04/1969	144	Jim's VIP outing for Hole-in-Heart girl Julie
16/04/1969	54	Jimmy Savile as a record 'food grabber'
09/06/1969	5	Beach boys play at the LGI
17/07/1969	91	Jim moves in to a 60mph home
14/08/1969	119	Jimmy thanks young helpers of infirmary
14/10/1969	159	Savile's travels will save lives
18/10/1969	49	Savile's travels help to save lives
22/10/1969	4	More pupils rally to Jim's call
27/10/1969	48	Jim takes on United at their own game
30/10/1969	145	His firework money is for Jimmy
08/11/1969	44	Jimmy Savile's marathon mania is spreading
17/11/1969	141	Injured Jimmy runs tomorrow
18/11/1969	51	Jimmy home in charity marathon
19/11/1969	31	Just three hours sleep for Jimmy
19/11/1969	94	Savile marathon ends ahead of schedule
26/11/1969	93	Auntie Flo's Big Night Out
28/11/1969	95	Jimmy marathon fund snowballs past £3,000 mark
01/12/1969	53	Jimmy's marathon fund gets a boost
20/12/1969	107	Girls give Jimmy £820 for fund
11/02/1970	3	Singers help hospital
09/03/1970	35	Cheque in…the end of a long walk
06/10/1970	118	JS inspects feet of volunteered walkers
04/11/1970	79	Near completion of kidney unit
04/02/1971	73	Jimmy opens new studio
02/03/1971	96	Having a good time…
15/12/1971	80	Jimmy remembers the old folk
01/01/1972	50	That OBE is a real tonic, says Jimmy
19/01/1972	75	Now Jimmy Savile gets OBE

Date	*Yorkshire Evening Post* ref.	Headline
27/01/1972	92	Why porter has palace date
20/03/1972	37	Up the mall, Savile-style
20/09/1972	32	Pornography is the pollution of people, says Jimmy
01/10/1972	101	Everybody's fool
04/12/1972	76	Why Polly said No – By Jim
04/12/1972	158	Savile's romance takes a jolt
08/12/1972	108	DJ tells PM: I am your physician, sir
27/02/1973	6	Mexico Bound
07/11/1973	12	DJ Jim's Top Pops 'in a hole'
21/03/1974	146	A streak of satire from Jim
23/07/1974	57	Gala gift for hospital
23/01/1975	43	Jimmy Savile signs up
19/03/1975	129	Stars Mike & Wilma for charity walk night
03/04/1975	122	Show for the two Jims fund
25/06/1975	126	Gentlement Jim to lead the ladies
01/01/1976	33	Chauffeur Savile
11/02/1977	149	Jimmy Savile's running mate
01/03/1977	8	Charity marathon raises £2000
09/06/1977	81	JS presents Jubilee Cake to children at LGI
13/09/1977	56	A smile and handshake to 12 year old boy
01/02/1978	151	Jim opens new ward scheme
02/02/1978	163	Jim'll collect it
09/02/1978	97	The Savile magic finds a funny side of being blind
21/06/1978	127	DJ's head line bowls 'em over
22/06/1978	99	Jim fixes it for hospice
14/08/1978	98	Jim pours out the cash
13/12/1978	45	Salute to Jimmy
08/02/1979	147	How I'd fix it – Jim
19/04/1979	165	It's magic! Angela's big treat
24/09/1979	121	Jim fixes it for 8 year old for police
13/10/1979	120	A triple bill as all action DJ spins into town
22/12/1979	7	Jim fixes it for playtime
22/01/1980	10	DJ heads Spinal Unit campaign
04/03/1980	166	New Garden project in LGI commences
13/05/1980	30	At the court of St James
06/01/1981	148	Jimmy's in the money
12/05/1981	100	Jim pops in to present awards
04/06/1981	109	How's about that then... Jim fixes it
02/10/1981	60	Jimmy Savile fixes a rest
03/10/1981	110	Savile's travels that never stop
15/10/1981	173	Jimmy and team in step for Leeds marathon
01/12/1981	150	Jim fixes it for the fund

Date	*Yorkshire Evening Post* ref.	Headline
02/01/1982	167	Jimmy's thanks for the £1/2m helping hand
25/01/1982	64	Help for Jimmy
23/02/1982	19	Jimmy's in the running for No. 4
22/05/1982	115	Things I wish I'd known at 18
26/08/1982	77	There's no lady fast enough
28/09/1982	23	Jimmy's charity chums are lending a hand now
22/12/1982	78	Maggie fixes it, Jim gets holiday invite
06/01/1983	168	XJS for JS
17/01/1983	17	A fix-it by fundraisers
07/02/1983	59	Just for fun says Jimmy
04/03/1983	112	Jimmy on the run again for charity
08/03/1983	160	Marathon man Jimmy remembers pit-down days
08/03/1983	161	Jimmy Savile's marathon results
12/04/1983	61	Jim hits back at 'Godfather' label
28/04/1983	114	Jim fixed it for coma girl Gillian
11/05/1983	16	Jimmy sees stars… before his eyes
06/07/1983	170	Charity boost for Jimmy
30/12/1983	14	Maggie's new year honour for Jim
22/02/1984	41	Owzabout that then! Jim joins toffs' club
22/03/1984	69	I'll be there for big run, says Jimmy
01/05/1984	9	Mile after Mile… Jim pounds the charity beat
23/05/1984	13	Jim's vigil at brother's side
01/09/1984	18	How's about that! Jim's month on the run
22/11/1984	106	End of road for Savile's travel team
14/12/1984	84	Kid's fix it for Children's Society
17/12/1984	143	Jim hands over wheelchair cash
08/03/1985	2	Jim's back in the running
04/03/1986	85	Runner helping to foot the bill
12/05/1986	67	Mr Fix It visits hospital
14/05/1986	128	Now it's doctor Jim
14/05/1986	132	Honorary doctorate for Jimmy Savile
11/09/1986	40	Jim in bid to fix it for heart unit
22/05/1987	154	Jimmy's pals turn out for fun run
03/11/1987	21	Helping Hand: JS pours tea to volunteer
03/11/1987	133	Hospital 'kept Savile from bottle'
09/11/1987	65	Jimmy – the hot Gospeller
02/01/1988	131	Savile fixes moves from Broadmoor
16/03/1988	135	Jim's out to fix it with Kidney Plea
22/09/1988	62	DJ uses princess in Huge Fix-It
24/01/1989	171	Star keeps promise
31/01/1990	20	Jimmy gives £5000 to appeal
06/06/1990	15	Sir Jim celebrates with cuppa

Date	*Yorkshire Evening Post* ref.	Headline
06/08/1990	152	Jimmy put to sword
10/05/1991	87	Lucky Jim
31/07/1991	66	Sir Jim fixes it
03/12/1991	22	Sir Jimmy cheers up Stuart Guest during his visit to the LGI
04/12/1991	174	L' of a shock for Jim
09/04/1992	82	Fitness session a day on QE2
13/05/1992	39	Family protests over Fix It strip
13/05/1992	130	Sir Jim fires back at critics over 'Fix-it' Strip
24/12/1992	63	Lift-off for LGI keyhole unit
04/01/1993	68	Sir Jim takes a peep at new micro surgery
08/01/1994	88	Maybe I'm just an oddball
08/01/1994	116	
22/02/1994	138	Twenty Questions
08/03/1994	42	Sir JS works out in the new gym as Mi Sek, a visitor from Eastern Europe, mops his brow
24/05/1994	155	Sir Jimmy aids victim groups
20/07/1994	172	BBC finally fixes it for a surprised Sir James
29/07/1994	113	Sir Jimmy relays more help for charity
20/06/1995	111	Sir Jim fixes it
12/07/1995	153	Still frisky at 68
12/12/1995	86	Jim's £20,000 gift
20/07/1996	140	Them bones, them bones, them famous bones
10/08/1996	137	Dunce's cap for Sir James
06/09/1996	24	Patients' thanks as Sir Jimmy fixes it
31/10/1996	25	70 today - but life is still one long fun run for top Mr Fix It
02/11/1996	27	His mother died 23 years ago but he still cleans her clothes and says she is at home
28/05/1997	83	I promised you a rose garden
04/08/1997	134	Thanks for my life
08/08/1997	26	Surgeon fixes it for Jimmy
09/08/1997	156	Mr Fixit' on mend after heart op
09/08/1997	169	Sunny outlook for Sir Jimmy
15/08/1997	157	Sir Jimmy says a hearty thankyou
30/08/1997	28	The energetic Sir Jimmy Savile talks for the first time about his quadruple heart by-pass operation
30/08/1997	125	Sir Jimmy makes a start
30/08/1997	175	Sir Jimmy makes a start
08/01/1998	1	Sir Jim is in very good heart
28/04/1998	11	Fix-it-Jim to pay last respects
10/07/1998	72	Sir Jim makes an entrance
13/07/1998	71	Jim turns on style at Gala
03/07/1999	47	Savile threat to sue Stoke Mandeville
26/09/1999	89	Jim fixed me

Date	*Yorkshire Evening Post* ref.	Headline
11/04/2000	90	In bed with Jimmy
26/12/2004	117	It's everyone else who's odd
Date unknown	46	Hospitals share £30,700
Date unknown	38	T-shirts in the mayor's parlour
Date unknown	70	Generous Jim fixes it for trainees at LGI
Date unknown	139	I'm not a lonely child hating man
Date unknown	123	Everyone a winner in cake contest
Date unknown	34	Chaperones? Ridiculous says Jimmy
Date unknown	52	JS marathon fund suceeded dramatically in efforts to expland Artifical Kidney Treatment unit at LGI
Date unknown	58	I swear it's not true to life, says Jimmy
Date unknown	124	Even Losers Share Bonanza
05/11/2002	YEP Online	Readers push appeal through £1.5m mark http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/readers-push-appeal-through-163-1-5m-mark-1-2090411
18/01/2005	YEP Online	Jim steps in for tsunami http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/jim-steps-in-for-tsunami-1-2276085
15/07/2006	YEP Online	The day our Jim fixed it for the doctors of the future http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/the-day-our-jim-fixed-it-for-the-doctors-of-the-future-1-2053638
30/10/2006	YEP Online	A national treasure http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/a-national-treasure-1-2077439
01/11/2006	YEP Online	Campaign now under way for tribute to city's favourite son http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/campaign-now-under-way-for-tribute-to-city-s-favourite-son-1-2077766
31/10/2006	YEP Online	Fix it for Jim to be Freeman! http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/fix-it-for-jim-to-be-freeman-1-2077549
01/11/2006	YEP Online	It's cry freedom for our Jimmy http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/it-s-cry-freedom-for-our-jimmy-1-2077707
22/11/2006	YEP Online	We'll fix it for Sir Jim http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/we-ll-fix-it-for-sir-jim-1-2082243
14/12/2006	YEP Online	Sir Jimmy Savile passes state-of-the-heart test http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/sir-jimmy-savile-passes-state-of-the-heart-test-1-2081402
09/06/2007	YEP Online	Sir Jim fixes it for finest medical talent http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/sir-jim-fixes-it-for-finest-medical-talent-1-2106661
27/08/2008	YEP Online	Build a statue to honour Jimmy http://www.yorkshireeveningpost.co.uk/news/letters/build-a-statue-to-honour-jimmy-1-2190588

Date	*Yorkshire Evening Post* ref.	Headline
29/08/2008	YEP Online	Trophy moment for Saran as junior doctor wins Sir Jimmy's award http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/trophy-moment-for-saran-as-junior-doctor-wins-sir-jimmy-s-award-1-2190799
30/08/2008	YEP Online	LGI medic wins Sir Jimmy Savile award http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/lgi-medic-wins-sir-jimmy-savile-award-1-2190835
03/07/2009	YEP Online	Sir Jimmy's award to junior doctors http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/sir-jimmy-s-award-to-junior-doctors-1-2216694
09/12/2010	YEP Online	Leeds students thank you to Sir Jimmy http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/leeds-students-thank-you-to-sir-jimmy-1-3015984

Appendix five: Expert opinion biographies

Dr Jane Brooks

Dr Jane Brooks is Director of the UK Centre for the History of Nursing and Midwifery and a lecturer at the School of Nursing, Midwifery and Social Work at the University of Manchester.

Dr Jennifer Bolton

Dr Jennifer Ruth Bolton is a Bachelor of Medicine, Bachelor of Surgery (MBChB) and Fellow of the Royal College of Pathologists (FRCPath). She is a registered medical practitioner with sub-specialty registration in Forensic Pathology, a visiting fellow to Northumbria University and a Home Office pathologist for the north east of England.

Professor Aidan Halligan

Professor Aidan Halligan was the first NHS Director of Clinical Governance and Deputy Chief Medical Officer for England. He is currently Chief of Safety, Brighton and Sussex University Hospitals NHS Trust, and Director of Education, University College London Hospitals NHS Trust. His teaching interests relate to leadership in healthcare.

He became a professor in fetal and maternal medicine in Leicester before taking on a national role as the first Director of Clinical Governance for the National Health Service. From January 2003 until October 2005, he served in the UK Department of Health as Deputy Chief Medical Officer for England, with responsibility for issues of clinical governance, patient safety and quality of care across the NHS in England.

History and Policy

History and Policy is a unique collaboration between King's College London and the University of Cambridge.

It is a national network of 500+ academic historians. It publishes high-quality historical research freely accessible online and create opportunities for historians, policy makers and journalists to connect.

This is done to demonstrate the relevance of history to contemporary policy making and to increase the influence of historical research over current policy. The collaboration also advises and assists historians wanting to engage more effectively with policy makers and media.

Appendix six: Local Oversight Panel terms of reference

Investigation into matters relating to Jimmy Savile

The Board of Leeds Teaching Hospitals NHS Trust (LTHT) has, in accordance with its Serious Incident Policy, commissioned an investigation into Jimmy Savile's association with the Leeds General Infirmary, and other institutions under the management of LTHT and its predecessor bodies following allegations that he sexually abused patients and staff during his voluntary or fund-raising activities there.

Purpose

The purpose of the Local Oversight Panel (LOP) is:

To receive monthly progress briefings on the progress of the Leeds investigation and also high level briefings on the other NHS/DH investigations. Written briefings will be provided to the LOP by a member of the investigation team.

To provide oversight and assurance to the Trust Board and National Oversight Team in relation to the scope, pace, proportionality and comprehensiveness of the Leeds investigation.

To understand and monitor the risks (reputational and financial) associated with the running of the investigation, and associated with emerging issues arising from the investigation.

To provide a reference point for the progress of the implementation of internal audit reports concerning matters related to the investigation and their impact on current service assurance, governance, policies and behaviours.

To communicate at least bi-monthly to the Trust Board through its confidential meetings processes. Written bi-monthly reports will be provided to Trust Board by the Director of Governance.

To initiate actions on matters arising from the investigation deemed to required urgent attention and to advise the Board and National Oversight Team accordingly.

Receive quarterly financial reports prepared by the Investigation Team and ensure that the Investigation Team has access to necessary resources.

To advise the Investigation team on practical or detailed implementation matters concerning recommendations arising from the investigation.

To treat all information received as confidential and not to disclose information beyond the Local Oversight Panel membership.

Membership

Chair – Caroline Johnstone, Non Executive Director Leeds Teaching Hospitals NHS Trust Board

Suzanne Hinchliffe, Chief Nurse Leeds Teaching Hospitals NHS Trust

External representatives

Diane Pae – Senior Service Delivery Manager Victim Support

Roger Gair – Registrar University of Leeds

Dr Paul Kingston – Chair Leeds Adults Safeguarding Board

Jane Held – Chair Leeds Children's Safeguarding Board

Joy Fisher – Leeds LINKs

Fiona Richards – Senior Regional Representative NSPCC

Other representatives may also be invited to contribute in conjunction with relevant issues emerging from the investigation.

Members of the JS Investigation Team will be in attendance:

Dr Susan Proctor (Oversight and Quality assurance – Independent and Chair of the Investigation Team)

Ray Galloway (Director of Investigations – Independent)

Rebecca Chaloner (Director of Governance – Independent)

Claire Jones (Senior Investigation Advisor – Independent)

David Thompson (Senior Investigation Advisor – Independent)

David Firth – Capsticks

Frequency of Meetings and Proceedings

The Local Oversight Panel will meet monthly. Towards the end of the investigation, there may be a requirement for additional meetings.

Notice of meeting dates for the rest of the year will be circulated with the agenda of the first meeting, and will include the potential for additional concluding meetings.

Agendas and papers will be circulated at least 5 working days in advance of meetings.

The quorum for the panel will be 50% attendance of members.

Reporting

The minutes of the meetings will be recorded and circulated for approval at the next subsequent meeting.

These will also be shared with the Trust Board in its confidential session, and with the National Oversight Team.

Dr Susan Proctor

February 2013

Appendix seven: Abortion Act 1967

Status: This is the original version (as it was originally enacted).

Abortion Act 1967

1967 CHAPTER 87

An Act to amend and clarify the law relating to termination of pregnancy by registered medical practitioners. [27th October 1967]

BE IT ENACTEDby the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

1 Medical termination of pregnancy.

(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.

(4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy

by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave, permanent injury to the physical or mental health of the pregnant woman.

2 Notification.

(1) The Minister of Health in respect of England and Wales, and the Secretary of State in respect of Scotland, shall by statutory instrument make regulations to provide—

(a) for requiring any such opinion as is referred to in section 1 of this Act to be certified by the practitioners or practitioner concerned in such form and at such time as may be prescribed by the regulations, and for requiring the preservation and disposal of certificates made for the purposes of the regulations;

(b) for requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination and such other information relating to the termination as may be so prescribed;

(c) for prohibiting the disclosure, except to such persons or for such purposes as may be so prescribed, of notices given or information furnished pursuant to the regulations.

(2) The information furnished in pursuance of regulations made by virtue of paragraph (b) of subsection (1) of this section shall be notified solely to the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department respectively.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations under subsection (1) of this section shall be liable on summary conviction to a fine not exceeding one hundred pounds.

(4) Any statutory instrument made by virtue of this section shall be subject to annulment in pursuance of a resolution of either House of Parliament.

3 Application of Act to visiting forces etc.

(1) In relation to the termination of a pregnancy in a case where the following conditions are satisfied, that is to say—

(a) the treatment for termination of the pregnancy was carried out in a hospital controlled by the proper authorities of a body to which this section applies; and

(b) the pregnant woman had at the time of the treatment a relevant association with that body; and

(c) the treatment was carried out by a registered medical practitioner or a person who at the time of the treatment was a member of that body appointed as a medical practitioner for that body by the proper authorities of that body,

this Act shall have effect as if any reference in section 1 to a registered medical practitioner and to a hospital vested in a Minister under the National Health Service Acts included respectively a reference to such a person as is mentioned in paragraph (c) of this subsection and to a hospital controlled as aforesaid, and as if section 2 were omitted.

(2) The bodies to which this section applies are any force which is a visiting force within the meaning of any of the provisions of Part I of the Visiting Forces Act 1952 and any headquarters within the meaning of the Schedule to the International Headquarters and Defence Organisations Act 1964; and for the purposes of this section—

(a) a woman shall be treated as having a relevant association at any time with a body to which this section applies if at that time—

(i) in the case of such a force as aforesaid, she had a relevant association within the meaning of the said Part I with the force; and

(ii) in the case of such a headquarters as aforesaid, she was a member of the headquarters or a dependant within the meaning of the Schedule aforesaid of such a member; and

(b) any reference to a member of a body to which this section applies shall be construed—

(i) in the case of such a force as aforesaid, as a reference to a member of or of a civilian component of that force within the meaning of the said Part I; and

(ii) in the case of such a headquarters as aforesaid, as a reference to a member of that headquarters within the meaning of the Schedule aforesaid.

4 Conscientious objection to participation in treatment.

(1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

(3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

5 Supplementary provisions.

(1) Nothing in this Act shall affect the provisions of the Infant Life (Preservation) Act 1929 (protecting the life of the viable foetus).

(2) For the purposes of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by section 1 of this Act.

6 Interpretation.

In this Act, the following expressions have meanings hereby assigned to them:—

" the law relating to abortion " means sections 58 and 59 of the Offences against the Person Act 1861, and any rule of law relating to the procurement of abortion;

" the National Health Service Acts " means the National Health Service Acts 1946 to 1966 or the National Health Service (Scotland) Acts 1947 to 1966.

7 Short title, commencement and extent.

(1) This Act may be cited as the Abortion Act 1967.

(2) This Act shall come into force on the expiration of the period of six months beginning with the date on which it is passed.

(3) This Act does not extend to Northern Ireland.

Appendix eight: National circulars received by the Board of Governors

Date of Meeting	National circular (relevant to investigation) received and referred by Board of Governors
01/02/1960	H.M. (60)3 with a new consolidated version of the terms and conditions of service of hospital medical and dental staff (England and Wales)
02/05/1960	H.M. (60)17: The future of nurse training
02/05/1960	H.M. (60)22: Employment of young persons in hospitals: remuneration and board and lodging charges
30/05/1960	H.M. (60)31: Promotion and appointment procedures for administrative staff
04/07/1960	H.M. (60)45: Prevention of harm to patients resulting from physical or mental disability of hospital medical or dental staff
04/07/1960	H.M. (60)50: Employment of young persons in hospitals: nurse cadet school
02/01/1961	H.M. (60)97: Selective recruitment and training scheme for hospital administrators in England, Wales and Scotland
06/03/1961	Employment of young persons in hospitals: nursing cadet schemes
02/10/1961	The Charities Act, 1960
02/10/1961	H.M. (61)80: Recruitment, training and promotion arrangements for administrative and clerical staff of the hospital service
01/01/1962	H.M. (61)112: Disciplinary proceedings in cases relating to hospital medical and dental staff
05/02/1962	Custody of unofficial funds and patients' monies
07/05/1962	H.M. (62)21 with appendix: Acceptance of gifts and hospitality
07/05/1962	H.M. (62)29 with circular 7/62: Voluntary help in hospitals
03/12/1962	H.M. (62)80: The charities official investment fund
04/02/1963	H.M.(62)82: Employment of young persons in hospitals: remuneration and board and lodging charges
10/06/1963	H.M.(63)37: The organisation of hospital nursing cadet schemes and the employment of young persons in hospitals
01/07/1963	H.M.(63)55: Hospital building: functions of regional hospital boards etc.
29/07/1963	H.M.(63)60 with a report: ''Communications'' in the hospital service
07/10/1963	H.M.(63)71 with enclosure: Advisory council for management efficiency (England and Wales) second report to the minister.
02/12/1963	H.M.(63)104: Employment of nursing cadets and other young persons in hospitals: remuneration, board and lodging charges and travelling expenses
03/02/1964	H.M.(64)4: In-patient accommodation for mentally and seriously maladjusted children and adolescents
07/12/1964	H.M.(64)94: Medical staffing structure in the hospital service
07/12/1964	H.M.(64)102 with enclosures: (Pink): Management problems in out-patient departments
14/06/1965	H.M.(65)37 (Pink) with enclosures: review of hospital plan
04/10/1965	H.M.(65)58: Nurses (amendment) rules, 1965

Date of Meeting	National circular (relevant to investigation) received and referred by Board of Governors
04/10/1965	H.M.(65)60 with local authority circular 14/65: review of hospital plan: development of local authority health and welfare services
04/10/1965	H.M.(65)70 with a report of the standing nursing advisory committee: duties of nurses in out-patient departments
04/10/1965	H.M.(65)78: Recruitment and training of potential domestic superintendents
01/11/1965	H.M.(65)81: Terms and conditions of service and hospital medical and dental staff (England and Wales)
01/11/1965	H.M.(65)91: Employment of nursing cadets and young persons in hospitals; remuneration, board and lodging charges and travelling expenses
03/01/1966	H.M.(65)99 with enclosure: Statistics of bed use in hospital management
03/01/1966	H.M.(65)104 with enclosures: Improving the effectiveness of the hospital service for the mentally subnormal
07/03/1966	H.M.(66)11: Use of restrainers for children nursed in hospital
04/04/1966	H.M.(66)13 with P.T.A circular No.125: social workers
04/04/1966	H.M.(66)15 (PINK): Methods of dealing with complaints by patients
04/04/1966	H.M.(66)18 (PINK): Visiting of children in hospital
02/05/1966	H.M.(66)24 with joint circular for local authorities: services for handicapped children and young people
02/01/1967	H.M.(66)82 (Pink): Handbook for members of hospital management committees
06/02/1967	H.M.(67) with M.D.B. circular No. 69 – Terms and conditions of service of hospital medical and dental staff
05/06/1967	H.M.(67)24: Recruitment and management development of administrative staff on the hospital service
05/06/1967	H.M.(67)30: Terms and conditions of service of hospital medical and dental staff (England and Wales) and headquarters medical staff of regional hospital boards (England and Wales)
02/10/1967	H.M.(67)50: Census of children and adolescents in non-psychiatric wards of national health service hospitals, June 1964 and March 1965
06/11/1967	H.M.(67)58 (PINK): Training of nurses (copy enclosed; copy already sent to members of nursing committee)
06/11/1967	H.M.(67)71: Procedures for the appointment of administrative staff in the hospital service
01/04/1968	H.M.(68)4: Staff: General Whitley Council handbook of conditions of service
06/05/1968	H.M.(68)10: Index of hospital memoranda, etc.
06/05/1968	H.M.(68)21: Abortion Act 1967
10/06/1968	H.M.(68)22: Voluntary services for hospitals by young people
10/06/1968	H.M.(68)36 with leaflet – Leaflet ''Care of Mother and Child''
01/07/1968	H.M.(68)41: Care of younger chronic sick patients in hospitals
05/08/1968	H.M.(68)48: Recruitment and management development of administrative staff with particular reference to finance administration
07/10/1968	H.M.(68)53: Employment of nursing cadets and young persons in hospitals
02/12/1968	H.M.(68)83: Accident and emergency services
06/01/1969	H.M.(68)101: Terms and conditions of service of hospital medical and dental staff (England and Wales) etc. – starting salaries
03/02/1969	H.M.(68)96 with report of working party on porters – training of ancillary staff
03/02/1969	H.M.(68)97 with N.M.C. circular No. 146 – Nurses and Midwives Whitley Council

Date of Meeting	National circular (relevant to investigation) received and referred by Board of Governors
03/03/1969	(d) Child surgery
03/03/1969	H.M.(69)4 (PINK): Accommodation of children in hospital in children's departments
31/03/1969	H.M.(69)14 with N.M.C circular no. 148 – Nurses and Midwives Whitley Council
05/05/1969	H.M.(69)9: Hospital portering services
07/07/1969	H.M.(69)37: Employment of nursing cadets and young persons in hospitals: remuneration, board and lodging charges and travelling expenses
04/08/1969	H.M.(69)56 with report – Procedures for the appointment of administrative staff in the hospital service
04/08/1969	H.M.(69)58 – Voluntary help in hospitals
06/10/1969	H.M.(69)59 (PINK): Relationship between the secretary of state, regional hospital boards and hospital management committees
06/10/1969	H.M.(69)64 with report – The selection and appointment of senior nursing staff in the hospital service
02/02/1970	H.M.(69)95 with P.T.B circular 243 – Post-mortem room technicians
04/05/1970	H.M.(70)17 (PINK) with enclosure – National health service hospital advisory service
06/07/1970	H.M.(70)35 (PINK): Action to improve the nursing situation
05/10/1970	H.M.(70)39: Employment of nursing cadets and young persons in hospitals
05/10/1970	H.M.(70)46 with P.T.B. circular 254 – Post mortem room technicians
01/02/1971	H.M.(71)1: Guide to good practices in hospital administration
05/04/1971	H.M.(71)27: Care of the health of hospital staff
03/05/1971	It was also reported that a pink circular HM(71)22 dealing with hospital facilities for children had been received and additional copies were being obtained for circulation to all members of the Board for the next meeting
07/06/1971	H.M.(71)22 (PINK): Hospital facilities for children
05/07/1971	H.M.(71)50: Visiting of patients by children
02/08/1971	H.M.(71)57: Employment of nursing cadets and young persons in hospitals – remuneration and board and lodging charges
01/11/1971	H.M.(71)59: Closed circuit television
03/01/1972	H.M.(71)91 with enclosure – Recruitment and management development of administrative staff in the hospital service
07/02/1972	H.M.(72)2: Children in hospital: maintenance of family links and prevention of abandonment
07/02/1972	H.M.(72)5: Voluntary help for hospitals: appointment of voluntary help organisers
07/02/1972	H.M.(72)6: Voluntary help in hospitals: liabilities and expenses
01/05/1972	H.M.(71)92 (PINK): Handbook for members of hospital management committees. Copies of the handbook had been sent to all members of the board and it was agreed that copies also be sent to the co-opted members of the House Committees
03/07/1972	H.M.(72)35: Staff: Contracts of Employment
07/08/1972	H.M.(72)41: Patients dying in hospitals
07/08/1972	H.M.(72)1: Reorganisation circulars
07/08/1972	H.M.(72)4: Command paper – National Health Service Reorganisation: England
02/10/1972	H.M.(72)52: Employment of management consultants

Date of Meeting	National circular (relevant to investigation) received and referred by Board of Governors
06/11/1972	H.M.(72)66: Employment of nursing cadets and young people in hospitals
05/02/1973	HRC(73)1: National Health Service Reorganisation: staff appointment and transfer arrangements
05/03/1973	HRC(73)3: Management arrangements for the reorganised N.H.S.
05/03/1973	HRC(73)4: Management arrangements for the reorganised N.H.S: defining districts
02/04/1973	HRC(73)4: Management arrangements for the reorganised N.H.S: defining districts
30/07/1973	HRC(73)18: N.H.S. Reorganisation Act 1973: proposals for implementation in England
01/10/1973	HM(73)39: Nurses and Midwives Whitley Council – revised handbook
01/10/1973	HRC(73)19: Management arrangements in two district areas
01/10/1973	HRC(73)20: Regional Health Authorities. determination of boundaries and constitution
01/10/1973	HRC(73)21: Transitional arrangements: staffing support for regional and area health authorities
01/10/1973	HRC(73)22: Membership and procedure of regional and area health authorities
01/10/1973	HRC(73)23: Transitional arrangements: Coding of health authorities and health institutions
01/10/1973	HRC(73)24: Area health authorities. Determination of boundaries and constitution
01/10/1973	HRC(73)25: Transfer of staff
01/10/1973	HRC(73)26: Statutory provisions: Framework of National Health Service after reorganisation
01/10/1973	HRC(73)27: Transitional arrangements: statistics of health service activities: summary of arrangements for securing continuity in 1974
01/10/1973	HRC(73)28: Operation and development of services: organisation of Pharmaceutical Services
01/10/1973	HRC(73)29: Transitional arrangements: transfer of hospital trust property
01/10/1973	HRC(73)30: Transitional arrangements: transfer of hospital trust property: appointment and functions of special trustees.
03/12/1973	HRC (73)36: Transitional arrangements: interim management arrangements for Health authorities
07/01/1974	HRC(73)37: Operation and development of services: organisation for personnel management
04/02/1974	HRC(74)2: National Health Service reorganisation: protection of salary and other terms and conditions of service
04/02/1974	HRC(74)4: Community Health Councils
04/03/1974	HRC(74)4: Community Health Councils
04/03/1974	HRC(74)5: Child Health Service
04/03/1974	HRC(74)10: Charities connected with hospital purposes: amendment of trust instruments

Appendix nine: Chronology

Year	Date	Event
1926	31.10.26	Birth of JS
1960s	1960	JS begins to attend LGI helping out with Hospital Radio
	1968	JS sanction by Board of Governors to become Volunteer Porter. JS joined BBC Radio One
	03.06.68	Martin Wing post fire clean-up (YEP154)
	08.06.69	Beach Boys play at LGI Nurses Home
	18.11.69	Marathon in aid of LGI (YEP53)
	31.12.69	JS hosts BBC/ZDF co-production 'Pop Go The Sixties'
1970s	06.10.70	Sponsored walk for Little Sisters of the Poor pictures with LGI Radiology staff (YEP130)
	04.11.70	JS presents names at extension to LGI Renal unit (YEP86)
	01.12.70	JS in Yorkshire Post press room with Prince Charles
	01.01.72	JS photographed with Doctor & child
	01.03.72	March '72 JS receives OBE
	09.10.72	JS mother dies
	16.10.72	JS mother's funeral
	23.07.74	Handing over artificial kidney to renal dialysis unit (YEP60)
	14.04.75	Variety show for Batley recreational facilities resident medical staff (YEP141, YEP134)
	29.06.75	Sponsored walk for recreational facilities resident medical staff (YEP138)
	28.02.77	Marathon with Andrew Kirk for children's play area (YEP161, YEP8)
	21.06.78	Opening of Wheatfields Hospice (YEP139, YEP115)
	22.10.79	Opening LGI children's play area (YEP7)
1980s	22.08.80	JS visits paralysed child at Stoke Mandeville, later that day he visits Stoke Mandeville with Royal Marines
	06.01.81	JS greets people at LGI with donations for Stoke Mandeville (YEP160)
	04.06.81	Opening 'Coachyard Gardens' at the LGI (YEP121)
	28.09.82	Receiving cheques for Stoke Mandeville at LGI (YEP68)
	06.07.83	Receiving cheques for Stoke Mandeville at LGI (YEP182)
	01.10.84	JS pictured at the House of Lords
	17.12.84	Various cheque handovers at the LGI (YEP155)
	10.05.86	Handing over cheque at LGI for a worked processor at Colitis Clinic, then at St James' for a disco for child kidney patients (YEP72)
	13.05.86	JS receives honorary degree at Leeds University
	16.03.88	JS launched Lithotriptor Appeal
	21.09.88	JS at Martin House children's Hospice with Princess Diana (YEP65)
	1989	JS attends High Royds centenary event.
	01.10.89	JS runs London Marathon

Year	Date	Event
1990s	1990	JS receives Papal Knighthood
	28.06.90	JS invited to the Prince of Wales' drinks party at St James' Palace
	30.07.90	JS invited to Best of British Youth awards presentation in the presence of Duchess of Kent at the Savoy Hotel
	18.09.90	Hard Rock Cafe celebration of JS
	08.10.90	JS invited to opening of the BT building
	01.11.90	JS receives Knighthood
	12.06.91	JS invited to the Prince of Wales' opening of the Prince of Wales Hospice
	16.07.91	JS invited to meet the Heads of Government attending the 1991 economic summit
	02.08.92	JS takes part in Fun Run for Leeds Foundation for Dermatological Research
	1993	JS helped to raise funds for the LIMIT Suite
	04.01.93	Launches keyhole surgery training unit at LGI (YEP73)
	23.03.95	Invited to the History of Broadcasting reception at the Council Chamber Broadcasting House
	18.07.95	Invited to celebrate Archbishop of Canterbury's birthday at Lambeth Palace
	01.10.95	JS opens Chapel Allerton Hip Centre (YEP24)
	19.07.96	Made an honorary member of the Royal College of Radiologists
	09.08.97	JS undergoes heart bypass operation at Killingbeck Hospital
	06.09.97	JS attends Princess Diana's funeral
	12.07.98	JS attends Wheatfields Gala (YEP77, YEP76)
	23.10.99	JS invited to a dinner party held by Tony Blair
2000s	01.11.05	JS becomes Freeman of the Borough of Scarborough
	25.12.05	JS presents one-off show for Real Radio
	14.01.06-15.01.06	JS in Big Brother House
	30.07.06	JS hosts last Top of the Pops show
	01.09.06	JS visits Otley Sailing Club with Princess Anne
	2007	JS interviewed by Surrey Police over assault claim from 30 years prior
2011	29.10.11	Death of JS

Appendix ten: Report regarding unattributable information

Report on intelligence relating to Jimmy Savile and unspecified hospitals

April 2014

Authors: Ray Galloway & Susan Proctor

Commissioned by the Department of Health

Executive Summary

During 2013, the Department of Health asked the Metropolitan Police Service (MPS) to review a significant volume of information gathered by Operation Yewtree since October 2012 on matters relating to Jimmy Savile and hospitals or health care settings. This review was duly conducted by the MPS and information concerning Savile and a number of NHS hospitals was passed to the Department of Health in October 2013. Part of this data included pieces of information concerning allegations connected to health care organisations where neither a location nor an identified victim, were specified.

The independent Jimmy Savile investigation team at Leeds Teaching Hospitals NHS Trust was requested to consider these matters and to report its findings to the Department and to Kate Lampard (who is appointed by Secretary of State to give assurance on all NHS Savile investigations). No specific Terms of Reference were given for the report other than to undertake all reasonable lines of enquiry to identify a specific NHS Trust or health care setting and, should that be achieved, for that organisation to be notified, via the Department of Health. Any further investigation required would then be undertaken by the NHS Trust concerned.

Eleven pieces of information were received. Four concerned two identical matters, so in total nine were separately reviewed. Some were complex; others provided only scant information. Two cases had no specific connection to the NHS. In one of these cases, referral was made to the relevant police force for further investigation. In two other cases, despite repeated attempts, it has been impossible to make contact with the individuals who made the initial allegations.

In the remaining five cases, one concerned an allegation in Leeds, and this was therefore included in the main Leeds Teaching Hospitals investigation; two concerned matters at Stoke Mandeville hospital and were therefore referred to this team for further investigation; (one of these also concerned South West London and St George's Mental Health Trust); one concerned a now closed mental health hospital, and Broadmoor hospital; and one has a possible link with Barts Health NHS Trust in London. Referral was made to named officials in these organisations with a request for them to pursue their own investigations.

Introduction

During 2013, the Department of Health asked the Metropolitan Police Service (MPS) to undertake a review of a significant volume of information that had been gathered by Operation Yewtree since October 2012, but had not been the subject of formal assessment by the MPS. The objective was to establish whether it included material relating to specific NHS Trusts or other health care settings.

In October 2013, having conducted their review, the MPS passed the relevant information to the Department of Health.

The information included allegations of abusive or inappropriate encounters with Savile at a further nineteen NHS organisations. The Department of Health forwarded details of these allegations to the respective NHS Trusts so they could pursue their own investigations.

Further pieces of information provided by the MPS, whilst relating to Savile did not include a specific hospital or health care location so it was not clear which organisation should carry out any subsequent investigation.

Embracing the principle that it is essential that all information be considered in order to learn the lessons for NHS settings, Kate Lampard (who was appointed by Secretary of State for Health to provide assurance on all NHS Savile investigations) recommended that the independent investigation team at Leeds should consider this information.

A letter of commission (Appendix 1) from the Department of Health was sent to the Leeds team requesting them to conduct enquiries in order to identify any hospital or relevant organisation relating to the information received. There were no separate Terms of Reference for this investigation, other than the request as set out by the Department of Health.

If an NHS Trust was identified from the information received and any subsequent enquiries, we were directed to notify the organisation, via the Department of Health and Kate Lampard. The Trust concerned would then conduct their own investigation under guidance provided by the Department of Health, and the role of the Leeds team would then be concluded.

As the Leeds team has been commissioned by Leeds Teaching Hospitals NHS Trust to conduct its own, dedicated and independent investigation, permission to take on this additional activity was obtained from the Trust Chief Executive, Julian Hartley, with the assurance that our main focus would remain the Leeds investigation.

Eleven pieces of information were sent to the Leeds investigation team for consideration. Four of these concerned two identical matters each so in total, we considered nine separate matters.

Subsequently, a second file of eight pieces of anonymous information was sent by the Department of Health to the Leeds investigation team. This material was either already known to the Leeds investigation team (four items) and had been considered as part of the main Savile Leeds investigation or was so general in its nature (four items) as to preclude any meaningful investigation. For example, an anonymous e-mail correspondent to Operation Yewtree who claimed that she had told her (unnamed) friend that she had received an autograph from Savile and her friend had asked what she had to do to obtain the autograph. No further details were provided and no reasonable lines of enquiry were available to develop that information which, in itself, did not contain any suggestion of impropriety.

This report concerns the analysis and investigation of the nine reported allegations only, in accordance with the letter of commission.

The Investigation

The material provided by the MPS varied significantly in its standard and detail. It consisted of hand written pro-forma documents, which briefly detailed the content of telephone conversations between police officers or staff and those who had contacted Operation Yewtree some months earlier. No associated narrative overview or report to accompany the respective pieces of information was provided.

In some cases additional contextual information was established as the result of our enquiries, and based upon documentation, that had been provided by MPS, such as copies of e-mail correspondence. No copies of any witness statements were provided.

To fully understand the context and factual descriptions of the reports, we contacted the individuals who had made the initial reports to the MPS (it should be noted that in all but one case, their original reports to the MPS had been made some 12 months previously, in October 2012. Consent had been given by all the informants for their details to be shared with the NHS investigations). Our contact with the informants was successful in all but two cases. In respect of those cases, a letter was sent to the home address of the witness, and e-mail contact was attempted, requesting that contact be made with the Leeds team.

Once contact had been established, the detail and context of the respective reports was developed and clarified. This resulted in a much clearer understanding of the allegations being made and identified further relevant lines of enquiry.

The individuals who had reported the allegations helped us to secure documentation and access to other witnesses who could confirm or assist in the identification of a date and/or location of the incidents in question. A key priority was to identify any NHS or health care setting to which any of the reports could be attributed.

In the cases where an NHS organisation was identified and further investigation was required, we contacted relevant managers at the organisations in question. Where appropriate, the Director of Investigation at Leeds provided professional specialist support to them in their subsequent investigation of the allegations.

Findings

The outcomes of our enquiries are summarised in Table 1 below. Each case is then described in more detail.

Table 1: Summary of Findings

Case number/witness	Category	Date (where specified)	Outcome
1. AB (female)	victim of sexual assault	1966	No NHS investigation; referral made to Derbyshire Police
2. AC & AD (couple)	allegation about JS access to mortuaries	1985	Referral to St George's Mental Health Trust & Cardiff and Vale University Health Board
3. AE (female)	contact with JS as a teenager	1970s	Referral to Hertfordshire Partnership Trust and Broadmoor

Case number/witness	Category	Date (where specified)	Outcome
4. AF (female)	high risk encounter with JS	1980s	Included in Leeds main investigation
5. AG (female)	allegation of JS suspicious behaviour	1970s	No contact made with the informant despite numerous attempts
6. AH (female)	rumour about JS access to mortuaries; also JS presence in Stoke Mandeville	1980s	Enquiries made concerning first allegation with no positive outcome; Referral to Stoke Mandeville
7. AJ(unspecified)	allegation about JS access to mortuaries	Not specified	No contact made with the informant despite numerous attempts
8. AK (male)	offer to access library of material on child abuse	n/a	No further action
9 AL (male)	allegation that suicides of elderly twins may be connected with JS	2012	Referral to Barts Health NHS Trust

Case 1

This account referred to an allegation of indecent assault by Savile, which took place in Derbyshire in 1966. In the statement from the victim to MPS and in our subsequent discussion, it was described as follows:–

AB was 16 years old at the time and had won a local beauty contest in her community. The indecent assault happened as she was being helped by Savile to climb onto a 'float' for a local parade in a market town in Derbyshire. Following the parade, Savile took AB and three other teenage contestants in his Rolls Royce to an unidentified hospital. AB cannot recall the name of the hospital, describing its location as a short (15 minute) drive from her home town. She does recall that the patients were all elderly and resting in their beds when they visited the hospital ward. No impropriety by Savile took place at the hospital.

Outcome

No offence was committed on NHS premises. Details of the indecent assault have been reported to Derbyshire Police.

Case 2

Two similar accounts concerning the same topic were made by separate witnesses; a married couple (AC and AD), to Operation Yewtree.

In the 1980s, a now deceased professional comedienne mentioned to AC that she had heard, via gossip in 'celebrity circles' that Savile was afforded access to a hospital mortuary by his brother, whom she did not name, who then worked at an unidentified hospital.

Following our discussion with AC, contact was made with the comedienne's widower. He confirmed the general rumours recounted to him by his late wife, but could not provide any additional details about them. He recalled a conversation of his own, in the 1980s with another comedian in Sheffield, about Savile's alleged access to the mortuary at a hospital in Leeds.

The comedian in question is still working professionally and we have made contact with him. He clarified that the rumour regarding Savile and access to a mortuary related to Stoke Mandeville hospital and not Leeds. He further explained that the source of the rumour was a journalist (now deceased) who used to work for the BBC.

Whilst acknowledging that there did not appear to be any factual basis for the rumour, the comedian contextualised the comments of the late journalist by recalling that he also shared with him rumours relating to former music producer and convicted paedophile, Jonathan King before these entered the public domain.

There are no further reasonable lines of enquiry to pursue other than speaking to any other members of the social group with whom the late journalist shared his 'knowledge', as a means of identifying any potential basis for the rumours. A request for contact has been passed to his former associates.

Outcome

The above information has been shared with the Stoke Mandeville Savile Investigation Team.

In terms of the allegation regarding Savile's brother, AD recalled meeting a man in 1985 who was introduced to her as Savile's brother. She did not recall his name. This meeting took place when she was on a summer placement at a hospital in the Richmond area of London.

Our further discussion with AD, was aimed at facilitating her contextual recall of meeting Savile's brother and eventually resulted in the identification of this hospital as Richmond Royal Hospital. This is a mental health facility currently run by the South West London and St George's Mental Health NHS Trust.

Further 'open source' enquiries, including internet searches, were conducted by utilising information that is publicly available. These suggest that Savile's brother, Johnny was dismissed from employment in 1979 from the Springfield Psychiatric Hospital, Tooting, South London for allegedly raping a patient. This allegation was reported in the national media but has yet to be verified by the hospital.

Both Springfield hospital and Richmond Royal are now part of the same Trust (South West London and St George's Mental Health NHS Trust). The nature of Johnny Savile's role in the hospital at this time needs to be confirmed as does the suggestion that he was the subject of a rape allegation. This is particularly important in light of the account from AD that he was working or volunteering in the same Trust some six years later.

We have contacted the Adult Safeguarding Lead manager at the Trust, Patrick Bull, to identify and progress the necessary lines of enquiry. In the first instance, he has attempted to establish any relevant employment history for Johnny Savile, and determine if Johnny could have provided access to the mortuary for Jimmy Savile.

To date, Mr Bull's enquiries have established that Johnny Savile volunteered at Springfield Hospital in the late 1970s both as an activities' organiser and as a contributor to the hospital radio service.

AD has agreed to speak to Mr Bull and her contact details have been passed on to him. In light of her evidence, clarification is needed to establish the actual facts of Johnny Savile's employment or voluntary roles in these hospitals. Further details of his specific role, including any potential access to the mortuary, and the circumstances of his leaving the Trust need to be determined. It will be important to confirm the nature of his role, and any involvement by Jimmy Savile during the 1970s and 1980s, or until the end of Johnny Savile's association with the hospitals.

Outcome

South West London and St George's Mental Health Trust are progressing this investigation.

Our enquiries also identified that another of Savile's brothers, Vince, had an association with a hospital in Cardiff. Between 1967 and 1974, Vince volunteered as a disc jockey on the hospital radio of the Cardiff Royal infirmary which is now run by Cardiff and Vale University Health NHS Trust. Jimmy Savile is known to have visited the hospital when he was in the area to visit families affected by the Aberfan disaster in 1967. Extended members of the Savile family also lived in the South wales area.

No evidence has been found which links Jimmy Savile with his brother, Vince in connection with access to mortuaries in Cardiff hospitals.

Contact has nevertheless been made with the Trust and all relevant information passed on. All necessary enquiries in Cardiff are being conducted by Mandy Rayani, Assistant Director of Nursing

Outcome

There does not appear to be a basis for further investigation in Cardiff with regard to these matters.

Case 3

AE is currently a serving police officer with the Metropolitan Police. Our enquiries revealed that when she was a teenager in the 1970s, she was part of a singing/dancing group in London, and frequently attended events and recordings where Jimmy Savile would be present. These included Top of the Pops and Jim'll Fix It, and also visits to Broadmoor and Leavesden Mental Health Hospitals, although we were informed that Savile was not present at the latter institution, which closed in 1997.

AE stated that she had never witnessed any inappropriate behaviour from Savile, and that she was always accompanied by an adult chaperone, the dance group manager, who is now deceased. She does recall Savile asked her to sit on his knee on one occasion in his dressing room and she did so. She told us that nothing improper occurred.

Outcome

Hertfordshire Partnership NHS Trust (which had responsibility for Leavesden) and Broadmoor Hospital have been informed. Christine Carter, the Lead Investigator at Hertfordshire Partnership NHS Trust has investigated and reported upon this matter. We have been informed by her that there are no known NHS related offences to investigate in these organisations.

Case 4

Information for this case came from the statement to MPS and a subsequent interview as part of the major Leeds Investigation into matters relating to Savile.

AF worked for a local radio station in the mid-1980s when she was in her twenties. She came into contact with Savile as a result of her involvement with a terminally ill boy and his family. The young boy had expressed a wish to meet him and AF arranged for the meeting at which Savile made a number of promises to the child in terms of future contact.

Savile did not honour his commitment to keep in touch and, upon becoming aware of this, AF rang him to berate him. Savile's response was to offer to meet the boy that same day, and he asked AF to accompany him to the hospital, inviting her to meet him at his flat so that they could travel there together.

An experienced female colleague overheard the conversation between AF and Savile and firmly advised her that 'under no circumstances' should she visit Savile alone. Heeding this advice, AF asked her father to accompany her to the flat, which he did.

That evening, having entered his apartment block, AF followed Savile's instructions on how to operate the private lift to access his flat. She duly arrived at Savile's flat with her hitherto unannounced father beside her. As the doors of the lift opened at the entrance to the apartment, Savile stood there naked apart from some transparent running shorts. On seeing her father, Savile was clearly startled and quickly got dressed. He subsequently accompanied the witness to see the young child at the Infirmary. No further improper conduct took place.

Outcome

Witness interviewed by Leeds team, and account included in main report.

Case 5

We received MPS information that related to contact made by the witness, AG in January and September 2013. In addition, the police log reference number was provided for this case

The initial account provided to MPS by AG described living opposite a family in Middlesex in the 1970s who appeared to be friendly with Jimmy Savile, and that he was a regular visitor to their home. The brief account in the documents received seems to suggest that teenagers regularly met in this family's house, and that they discussed a story about Savile taking a girl called Sandra to a hotel overnight.

The account then develops into an allegation of assault by Savile (the nature of which is not specified), which resulted in AG's hospitalisation (at an unspecified hospital), who at the time was 7 years old. The final aspect of the account summary relates to a claim by AG that following her viewing of the Exposure documentary about Savile in October 2012, she recognised some of Savile's victims as having visited the property opposite her home in Middlesex in the 1970s.

Outcome

Numerous attempts have been made to contact AG via phone, email and by letter to the home address cited in the MPS report. There has been no response to date. We are unable therefore to investigate this allegation further.

Case 6

AH contacted the MPS and disclosed two pieces of information to them. The first related to a recollection that approximately 20 years ago, a female friend from Sheffield introduced her to a young man. She recalls only his first name, Brendon and thinks he had the surname of Murphy.

Brendon told AH and her friend that he knew Savile was a necrophiliac who accessed dead bodies at an unnamed psychiatric hospital. AH believes Brendon is now living in Ireland and participates in the 'poetry circuit'.

Outcome

Our enquiries have been unable to identify Brendon based on the information received. We are therefore unable to pursue this matter further.

AH also spoke of her knowledge about a local shop owner in rural Lincolnshire who was a patient in Stoke Mandeville in the mid 1980s for seven months. He informed her that he recalled seeing Savile around the hospital often, especially at weekends, and noticed he was unpopular with the nursing staff.

We contacted this gentleman and he told us that when he was a patient in the 1980s he regularly heard the nursing staff remark about the regularity with which Savile took bodies to the mortuary. He believed that the nurses and a good proportion of his fellow patients considered Savile's behaviour in the hospital to be very odd.

Outcome

A referral has been made to the Stoke Mandeville Savile investigation team.

Case 7

Little detail has been provided to the MPS, but the witness, AJ informed them that he worked at an association for disabled people in Middlesex (date unspecified), and recalled a female colleague telling him that Savile would access hospital mortuaries, and that these visits were motivated by sexual matters. No timeframe or specific location has been recorded.

Outcome

Numerous calls and emails and letters to AJ have been unsuccessful in achieving a response. We are therefore unable to pursue this matter further.

Case 8

We received a 'pro-forma' from the MPS concerning AK who had contacted them with regard to Jimmy Savile. Our subsequent contact with AK confirmed that he is a retired doctor and a former police surgeon. Over many years of dealing with sexual abuse victims, he has developed an expertise in the analysis of this subject area. It is within this context that he contacted the MPS to offer his support to any of the Savile investigations.

Outcome

No further action required

Case 9

AL is a retired senior police officer who has lived in Spain for 25 years. He told us, he is an occasional adviser to the Spanish police. Whilst there is no basis to doubt this claim it has not been formally verified.

His communication with Operation Yewtree (which he has given his consent to share), related to the apparent suicide of elderly twin brothers in Spain in 2012. He asserts that the joint suicide may be linked to the revelations about Jimmy Savile.

The primary basis for this suspicion is his belief that one of the twins, James Chalkley, was formerly employed as a night porter at The Royal London Hospital, Whitechapel, London. The other brother, George Chalkley, on the day before he died, had shared with a friend the fact that his laptop was not working and when an offer had been made to repair the machine he disclosed that it was damaged beyond repair. This served to arouse the suspicions of AL, and motivated him to contact Operation Yewtree. There is no known link to Savile.

Outcome

We have reported this matter to the Barts Health NHS Trust who currently run the Royal London Hospital. The investigation is being progressed by the Deputy Chief Nurse, Tracey Carter with whom the lines of enquiry have been discussed.

Conclusion

Eleven pieces of information were passed to us from the MPS via the Department of Health to investigate any links connecting Jimmy Savile with then unspecified NHS organisations. In four cases, referrals were made to other NHS hospitals and they are pursuing further lines of enquiry as necessary, in accordance with our letter of commission.

Department of Health

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Susan Proctor
Independent Chair
Speaking Out Leeds Investigation
Leeds General Infirmary
Great George Street
Leeds, LS1 3EX

4th December 2013

Dear Susan,

NHS Investigations into matters relating to Jimmy Savile

In the course of Kate Lampard's work it was established that the Metropolitan Police Service ('MPS') held further relevant information regarding Jimmy Savile. The Department of Health asked the MPS, through an agreed information sharing process, to review the information to ascertain if it included material related to health and care settings. The MPS has now passed the information to the Department.

Within the material we have received from the MPS, there is a class of information which does not, on its face, name any particular institution and it is thus not obvious which hospital or institution should carry out an investigation (the "unattributable information").

It is essential that *all* information is considered in order to learn the lessons across NHS settings. Kate Lampard has recommended that the independent investigation team at Leeds Teaching Hospitals NHS Trust should consider and incorporate the unattributable information as part of its current independent Savile Investigation and report and the Department has accepted this recommendation. It is crucial that, in order to understand the full picture relating to Jimmy Savile's activities, any issues raised by the unattributable information should be investigated and any individuals spoken to.

Where the independent investigation team at Leeds Teaching Hospitals NHS Trust is able to identify, from the unattributable information, the hospital or relevant organisation concerned, please can you notify the Department of Health and Kate Lampard and pass on this information to the relevant organisation direct. It will then be for the identified organisation to consider and investigate the information as appropriate. We will send a guidance pack as appropriate to the hospital concerned. In these circumstances, the independent investigation team at Leeds Teaching Hospitals NHS Trust would not need to consider that information any further.

I understand that you kindly took receipt of this attributable information on 15 November and 25 November 2013. Please treat this letter as a formal request to consider and investigate this information. I would be grateful if you could confirm if your team are happy to undertake this additional work.

Yours sincerely

William Vineall
Deputy Director