



Department
of Health

West London Mental Health



NHS Trust

Jimmy Savile Investigation: Broadmoor Hospital

Report to the West London Mental Health NHS Trust and
the Department of Health



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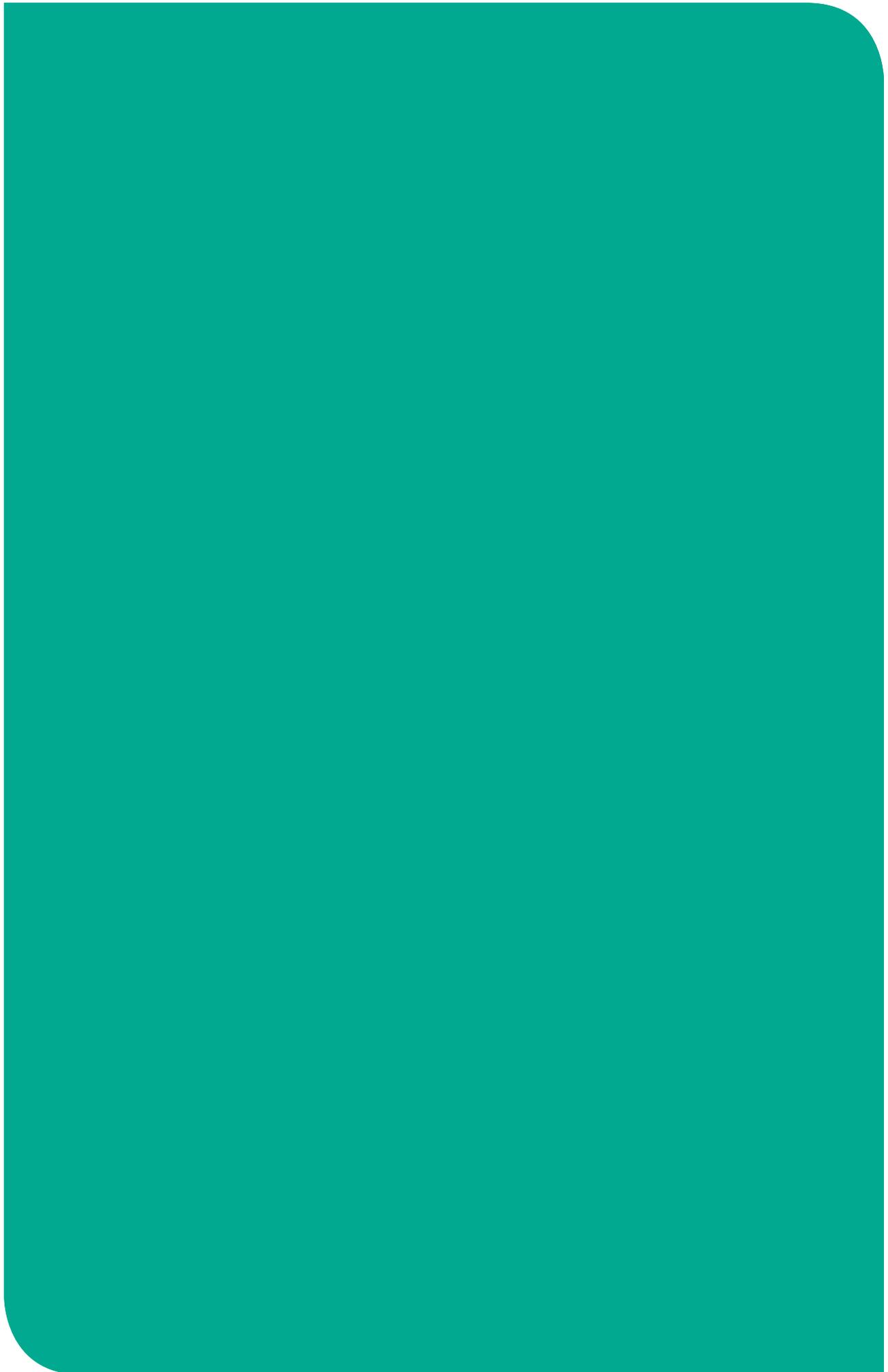
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1. Executive Summary

- 1.1. Broadmoor Hospital is one of three high-security specialist mental health hospitals in England. Jimmy Savile made contact with the hospital in 1968, thus beginning an association with it that lasted over three decades.
- 1.2. Savile's initial approach was endorsed by Dr McGrath, whose decisions as medical superintendent were regarded as unarguable. Dr McGrath's motives were to improve staff and patient morale, and to improve public perception of the hospital.
- 1.3. At some point over the next ten years, Dr McGrath authorised Savile's accommodation at Broadmoor and his use of keys, which allowed him unrestricted access to ward areas within the secure perimeter. McGrath regarded this as a mark of high trust. There is no evidence that the risks that this entailed were considered.
- 1.4. Savile was able to gain access to ward areas, day rooms and patient rooms using his keys. The existence of alternative entrances to some wards and to the female area, and patchy implementation of security procedures by some staff, allowed him to reach some patient areas unsupervised and without the knowledge of those in charge.
- 1.5. Some staff were strong characters who enforced strict security procedures; they were more likely to dislike Savile and to distrust his motives. Savile had little access to their wards, and they saw him less frequently. Other staff found him likeable; they were more tolerant of his presence in patient areas and failed to enforce strict security and supervision. Savile would visit these wards more frequently.
- 1.6. There were clear failings in the way that access to some wards was controlled and, where necessary, supervised. This was due in large part to lax observance of procedures in parts of the hospital. Security systems and adherence to procedures were improved incrementally over the period of Savile's association with Broadmoor, from 1968 to about 2004. His right to keys was not formally withdrawn until 2009, but the use of personal keys was superseded by new security arrangements in 1998. Following his briefing on how these arrangements operated in 2004, he ceased to visit the hospital.
- 1.7. The institutional culture of Broadmoor was previously closed and introspective, encouraging a custodial approach to 'inmates' and permitting instances of harsh treatment. Staff showed hostility to colleagues who questioned this approach or attempted to report specific incidents.
- 1.8. Savile could be charming and persuasive, at least to some, but at the same time he was grandiose, narcissistic, arrogant and lacking any empathy. He was also very manipulative, and many staff were convinced that he had close connections in high places and had the power to have them dismissed.

1.9. Savile's fundraising for Broadmoor was trivial. His relatively small donations of prizes and equipment were valued by staff, as was his ability to persuade some well-known entertainers to come to Broadmoor. His celebrity was seen as being of value to Broadmoor, although it is possible that his association with the hospital brought more benefit to him than to it: there is no evidence that he made any material difference to the public's perception of the hospital.

1.10. Savile's general behaviour toward women was often flamboyantly inappropriate, including extravagant forms of greeting, inappropriate remarks and physical contact. Many women were uncomfortable with this and found him objectionable, but they thought at the time that it was part of his public act, 'just Jimmy'.

1.11. Savile used his Broadmoor accommodation and his caravan to entertain a regular stream of female visitors, none of whom were patients. Some female staff regarded him with caution, although apparently not all. Department of Health officials were aware of his general reputation for leading a promiscuous lifestyle, but there was no suggestion then that this involved anyone underage. There is no evidence that his reputation or behaviour caused anyone to question his suitability to access the hospital.

1.12. We have descriptions of ten allegations of sexual assault directly related to Broadmoor, and one allegation of indecent exposure to a minor. Six of the allegations of assault involved patients at the time (one male and five female), two involved staff and two involved minors. On the basis of the detail and consistency of their accounts and the circumstances of the assaults, we conclude with confidence that at least five of the 11 individuals were sexually abused by Savile, and that it is more likely than not that he also sexually abused a sixth. Of these six, two (both patients) were subjected to repeated assault. We were unable to speak in detail to the other five. We assured those assaulted that we would not name them without their consent.

1.13. Until at least the late 1980s, female patients were obliged to strip completely to change into nightwear and to take baths, watched by staff. We conclude that Savile would sometimes attend wards at these times and watch. He would also look through doorways at female patients bathing, and would make inappropriate remarks. We found no reliable evidence that any staff or patient complaints about Savile at the time were reported to senior staff or investigated. Both staff and patients believed that Savile was in a position of power and authority and could make their lives much worse, and the institutional culture of Broadmoor at the time strongly discouraged both groups from reporting.

1.14. Fewer reported assaults by Savile have come to light at Broadmoor than at the other NHS hospitals with which he was most closely associated. We believe this is likely to reflect both a degree of under-reporting (because of understandable patient concerns about the consequences to themselves) and the likelihood that there were fewer opportunities for Savile because of the nature of Broadmoor. However, we have no reason to doubt that Savile was an opportunistic sexual predator throughout the time he was associated with Broadmoor.

1.15. Poor industrial relations in the hospital, focused on the Prison Officers Association (POA), came to a head in the late 1980s. It became clear that the closed institutional culture of Broadmoor was not only refractory but was also a significant barrier to introducing a more therapeutic and less custodial model of care. Broadmoor was the direct responsibility of the

Department of Health and Social Security (DHSS). A hospital board was appointed from January 1987, with Savile in a non-executive position, but unrest continued.

1.16. A significant coincidence of events occurred in the summer of 1988. There was a work to rule at Broadmoor, cost over-runs on redevelopment work were causing concern, and the DHSS was in the process of splitting into two separate departments, one for health and one for social security. Most ministers were away, and had not yet taken up their new roles in the separate departments. Mental health policy had only recently become the responsibility of a senior civil servant, Cliff Graham (now deceased), who took a much more entrepreneurial approach and a closer interest in the operation of the special hospitals (Broadmoor, Rampton and Ashworth) than had his predecessor.

1.17. Graham took the opportunity of this coincidence of events to push through a new set of management arrangements for the special hospitals, which in the case of Broadmoor included an interim 'task force' to manage the hospital in view of the urgent nature of problems there. He briefed returning ministers on these measures retrospectively, including Mrs Edwina Currie, who briefly took the ministerial lead for these services.

1.18. Graham had met Savile on his first visit to Broadmoor, quickly formed a close working relationship, and remained on close terms with him thereafter. He made Savile a leading member of the Broadmoor task force, with a direct managerial role in the hospital.

1.19. Savile met Mrs Currie, at his request, when she visited another hospital. He reported having discovered widespread false overtime claims, occupation of staff residences by people not entitled to them, and financial irregularities concerning the capital building project. He said he intended to use his knowledge of these to control the POA's activities by threatening to expose them to the press if the union would not cooperate with him. Mrs Currie did not discourage him in this, although it would have meant tolerating alleged fraud in return for union co-operation.

1.20. We found little evidence that Savile did deal with the POA in this way, or that there was a significant change in its approach after his appointment. There is no evidence of any consideration being given to the risks entailed in giving a position of significant responsibility and authority to someone with no previous relevant experience, other than as a fundraiser, and without any formal assessment of suitability.

1.21. Graham oversaw the appointment of general managers to run the special hospitals. In the case of Broadmoor, since the previous management team had been disbanded with the arrival of the task force, he made an interim appointment. At Savile's suggestion, this was Alan Franey, relatively inexperienced for such a challenging post in a difficult environment, but an acquaintance and running partner of Savile's. He was recruited, initially on a six-week secondment to the task force. Savile had already described Franey as 'General Manager, designate' in a letter to Graham five months before his substantive appointment. Savile's influence in the appointment was inappropriate.

1.22. Savile took little part in any formal processes, either as part of the task force, or in his next (and final) formal role as chair of the Hospital Advisory Committee. However, he continued to present himself to hospital staff as having significant power and influence behind the scenes.

1.23. Franey did try to improve the ward environment initially, but encountered widespread resistance and hostility, and progress stalled. Widespread stories about his personal conduct circulated within the hospital and outside it, damaging his stature and credibility and hampering his ability to lead improvement.

1.24. There is considerable evidence that one particular case caused significant concern among members of staff at Broadmoor. A female nurse was reported to have had a sexual relationship with a female patient, and was dismissed for unprofessional conduct. After her appeal was turned down, she lodged an industrial tribunal case, at which she threatened to make public embarrassing revelations about the hospital's management. Documents from the time show that this was believed to include allegations about Franey's personal conduct, involving herself and other members of staff.

1.25. The tribunal case was withdrawn, but remarkably we have been unable to find either any documentation about it or anybody who can remember why the case was dropped. Although it is possible that the nurse decided to withdraw voluntarily without compensation, we cannot exclude the possibility that an irregular payment was involved. This must be properly investigated by the responsible authorities.

1.26. This case, and the view widespread among staff that the nurse received financial compensation after she had committed gross professional misconduct by abusing a vulnerable patient, contributed to an atmosphere within the hospital that tolerated inappropriate behaviour, including sexual misbehaviour, and that discouraged reporting. The nurse concerned was, like Savile, a close associate of Franey's.

1.27. We conclude that the institutional culture in Broadmoor was previously inappropriately tolerant of staff–patient sexual relationships and could be hostile to anyone who tried to report one. Sexual relationships with patients constitute a 'boundary violation', involving security risks and potential exploitation, as well as breaching professional standards. This was a clear, repeated failure of safeguarding standards.

1.28. Over most of the time of Savile's association with Broadmoor, there was a notable absence of written policies and procedures. Inappropriate behaviour seems to have been deterred mainly by custom and practice, and by the disapproval of the medical superintendent and senior nurses. If there was written guidance that was subsequently not archived, it was not well known to the staff who would have had to put it into practice.

1.29. Current policies, procedures and practices seem to us to minimise the probability of a recurrence of the sort of abuse seen in Savile's time; but no suite of documents can guarantee this. There is some formal monitoring of practice, but this in itself would not necessarily have detected the activities of someone with the sort of free access to ward areas that Savile had. Prevention at ward level relies on a change of culture, which, we recognise, takes time in any institution. We believe that considerable progress has been achieved at Broadmoor, but that more remains to be done. We believe the most effective single measure to prevent any recurrence is to ensure that nobody, whether staff or visitor, is granted access to clinical areas except under close supervision, no matter how well meaning they appear to be or how famous they are.

2. Introduction

2.1. In October 2012, the West London Mental Health NHS Trust (WLMHT) board and the Department of Health initiated separate investigations, following allegations that Jimmy Savile had sexually abused patients at Broadmoor Hospital.

2.2. It quickly became clear that the two investigations would be better conducted as one, and in November 2012 an independent investigation was commissioned jointly by the WLMHT and the Department of Health. This decision reflected Broadmoor's varied management history over the period of Savile's association with the hospital: when it began in 1968, Broadmoor was managed directly by the Ministry of Health; when it ended with his death in 2009, the hospital was part of the West London Mental Health NHS Trust. Dr Bill Kirkup was appointed as an independent investigator to lead a single investigation into Savile's role at Broadmoor.

2.3. The terms of reference were as follows:

- *thoroughly examine and account for Jimmy Savile's association with Broadmoor Hospital, including approval for any roles and the decision making process relating to these;*
- *review the access arrangements and any privileges accorded to Jimmy Savile, the reasons for these and whether they were subject to usual or appropriate supervision and oversight;*
- *review relevant policies, practices and procedures which were in place during Jimmy Savile's association with Broadmoor Hospital and compliance with these;*
- *investigate past and current complaints concerning Jimmy Savile's behaviour at Broadmoor Hospital or connected to his role there, including: what occurred, who was involved, whether complaints were appropriately reported, investigated and addressed and, if not, the reasons for this. 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 commission of criminal and/or disciplinary offences, the police and/or relevant employers will be informed;*
- *review Jimmy Savile's fund raising activities associated with Broadmoor Hospital and any issues that arose in relation to the governance, accountability for and the use of the funds;*
- *consider the part played by Jimmy Savile's celebrity status or his fund raising role in relation to the matters mentioned above;*
- *review the adequacy of current complaints, safeguarding, whistleblowing and other relevant policies, practices and procedures relating to the matters mentioned above relevant to the Department of Health and Broadmoor Hospital; and*
- *identify recommendations for further action.*

2.4. Savile was also associated with other NHS organisations. In particular, allegations of sexual abuse have centred on his roles at Leeds General Infirmary and Stoke Mandeville. Leeds Teaching Hospitals NHS Trust and Buckinghamshire NHS Health Trust commissioned parallel investigations into those allegations and his roles at those hospitals.

Events leading to the setting up of the investigation

2.5. On 3 October 2012, ITV broadcast an edition of the *Exposure* programme entitled ‘The Other Side of Jimmy Savile’, which featured five women who recounted having been abused by Savile during the 1970s. In the wake of the programme, hundreds of people came forward to say that they, too, had been abused by him and others.

2.6. On 5 October 2012, the Metropolitan Police Service (MPS) set up an investigation – Operation Yewtree – to investigate the allegations. The MPS worked in partnership with the National Society for the Prevention of Cruelty to Children (NSPCC) and the National Association for People Abused in Childhood (NAPAC), and on 11 January 2013 a joint MPS/NSPCC report was published: *Giving Victims a Voice*.

2.7. The three NHS investigations – at Broadmoor Hospital, Leeds General Infirmary and Stoke Mandeville – were instigated in response to the 3 October 2012 broadcast.

Investigation oversight and support

2.8. Jeremy Hunt, the secretary of state for health, appointed Ms Kate Lampard to provide oversight of these three investigations. Ms Lampard is a former barrister, and was supported in this role by Verita, a firm with experience of complex investigations. Her brief was to ensure that the three investigations followed a robust process, aimed at protecting the interests of patients. She was also asked to draw on the findings and recommendations of the investigations to identify any themes that could improve processes or guidelines more broadly. This is an important part of learning lessons from the investigations undertaken.

2.9. On 19 December 2012, the secretary of state announced the appointment of the lead investigator in the Broadmoor investigation and the members of the Local Oversight Panel that would provide challenge and advice to the investigation team as the work progressed (see Appendix 1).¹ The seven members all had valuable expertise in mental health services and safeguarding.

2.10. The independent lead investigator, Dr Kirkup, was assisted by Paul Marshall, an independent investigator, and a team of staff members loaned from the Department of Health.

¹ ‘Investigation team and panel for Jimmy Savile investigation announced’: <https://www.gov.uk/government/news/investigation-team-and-panel-for-jimmy-savile-broadmoor-investigation-announced>

3. Methodology and Material Considered

3.1. The working methods were developed by the investigation team and approved by the Local Oversight Panel, which also met periodically to oversee their implementation and the rigour of the team's processes. The robustness of the process was also tested by the National Oversight Group, through periodic sampling of the work by Verita. Neither the Local Oversight Panel nor the National Oversight Group influenced, or was involved in, the investigation's findings.

Documentary review

3.2. Since the 1960s, both Broadmoor and the Department of Health have experienced changes to their management arrangements and responsibilities. It is a general principle that, where functions are transferred out of the Department of Health to other organisations, the records (both current and historical) are also transferred. This means that the investigation team has had to review documentary material from a wide range of sources, including other government departments and The National Archives. Responsibility for Broadmoor's documents has, at different times, rested with the relevant government department, the Broadmoor Special Health Authority and now the West London Mental Health NHS Trust; responsibility for documents of the bodies that have overseen Broadmoor has, at various times, resided with the Special Hospitals Service Authority, NHS London and now NHS England.

3.3. Every organisation approached had sight of the investigation's terms of reference and was given a set of parameters to assist it in its searches of archives and electronic filing systems.

3.4. Most of the material reviewed by the investigation was from the Department of Health archive, Broadmoor Hospital, and Berkshire Record Office (where Broadmoor had previously sent some of its files for archiving). Owing to the redevelopment of buildings at Broadmoor and the decommissioning of various wards over the years, the paper material still held by the hospital was found to be in a disorderly state and often in poor condition. This material was reviewed twice – once at the start of documentary review and once at the end – to ensure that everything relevant to the investigation had been considered and captured.

3.5. The Department of Health and other public bodies approached are required to adhere to the Public Records Act 1958, which stipulates that public bodies may hold records for a maximum of 30 years, after which time they must either be destroyed or passed to the Public Record Office (now The National Archives) for permanent preservation. It is for The National Archives to determine what they retain as contributing to the official history of the UK and

government. Savile's association with Broadmoor extended right back to the 1960s; however, few papers survive from that early period.

3.6. The NHS Code of Practice sets minimum periods for the retention of papers, including 30 years for board agendas and minutes.² However, records for the last 30 years retained by Broadmoor Hospital and the bodies responsible for it at different times are incomplete. In some cases, we were unable to locate certain papers that we are confident must have existed (such as most of Broadmoor's board papers for 1997); in other cases, the records did not hold documents that we believe, but cannot be certain, existed (such as letters appointing the members of the task force in 1988).

3.7. The investigation team considered more than a thousand files of evidence. Files held by Broadmoor Hospital and Berkshire Record Office were read on site, while all other files were removed and held securely by the investigation team. All files were read and recorded using a consistent process, which included reading against search criteria designed to help extract the relevant evidence. All evidence relevant to the investigation was centralised on a database before being migrated to a document management system. This enabled intelligent searching to be undertaken, in order to ensure that nothing had been missed in the initial reading of documents and to highlight any areas that required further, secondary searches.

3.8. Information that was found to relate to other Jimmy Savile investigations was shared with the appropriate teams, in accordance with good information-governance practice.

3.9. One of the independent investigators sampled some of the files reviewed by the reading team to ensure that the process used was robust, and that nothing had been missed. The investigation team conducted regular audits of its own work to ensure that all files expected had been received, that all files had been read, and that all relevant material had been recorded and made accessible to the investigators via the document management system.

3.10. This auditing was supplemented by the Verita sampling team. This independent team was asked by Kate Lampard to sample the systems and processes used by all three NHS Savile investigations, and to report to her on their robustness. The Broadmoor investigation team had seven meetings with the Verita team to update it on progress and to share evidence of the systems and processes being used.

Interviews

3.11. The investigation had direct contact with over 300 individuals. Many told us that they had no relevant information, although some did suggest other people who might have, while others provided information about the circumstances of the period when they were at Broadmoor – information that was duly noted. 70 indicated that they might have significant information and were interviewed in person, usually by both independent investigators; their interviews were recorded and transcribed. A further 31 provided significant information during telephone conversations, which were recorded and transcribed or noted. A breakdown appears at Appendix 2.

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200139/Records_Management_-_NHS_Code_of_Practice_Part_2_second_edition.pdf

3.12. Before being interviewed, individuals were sent the investigation's terms of reference, guidance on how the information they provided would be used, information about what to expect when they were interviewed, and details of the specialist support available to them (including support under a contract for the investigation with the Tavistock and Portman NHS Trust to provide counselling and, if necessary, mental health services). After the interview, they were offered the opportunity to add to or amend the transcript of their interview. Notes of significant telephone conversations were also sent to the person concerned for checking. The proforma documents are reproduced at Appendix 2B. A sample of communications with witnesses, including transcripts of their interviews, was audited by the National Oversight Group.

3.13. There were four individuals who were of interest to more than one investigation team. Either they were interviewed jointly or, where appropriate, one investigation team took the lead.

3.14. The investigation had no legal powers to compel anyone to come forward to be interviewed, but the investigators were able to speak to everyone we were able to contact.

3.15. The Department of Health set up and publicised a confidential telephone helpline which, by March 2014, had taken 90 calls from 59 individuals. If callers agreed, they were put in direct touch with the investigators.

3.16. Everyone at Broadmoor was encouraged via the Trust's intranet and Broadmoor's plasma display screens to contact the investigation if they had relevant evidence. A first tranche of individual written invitations was sent to all current Broadmoor patients and to current staff members who had been at the hospital in Savile's time (defined for this purpose as 1968–2001, after which time Savile had no contact with patients). Staff were encouraged to arrange a formal interview or just to 'drop in' on the investigation office without an appointment. Invitations were later sent to all past Broadmoor staff members who had been there between 1968 and 2001 and whose addresses were known to NHS Pensions, as well as to all past staff in the Department of Health (all years), the Special Hospitals Service Authority (1989–96) and the Special Health Authority (1996–2001) who had held relevant posts and whose addresses were known to Civil Service Pensions or NHS Pensions, including former health ministers and permanent secretaries. The Department of Health's intranet was used to encourage any current staff who had previously held relevant roles to contact the investigation, in order to assist in building up a picture of how the Department had been managed over time at both the divisional and the ministerial level. Where individuals who had not responded to (or received) an invitation were subsequently identified as being of interest, efforts were made to contact them via different routes.

3.17. Ex-patients and staff who had made or been mentioned in allegations investigated by the police were approached, provided the individuals had told the police that their details could be passed to the investigation, and so long as a police investigation was not still in progress. All ex-patients and staff were encouraged by our communications strategy to come forward.

3.18. Selected third parties – such as journalists, solicitors and members of the Crowthorne community – were also invited to speak to the investigation team.

3.19. Attempts were made to identify and contact individuals mentioned in media reports. Summary information relevant to Broadmoor was provided by the maker of the original *Exposure* ITV programme (see paragraph 2.5), although this did not lead to any contacts that we had not already made. This report does not repeat media allegations of abuse by Savile in Broadmoor if such allegations could not be confirmed by the investigators.

3.20. This report identifies witnesses by name if they were in senior positions (such as government ministers, senior departmental officials, board members and directors) or if they played a central role in Savile's connection with Broadmoor. Others are described in terms of their general role or their position, so long as this would not identify them individually.

3.21. Where the report criticises individuals, those people were given advance sight of the relevant text and were invited to respond. Our report takes any such responses into account.

Communications

3.22. The main elements of the communications strategy set out how both proactive and reactive tactics would be employed to deliver the greatest possible response to the investigation's call for witnesses. From January 2013, all channels of communication were used, including internal communications, NHS partners (particularly high-security services at Mersey Care NHS Trust and Nottinghamshire Healthcare NHS Trust), media at the national, regional and local levels, social media, the Trust's website, and relevant NHS trade press. The Broadmoor investigation also 'piggybacked' additional calls for witnesses onto other investigations' announcements, further raising awareness of its own investigation. These included the Metropolitan Police's Operation Yewtree, the BBC, and Her Majesty's Inspectorate of Constabulary. A further call for witnesses was issued in June 2013 via a regional media campaign, with a press release targeted at regional media titles, London and Berkshire broadcasters, and the trade press; and Dr Kirkup gave interviews to local TV and radio, both in June. There has been significant coverage in the trade press, including in the *Health Service Journal* and the *Nursing Standard*. There has also been publicity through the Department of Health, NHS England and Kate Lampard in her role of overseeing all three NHS investigations.

Report writing

3.23. The investigation's findings were agreed, following detailed discussion between the investigators, after which both led on writing specific sections of the report. All sections were peer reviewed by the other investigator and re-edited accordingly.

4. Context: national

Approach

4.1. This report is concerned with Jimmy Savile's association with Broadmoor Hospital, from its beginning in 1968 to its conclusion in about 2004. Society was in a state of continuous development across those nearly four decades. Over the same time period, management of the NHS in general – and of Broadmoor in particular – underwent a series of major changes. This chapter therefore provides a broad overview of the key developments in both society and the NHS, in order to provide the background to Savile's position and activity in the hospital over this extended period. It is not intended to provide a complete social history, nor a comprehensive account of the various NHS reorganisations.

4.2. Specifically to help the three NHS Savile investigations with this aspect of their task, and to assist her in her national oversight of the investigations, Kate Lampard commissioned a social history and policy discussion event. This was held at King's College London on 7 May 2013, and included a presentation by Diane Carpenter on 'Broadmoor: Culture and complexity'.³ We understand that all the presentations are to be published. The following is a synthesis of information presented at the discussion event, with additional material specific to Broadmoor.

Sexual mores

4.3. The 1960s was famously the decade of sexual revolution, when both men and women felt freer to express their sexuality. Although the pace of change was not the same across the nation, in some circles greater sexual freedom was expected. The popular music scene, where Savile's career was based, was one of the most sexually liberated. Young teenage 'groupies' often pursued pop idols.⁴ While public attitudes remained remarkably tolerant of the occasional actual or rumoured liaison with a girl who was post-pubescent but below the 'age of consent', paedophilia involving pre-pubescent girls (or boys, regardless of sexual maturity) remained taboo, and became the subject of intermittent moral panics from the mid-1970s.

4.4. The concept of sexual harassment became current in the 1980s, and resulted in some legislative changes.⁵ Workplace culture was slower to change, and it can be argued that real change has come about only in the present century.

³ http://www.historyandpolicy.org/kl/dcarpenter_text.pdf

⁴ Chris Welch, *Melody Maker*, 9 March 1968

⁵ The Sex Discrimination Act 1975 was modified in 1986 to establish sexual harassment as a form of discrimination

4.5. From Victorian times and well into the twentieth century, the prevailing culture included the paradox that rape and sexual assault of the innocent – the younger the girl, the more innocent she was deemed likely to be – was viewed as one of the most heinous offences, yet they were among those least likely to end in conviction. The mantra has been that it is an easy accusation to make, but is hard to prove and hard to counter. Rape allegations have, therefore, traditionally been treated with caution. Until the mid-1980s, the police often embarked on such investigations by assuming that a rape accusation was not genuine and had to be tested through interview. Some 72% of high court rape trials resulted in conviction in 1965, as did 92% of cases involving unlawful sex with girls aged 13–15; but many cases did not come to trial at all. In fact, only 15% of reported complaints involving unlawful sex with girls aged 13–15 resulted in conviction.⁶ It should also be remembered that many victims of rape and assault did not even report the offences to the police.

4.6. The recent spate of cases of organised sexual abuse of children (e.g. Rochdale and Oxford) and the continuing debate about how child witnesses are treated in court in sex abuse cases suggest that some things have not changed as much as we might like to think.⁷

Celebrity culture

4.7. Savile's association with Broadmoor Hospital began in 1968, when he was already well known as a disc jockey. The medical superintendent there decided that Savile would bring unique benefits to the hospital, including helping to render it more normal in the eyes of the public. Today, campaigns of all sorts commonly identify celebrities as figureheads. Sometimes the value of celebrities centres on their personal experience or knowledge. In healthcare, campaigns often work with celebrities who have direct experience of particular conditions, or who have expertise in areas targeted for improvement. For example, Brian Blessed has spoken out on mental health care, while a series of celebrity chefs and food writers – including Loyd Grossman in 2001 and Heston Blumenthal in 2010 – have been engaged in trying to transform hospital catering. Sometimes a celebrity's value lies in their power to resonate with a target audience. This is hardly a new phenomenon: in 1971, Savile himself fronted a campaign to encourage people to use seatbelts. 'Clunk Click' depended on his personal profile, rather than on any particular expertise in the area.

4.8. Even with such a high public profile, it was most unusual when, in 1988, Savile was given a formal management role in Broadmoor and unrestricted access to the hospital. The Trust Development Authority informed us that even today there are no media celebrities in NHS non-executive director positions.

Fundraising

4.9. There is a long tradition of charitable fundraising to support health services which persisted in the UK even after the establishment of the NHS as a universal service largely

⁶ Data quoted by Louise A Jackson in her presentation 'Criminal Justice and Policing since the 1880s' at the May 2013 seminar http://www.historyandpolicy.org/kl/ljackson_text.pdf

⁷ The Crown Prosecution Service updated its guidance in 2013 following these two cases: http://www.cps.gov.uk/legal/a_to_c/child_sexual_abuse/

funded from taxation. Fundraising has covered, and continues to cover, a variety of extra-government provision in areas such as amenities for patients and staff, medical research, and buildings renovation and improvement. Taking Savile's case in particular, his fundraising and charitable donations ranged from the development of entire buildings and services (as at Stoke Mandeville) to the provision of prizes for staff social events (as at Broadmoor). (See chapter 8 for Savile's fundraising at Broadmoor.) This sort of activity was not unique, but Broadmoor was not the sort of hospital that would typically generate much public sympathy – unlike, say, Stoke Mandeville. Comparatively small contributions may well have bought more goodwill at Broadmoor because staff were used to being part of an organisation that did not normally attract such generosity.

Safeguarding children and vulnerable adults

4.10. There is a long history of legislation for the protection of children: the first Act was passed in 1889. Commonly known as the Children's Charter, it enabled the state to intervene in relations between parents and children. The legislation has been much amended and extended over time, sometimes as a result of particularly shocking or high-profile cases. In 1974 the inquiry into the death of Maria Colwell at the hands of her stepfather led to the establishment of area child protection committees. These were intended to coordinate local efforts to safeguard children at risk. The Children Act 1989 gave every child the right to protection from abuse and exploitation. Its central tenet was that the child's best interests were paramount. The UK is also a signatory to the 1989 UN Convention on the Rights of the Child, which came into force in the UK in 1992. In 1999, the Protection of Children Act was passed with the aim of preventing paedophiles from working with children. In the same year – in response to the Fallon Report,⁸ which had found serious failings at Ashworth Hospital – the Visits by Children to Ashworth, Broadmoor and Rampton Hospitals Directions were put in place. These introduced stringent rules to ensure the safety of children visiting patients at the secure hospitals, and in particular to ensure that such visits were in the child's best interests.

4.11. Safeguarding vulnerable adults is effectively Broadmoor's raison d'être, as a high-security psychiatric hospital – or 'asylum', as such places were once called. Indeed, 'Keeping people safe' appears as a heading on Broadmoor Hospital's home webpage. The legislation underpinning this is the Mental Health Act 1983, amended in 2007. The Mental Health Act Commission was charged with overseeing it in practice. Commissioners visited Broadmoor regularly to meet patients, so that they could take action on any issues that needed to be addressed. That function has now passed to the Care Quality Commission.

4.12. A full list of relevant national policies, including guidance entitled 'No Secrets', is available at Appendix 3.

⁸ P Fallon, R Bluglass, B Edwards and G Daniels, *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*, 1999, Cm 4194-ii

Rights

4.13. It is arguable that society as a whole now pays greater attention to human rights than it did in the past. It is certainly the case that more attention is paid now to patients' rights in the NHS in general – and in mental health facilities in particular.

4.14. This increased emphasis on rights coincides with a general decline in the deference shown toward people in authority: for example, in the NHS the consultant often used to be treated with exaggerated respect.

NHS management

4.15. NHS management styles, structures and lines of accountability have been subject to regular and repeated development. Over the decades of Savile's activities, they changed several times.

4.16. The National Health Service Reorganisation Act 1973 introduced 14 regional health authorities (RHAs), overseeing 90 area health authorities (AHAs). The Health Services Act 1980 replaced the AHAs with 192 district health authorities (DHAs), and emphasised devolution of management to smaller units. In 1984, the Griffiths Report⁹ led to the replacement of former 'consensus management'¹⁰ in RHAs and DHAs with management teams reporting to a general manager, who was accountable to his or her health authority. The 1989 White Paper *Working for Patients* introduced the purchaser–provider split and the concept of NHS trusts – self-governing hospitals, which owned their own assets; the first NHS trusts were established in April 1991.

4.17. The three special hospitals, however, including Broadmoor, were for some time out of step with the rest of the NHS. The most notable feature of this was that they were directly managed in the 1970s and 1980s by the Department of Health and Social Security (DHSS). Moreover, they did not introduce general management, as understood in the rest of the NHS, for at least another four years after 1984.

4.18. At the local level, Broadmoor continued to operate under the consensus management arrangements set out in the 'Grey Book' of 1972,¹¹ which prescribed a multidisciplinary management team: at Broadmoor, this was a tripartite team of administrator, nurse and doctor. In the 1980s, each of the high-security hospitals established new 'hospital boards' – in Broadmoor's case, in January 1987. At Broadmoor, this was a short-lived arrangement: in September 1988, the board was suspended and replaced by a 'task force' (until March 1989), which was considered better suited to tackling the hospital's combination of pressing management challenges.

⁹ NHS Management Inquiry. Letter dated 6 October 1983 to the Secretary of State, Norman Fowler, from Roy Griffiths, Michael Betts, Jim Blyth and Sir Brian Bailey

¹⁰ Consensus management, a belief that in a multidisciplinary NHS all skills groups should have a voice in decisions: <http://www.nhshistory.net/shorthistory.htm>

¹¹ The 'Grey Book' set out the management arrangements for the reorganised health service in 1972: http://www.nhshistory.net/strategy_&_stringency.htm

4.19. In 1989, management of the special hospitals moved away from direct Department of Health control. The Department created a new Special Hospitals Service Authority (SHSA) and appointed general managers (later called chief executives) to each of the special hospitals. In 1996, a special health authority was created for each of the special hospitals, and the new High Security Psychiatric Services Commissioning Board was created to commission services from them. In 2001, the Broadmoor Special Health Authority was merged with the West London Mental Health NHS Trust. Crucial to Savile's position at Broadmoor was the introduction of the task force in 1988, followed immediately in 1989 by general management and a complete overhaul of the way the hospital was run. This coincided with a major restructuring of the government department to which the NHS, including Broadmoor, answered – in July 1988 the Department of Health and Social Security was divided into two separate departments.

5. Context: Broadmoor

5.1. By dint of its nature, Broadmoor has housed some of the most difficult people to look after – people whose behaviour can be extremely challenging and potentially dangerous to staff, to themselves, and to other patients. The personal demands posed by the day-to-day care of such individuals were (and remain) very considerable. The majority of staff deserve great credit for coping with these demands with professionalism and compassion. Parts of our report necessarily focus on the converse – the aspects where care, compassion and professional standards lapsed. This should not detract from the achievements.

The staff

5.2. Broadmoor Hospital in the last century was very different from the current establishment. There is considerable evidence from reports, papers and personal accounts that the prevailing culture there – at least until the 1990s – was strongly institutional, based on an underlying view that the hospital's principal function was custodial.¹² Residents were 'inmates', rather than patients, regarded as criminals whose mental health happened to be impaired, rather than there because their behaviour was the result of their mental health. Until the 1970s, staff were 'attendants' not nurses. 'Inmates' had to be controlled, first of all by humiliating 'initiation rituals' on admission, and then by rigid rules, such as those governing access to bathrooms. White lines that were not to be crossed separated the 'inmates' from the staff. Those who broke these rules were punished by measures such as seclusion. Some of this (though by no means all) was common to other large institutions for those with impaired mental health, the 'county asylums', and was regarded as part of the care regime; but by the 1970s, attitudes to care were beginning to evolve significantly away from a custodial approach – a development assisted by the introduction over the previous decade of the first effective drugs for major psychotic illness.

5.3. Until the 1990s, most nurses in the three high-security hospitals were members of the Prison Officers Association (POA); today, although there are members of several unions, most belong to the Royal College of Nursing. According to the POA website, the union 'owes a considerable debt of gratitude to the forefathers of the Union based at Broadmoor Criminal Lunatic Asylum'.¹³

5.4. Many nurses were recruited straight from the armed forces and were accustomed to respect for authority. A symbol of the nurses' control over patients was their set of keys, often

¹² Quoted at King's College discussion event, May 2013 (see paragraph 4.2)

¹³ www.poauk.org.uk/index.php?poa-history-in-special-hospitals-1

prominently on display; the aura of authority this gave extended to Savile once he was given keys, in the 1970s.

5.5. Many staff came from families that had a strong association with the hospital and had had several generations of family members working there; they trained at Broadmoor and spent their entire working lives there. This led to a deep sense of loyalty and camaraderie among staff, but also to a traditional and inward-looking culture that was resistant to change. Until the 1990s, staff wore a uniform that dated from Victorian times. Nowadays, staff members travel from a wider area to work at Broadmoor, and there is greater turnover of staff who wish to gain experience and develop clinical skills.

The patients

5.6. There has been a significant change in the patient population at Broadmoor. The hospital has always provided care and treatment for mentally disordered people who have either been convicted or are facing prosecution for serious criminal offences, but until the 1990s it also provided care and treatment for other men and women who presented significantly less risk. The development of medium-security facilities across the country (regional secure units were introduced in all NHS regions in the 1980s) and specialist facilities for women has helped reduce the requirement for high-security beds. There have been no women patients at Broadmoor since 2008.

5.7. The perceived need for military-style respect for the nurses was exacerbated by the high ratio of patients to staff: the relatively few staff, who needed to control many, often difficult, patients would see themselves as justified in exercising rigid discipline. Patient numbers more than halved in Savile's time (from 821 in 1971 to 382 in 2001), and have since halved again (to 194 in September 2013). Meanwhile the number of nurses has risen (from 359 in 1971 to 620 in 2001 and 435 in 2013), so the nurse–patient ratio has improved five-fold since 1971. It was the charge nurses and sisters who exercised day-to-day control over the lives of the patients: until relatively recently, the small number of consultants at the hospital (in 1985 there were 8 posts, of which several were vacant, compared with 13 posts now for far fewer patients) and the heavy administrative workload generated by a large number of patients meant that the consultants were an infrequent presence on wards.

5.8. The type and range of patient activities have also changed, reflecting in part the changes in the make-up of the patient population. For example, until the 1990s some patients were employed in activities outside the hospital, and there were more rehabilitation trips into the local community, as well as coach trips to the coast or to see the Oxford Street Christmas lights. There were also links with the local community, including sports teams coming into the hospital to play against the patients, and members of the public being invited to attend shows organised and performed by the patients.

5.9. The Tilt review of security in 2000 (see paragraph 5.18 below) recommended the 'Accelerated Discharge Programme' for long-stay patients who did not need such physical security. These were generally the patients who had been able to take advantage of such outings. The loss of this critical mass of relatively settled, long-stay patients has meant that the opportunity for excursions and other activities in the 2010s is more limited. Patient numbers

are smaller, and the activities are targeted more at a group that is generally much more unwell than its predecessors of a generation or two ago. These days such activities are provided in medium-security units, to which Broadmoor patients are now transferred much more promptly than when the hospital had 1,000 beds.

Security

5.10. In the 1960s, the Victorian main gate into the hospital and the female wing entrance formed part of a walled perimeter around the hospital. Staff obtained their own bunch of security keys from cupboards in the respective entrances by exchanging a numbered token for a corresponding set of security keys. In the 1970s, the female wing entrance was closed and all staff used the main gate, where access was controlled by gate staff activating an electronically powered door; staff then obtained their keys by presenting their numbered token through a key chute (the process was reversed when leaving the hospital). The Gate House building incorporated a small control room, which maintained details of the location of patients and visitors – but not staff – and initiated responses to alarms. The walled perimeter was about 14 feet high, but in the area of the hospital occupied by women it was only about 11 feet high in places (it is now 17 feet high).

5.11. The security perimeter was improved as part of a wider redevelopment during the late 1980s and early 1990s, with further improvement in the wake of escapes in 1991 and 1993 (since when there have been none). The perimeter was reconfigured to incorporate some of the new buildings, which included a new entry reception building and control room. Closed-circuit television (CCTV) was introduced to help the control room monitor the site (initially 24 cameras). The new reception building included a security key lobby, where key holders could collect their allocated security keys from a security key bank operated by a personal unique key assigned to them. Entry to the key lobby was controlled by reception staff.

5.12. In 1992, the Special Hospitals Service Authority (SHSA) reviewed security at the special hospitals,¹⁴ and in 1994 a joint Department of Health and Home Office review of services for mentally disordered offenders¹⁵ included a Working Group on High Security and Related Psychiatric Provision, which also considered security in the special hospitals. In 1996, the SHSA stipulated that the level of security in a high-security hospital should be equivalent to the level of security needed for Category B prisoners.

5.13. In 1998, the way in which key holders entered and exited the hospital was changed from being administered at reception to being regulated using a personalised access device, which allowed access to the key lobby via a turnstile. This ensured more effective control of movement, and also eliminated the possibility of security keys being removed from the hospital. Key holders who were not regular visitors to the hospital (and did not, therefore, have a dedicated set of security keys) were issued with a fob that gave them access through a revolving door. They then presented the fob to reception staff and received in exchange an access device to reach the key lobby.

¹⁴ J Kinsley, *Security in the Special Hospitals: A Special Task*, 1992

¹⁵ Reed Report 1994

5.14. Since then, physical security has been further strengthened, prompted by the Fallon and Tilt reports. These changes were not in place during the period when Savile was visiting Broadmoor, but are relevant in that they may have deterred him from visiting, and support Broadmoor's present policies, practices and procedures in safeguarding patients (see chapter 9).

5.15. The Fallon Inquiry report¹⁶ of January 1999 into the management of the Personality Disorder Unit at Ashworth Hospital, and the Department of Health's Safety and Security Directions for the high-security hospitals (HSC 1999/150)¹⁷ introduced new security requirements, including random searches of staff and their possessions on their way into and out of the hospitals, and the searching of all visitors and their possessions on their way into the hospitals. Broadmoor's reception area was reconfigured to incorporate search areas, X-ray and metal-detection portals.

5.16. The Fallon Inquiry report also recommended a review of security at the high-security hospitals, and this was carried out in 1999 by Sir Richard Tilt. His report, issued in February 2000,¹⁸ recommended that the perimeter be strengthened to prison service Category B standards: this resulted in a double-skin perimeter with additional alarms, as well as improved CCTV coverage of the site and better lighting. Magnetic locks were fitted to the external doors on buildings occupied by patients; this led to a new security key being added to the security key sets of all key holders, and all key holders were required to be trained in its use.

5.17. In 2001, the staff search area and key lobby were moved to their current locations. The changes in the way key holders now entered and left the hospital through a number of electronically controlled doors and the staff search area, using their unique access devices, provided an electronic audit trail record of key-holder movements through the reception building and into the hospital (and in reverse). Biometric fingerprint scans were later introduced: for visitors in 2009, and for staff in 2010.

5.18. The Tilt Report also recommended the use of CCTV on wards. After a limited trial, the first CCTV ward-based system was introduced in 2007. CCTV systems have subsequently been introduced in the common areas of most wards, and there are plans to introduce them onto all other wards. There are now some 220 CCTV cameras. We were told that external CCTV cameras are monitored at all times via the control room (and we have circumstantial evidence of this, based on the recent dismissal of a staff member for activity observed via CCTV); internal cameras, including those on wards, are checked intermittently.

5.19. We were told that there have always been policies and procedures covering patient treatment, staff attitudes and behaviour, patient observation and supervision, incident reporting, control of risk items, the checking of physical security measures, the management of security keys, the maintenance of confidentiality, and responses to incidents. However, there are few records of written policies from before the 1990s, and interviewees told us that much of what would now be set out as written procedures was governed by custom and practice.

¹⁶ <http://www.archive.official-documents.co.uk/document/cm41/4194/ash4194.htm>

¹⁷ The latest version of the Directions can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191052/psychiatric_services_directions.pdf

¹⁸ R Tilt, B Perry, C Martin et al., *Report of the Review of Security at the High Security Hospitals*, 2000

5.20. Until the issue of the Safety and Security Directions in 1999, these procedures were determined, in content and extent, by local managers. The Safety and Security Directions placed a legal requirement on the high-security hospitals to implement certain procedures, and also specified how and when this should be done. The Directions have been revised on several occasions, most recently in 2013. In addition to the Directions, the Department of Health's National Clinical Security Framework (NCSF) sets core security standards; this replaced the Security Manual for the High Security Hospitals, which was developed in response to the Tilt Report.

5.21. The Tilt Report recommended the introduction of a security intelligence system and an increase in the number of security liaison nurses (SLNs) to ensure that there is regular security input into clinical team meetings. Each SLN has responsibility for no more than four wards. Their contribution ensures that there is a security input into patient risk assessment and management planning, based on knowledge and understanding and using information from (among other sources) the security intelligence system.

6. Savile's Association with Broadmoor

First contact with Broadmoor

6.1. Savile's involvement at Broadmoor Hospital dated back to the 1960s. Almost 50 years later, none of those in senior positions at the time are still here to give eyewitness accounts, but some contemporary documents do survive and outline how it began.

6.2. The head of the hierarchical Broadmoor organisation was, until 1981, the considerable figure of Dr Pat McGrath, the last true medical superintendent of the hospital.¹⁹ It is clear from the evidence of then-junior staff that he was regarded throughout the hospital with a mixture of respect, affection and deference, and that his decisions were treated as final. He worked to modernise the hospital, recognising that the ward environment needed to be less custodial and more therapeutic. Nevertheless, the culture within Broadmoor was so resistant that even he was unable to change it as he would have liked. Former staff who were there in Dr McGrath's time, albeit in a junior capacity, told us that he was careful to maintain good working relations with all staff in the hospital. On the basis of what we heard, it seems to us unlikely that he would have felt able directly to challenge unduly custodial practices in the face of the strong opposition we had described to us.

6.3. In 1968, Dr McGrath was contacted by Savile.²⁰ A number of patients had written what seem to have been fan letters to Savile, and Savile suggested in a call to the entertainments officer, Mr Britton, that he might visit the hospital. Dr McGrath saw an opportunity, and at the end of the successful visit he personally met Savile in Broadmoor. Although Dr McGrath's son has said that his father disliked Savile intensely,²¹ he also apparently saw the benefits that the disc jockey could bring to the patients and staff, including by generating positive publicity for the hospital. Savile was asked to help provide entertainment within the hospital, and could, Dr McGrath thought, help to improve the general perceptions of Broadmoor by being publicly associated with the hospital. Dr McGrath told a local newspaper that Savile had a "very real insight" into the patients' problems.²²

6.4. This developed into an unofficial role in patient entertainment, which Savile would later describe as 'Honorary Entertainments Officer', as is clear from contemporary newspaper articles. Former staff told us that Dr McGrath subsequently agreed that Savile should have accommodation and car parking on the site, just outside the secure perimeter, and that he should have keys allowing him access to the secure areas of the hospital. In an article dated

¹⁹ Dr McGrath preferred the title 'physician superintendent' but the alternative was in more general use

²⁰ Letter from Dr McGrath to Mr Bolton, Ministry of Health (see Appendix 2A(i))

²¹ Patrick McGrath, *Herald Scotland*, May 2013

²² Sandhurst Chronicle, 1969

November 1978, Savile was reported as having keys ‘to take him anywhere throughout the sprawling buildings’,²³ which, Dr McGrath is quoted as saying, is ‘in a special security hospital... the highest mark of trust the management can offer’.²⁴ It is clear to us that, however Dr McGrath regarded Savile on first acquaintance, the relationship became one of trust; otherwise, we believe, Dr McGrath would not have granted Savile unlimited access, and nor would he have spoken of him in such warm terms.

6.5. Whether Dr McGrath considered the potential risks of inviting an entertainer to have unrestricted access to the hospital is not clear, either from the little documentation that survives or from staff accounts. Concepts such as safeguarding patients from actual and potential abuse were almost entirely undeveloped at the time. Nor was the need to consider potential abuse generally recognised. Yet Broadmoor was, and remains, a high-security hospital, with patients who are considered to be a significant risk both to themselves and to others, and who are also deemed to be at significant risk of exploitation by reason of their mental health and their incarceration.

6.6. Savile’s first visit to Broadmoor was on 13 September 1968, and we heard that the pattern of his presence was set soon afterwards. He would arrive at his accommodation – a house just outside the secure perimeter – irregularly and unannounced, and would park his car.²⁵ It was reported to us that his caravan was also often on the site, and indeed in the 1970s was often within the secure perimeter. Later, we were told, the car would be serviced, washed and valeted in the hospital’s garage,²⁶ and his caravan would be cleaned – sometimes, it seems, by patients.²⁷ He would access secure areas unannounced and unescorted, and would walk onto wards using the set of keys provided for him. He would ‘hold court’²⁸ in his accommodation with those staff who became his acquaintances. After one or perhaps two nights, he would leave as abruptly as he had arrived.

6.7. It is clear to us from the accounts we heard that not all staff liked him, and some questioned the reason for his presence from the outset. Their doubts, however, always washed up against the same immovable rock: Dr McGrath had authorised his presence, his accommodation and his unrestricted access, and the medical superintendent’s decisions were incontestable. A nurse at the time said that his reaction was ‘... well I suppose the old man [McGrath] knows what he is doing’.²⁹ It is important to recognise that such was Dr McGrath’s standing in the hospital that this reluctance to question any decision seen to be his persisted for some time after he had retired, as we heard from former staff.

²³ *Reader’s Digest*, November 1978

²⁴ *ibid.*, quoting Dr McGrath

²⁵ Former Broadmoor Hospital staff member (aa)

²⁶ Don Bennett, former transport manager, Broadmoor Hospital

²⁷ Former Broadmoor Hospital patients (l), (ee)

²⁸ Several staff who took part described it in these terms

²⁹ Bob Barber, later head of security, Broadmoor Hospital

Access to ward areas

6.8. During the early part of Savile's association with the hospital, security was primitive by current standards. Over the next three decades, however, changes were introduced progressively to the access arrangements within the hospital, and have continued to evolve since. This complicates the assessment of interviewees' accounts of what access would have been possible and what would not.

6.9. By 'custom and practice' long established in every hospital and well known to all NHS staff, anyone visiting a hospital ward should make themselves known to the nurse in charge. This would include medical and administrative staff, as well as any other visitors, and would be even more important in a high-security environment such as Broadmoor. Some of those we interviewed did not believe that Savile would have been allowed to avoid this, and therefore his presence would always have been known and supervised.³⁰ One former staff member was sure that Savile could not have accessed patient areas unsupervised at any time;³¹ others told us that they doubted he could have been on a female ward without the nurse in charge knowing and without being escorted.³² During most of the time that Savile was involved with the hospital, a staff member with a walkie-talkie radio, known as a 'radioman', was routinely stationed near the entrance to each ward to call for assistance in case of disturbance and to report who was entering or leaving the ward, further reinforcing the view that his presence would always have been known.

6.10. It is clear to us from many other accounts, however, that it would often have been possible for Savile to avoid these measures. On some wards, we were told, he would simply walk past unchallenged, presumably because some staff accepted his presence.³³ According to a member of the hospital security staff, adherence to proper practice on entering wards with a radioman was 'not universal at all'.³⁴ Another staff member told us that Savile 'just walked on the ward ... he had his own keys and could go wherever he wanted'.³⁵ A former nurse told us that Savile 'would come onto wards unannounced and it was easy for him to walk past the radio table and into patient rooms'.³⁶

6.11. Some former members of staff pointed out to us that the female wards in the 1970s and 1980s were in a discrete area or wing that had a separate entrance. This, they suggested, meant that Savile would have had to 'check in', again alerting staff to his presence.³⁷ We also heard, however, various independent and detailed accounts from both former staff and patients that Savile was able to use the alternative entrances that existed to some wards – accessible to anyone with keys – that bypassed the front entrance and the 'check-in' to the

³⁰ Former Broadmoor Hospital staff members (a), (b), (c), (d)

³¹ Former Broadmoor Hospital staff member (a)

³² Former Broadmoor Hospital staff members (b,) (c), (d)

³³ Former Broadmoor Hospital staff members (e), (f), (g)

³⁴ Former Broadmoor Hospital staff member (h)

³⁵ Former Broadmoor Hospital staff member (f)

³⁶ Former Broadmoor Hospital staff member (e)

³⁷ Former Broadmoor Hospital staff member (d)

female wards.³⁸ We were consistently told that there was access to the female wards from garden entrances and stairwells, and there was no need to go through the separate entrance to the female wing.³⁹ Another former member of staff who worked in the occupational therapy area told us that there was a door from there directly into the women’s area that could be used by anybody with a set of keys.⁴⁰ We were told that with keys it was ‘easy just to walk in’⁴¹ to female wards by various routes,⁴² bypassing the ward office, and to gain access to dayrooms, sleeping areas and bathrooms unaccompanied; this remained the case until the early 1990s.⁴³

6.12. We were told not only that Savile would walk around some wards unaccompanied and unsupervised, but also that on several occasions he was seen to be on his own with female patients or nurses; we heard that this persisted until at least 1998.⁴⁴ Some staff told us they were concerned that his behaviour posed a risk to himself and to staff, including those who would be required to come to his aid if he were attacked. One former staff member told us that Savile ‘would not take no for an answer’,⁴⁵ ignoring, for example, a request not to talk to a particular patient whose mood the staff member recognised as posing a risk to others – even when it was pointed out to Savile that this was a potential danger to the patient, himself, the staff member and other staff who might have been required to intervene.⁴⁶

6.13. We conclude that, for a considerable part of Savile’s period of association with the hospital, and certainly up to the 1990s, it was possible for him to access ward areas without ‘checking in’ either with ward staff or at the separate entrance area to the female wing. We recognise that some of those we spoke to will find this conclusion difficult to reconcile with their own views of how the hospital operated. To some extent, this reflects the progressive changes in security over the years: some of the earlier systems – and the laxity with which, we were told, some staff operated them in practice – were simply not known to more recent staff members. Having listened carefully during the course of interviews with the many current and former staff members we spoke to, however, we believe that there are two further important factors underlying the differences presented to us.

6.14. First, we were struck by the correlation between some of the characteristics of interviewees and how they perceived that wards were run and how Savile was dealt with when visiting. A number of former staff members were clearly authoritarian and rather formidable characters who presented themselves to us very confidently and assertively; this was unsurprising in view of the nature of the work they had undertaken. These interviewees made it clear to us that they ran wards as a ‘tight ship’, brooked no interference by Savile or anybody else, and insisted to all their staff and visitors that breaches of procedure would

³⁸ Former Broadmoor Hospital staff members (i), (j), (k); former Broadmoor Hospital female patient (l)

³⁹ Former Broadmoor Hospital staff member (i); former Broadmoor Hospital female patient (l)

⁴⁰ Former Broadmoor Hospital staff member (k)

⁴¹ *ibid.*

⁴² Former Broadmoor Hospital staff member (j)

⁴³ Former Broadmoor Hospital staff member (k)

⁴⁴ Former Broadmoor Hospital staff members (k), (g), (m)

⁴⁵ Former Broadmoor Hospital staff member (k)

⁴⁶ *ibid.*

not be tolerated. One, for example, described Savile as a 'buffoon' for whom he had no time; neither, he said, did the responsible medical officer he worked with, who was 'a formidable character'.⁴⁷ These interviewees almost all described Savile's visits as infrequent and properly managed when they did occur. In speaking to us, it was evident that they assumed that proper procedures were equally well enforced throughout the hospital, and that Savile's presence was as infrequent elsewhere. Those staff members who were rather less authoritarian and assertive presented a very different picture, however. They pointed out the breaches in procedure and the multiple access routes, and spoke of Savile being a frequent visitor to the hospital and to ward areas, unannounced and unaccompanied, at least up to the 1990s.

6.15. Second, it was clear during the course of the interviews that staff were strongly polarised in their views both on Savile himself and on his presence at Broadmoor. In the words of one senior manager, he was 'like Marmite'.⁴⁸ On the basis of what we heard, we believe it is clear that Savile avoided those areas where he was disliked and his presence resented. These were often the areas run by strong characters who were more successful in limiting his access. This, we believe, is why they reported seeing him much less often and believed that he was only rarely in the hospital.⁴⁹ When pressed, however, they all conceded that they could speak with direct knowledge only of the wards they knew, and simply assumed that their practice would apply across the hospital. It is clear to us from what we heard, however, that practice varied widely around the hospital, and as late as 1997, one external report described Broadmoor as not so much a single hospital as '23 federal institutions'.⁵⁰ We conclude that Savile was frequently in the hospital up to the 1990s, and that he spent time predominantly in those areas where staff liked him (or, as we were told, were 'taken in by him'),⁵¹ accepted his presence, and tolerated access that bypassed the usual procedures.

6.16. During the earlier part of the period of Savile's association with Broadmoor, it is likely that he kept his keys with him when he left the hospital. This was stated unequivocally by his personal assistant at the time, who was based at Stoke Mandeville but who quite often accompanied Savile to Broadmoor.⁵² She told us that she had witnessed him on many occasions taking his own set of keys out of a case where he kept them, and replacing them there after he left the hospital. Although staff familiar with later security procedures may doubt it, it was for a long time possible for someone to walk out of the main entrance without hanging up their set of keys (usually through forgetfulness). One former member of staff described to us how he had walked out with his keys while he was distracted by talking to a colleague, and had had to go back to return them.⁵³ From what we were told, however, we believe that Savile did this routinely, keeping his keys with him, which further increased uncertainty about whether or not he was within the secure perimeter.

⁴⁷ Bob Barber, former nurse and head of security, Broadmoor Hospital

⁴⁸ Michael Morgan, former senior manager, Broadmoor Hospital

⁴⁹ Former Broadmoor Hospital staff members (b), (c), (d), (j)

⁵⁰ M Donovan, 'Broadmoor Hospital: External management review', 1997

⁵¹ Bob Barber, former head of security, Broadmoor Hospital

⁵² Janet Cope, Savile's Personal Assistant at Stoke Mandeville hospital until 1999

⁵³ Former member of staff, Broadmoor Hospital (k)

6.17. Savile’s unrestricted access to secure and clinical areas of the hospital remained unchallenged for many years. Initially, we were told, this was because it was seen as having been authorised by Dr McGrath;⁵⁴ later it was seen as having been authorised by those overseeing the hospital, including ministers, the Special Hospitals Service Authority and the hospital management team.⁵⁵ Authority to use keys was available to some external visitors, including those statutorily responsible for hospital inspections, but we heard no suggestions of misuse. In the mid-1990s the frequency of his visits declined, and a security officer told us that around 1996 he had observed that the keys ‘had a significant layer of dust on them’.⁵⁶ In 1998, irregular visitors had their keys replaced with personalised fobs; but Savile did not obtain one. From 1998 on, Savile would have needed to obtain a non-dedicated set of keys by presenting his identity card to reception staff, or else entered the hospital as a visitor without access to security keys. Since 1999, all use of keys has been recorded (although records have not been retained for 1999–2001), and there is no record of Savile having entered Broadmoor, except for refresher training in the use of keys in 2004. The then head of security told us that in 2009 he had contacted Savile when he found that he was still an authorised key holder, and Savile had agreed that his authority to use keys should be withdrawn, which it was.⁵⁷

Honorary entertainments officer

6.18. Savile did arrange for well-known acts to go to Broadmoor to entertain patients and (separately) staff. These included, most notably, Acker Bilk⁵⁸ and Pan’s People,⁵⁹ as well as other celebrities like Frank Bruno (see paragraphs 8.16–8.17). His role in relation to other entertainment – for example, Royal Shakespeare Company productions of *Macbeth* and *Hamlet* – is less clear, although he may well have claimed some credit. We heard that he also had a degree of involvement in arranging football tournaments for patients, and some discos; but again, it is not clear how frequently this was the case. Former staff members also told us that Savile arranged some outings for patients, for example to Bournemouth and to a wildlife centre at Burford; we were told that these visits always involved appropriate escorts from among the nursing staff and appropriate selection of patients to go. The minutes of hospital management team meetings from 1988 show that authorisation for such trips came from a senior level. It was quite usual for Broadmoor patients to take part in escorted external trips at the time, if they were judged suitable; but we found no evidence of the participation of any other celebrities.

6.19. Former staff told us that they remembered clearly Savile’s patronage of the staff club and his fundraising activities. The staff club was a controversial feature of Broadmoor that predated Savile’s involvement with the hospital. The majority view among the more established, traditionally minded staff we spoke to was that it provided an appropriate focal point for staff

⁵⁴ Bob Barber, former head of security, Broadmoor Hospital

⁵⁵ Alan Franey, former general manager/chief executive, Broadmoor Hospital

⁵⁶ David Lee, former security manager, Broadmoor Hospital

⁵⁷ Mike Humphreys, former head of security, Broadmoor Hospital

⁵⁸ Former Broadmoor Hospital staff member (a)

⁵⁹ *Radio Times*, 29 May 1975

leisure, increasing camaraderie and allowing staff to 'decompress' after stressful, arduous and potentially threatening stints on the ward in a private environment, away from the public gaze, and to exchange useful clinical information. Others told us they took the view that it was an unhealthily introspective environment, reinforcing prejudice and a closed culture, and encouraging lunchtime drinking before a return to work. We also heard that there were what appear to have been not infrequent fights between staff members.⁶⁰ Savile became both a supporter and a patron of the staff club. We were told that he participated in Christmas parties and other outings arranged by the staff club which included the children of staff. This was reported to us in mixed terms by interviewees. On the one hand, some pointed to their lack of reluctance to allow their own children to participate as evidence that they could not have had any reservations about Savile at the time. On the other hand, at least some staff reported to us that they would not allow their children to attend because of a non-specific feeling of unease about Savile's character and suitability around children.⁶¹ One interviewee told us that she had an instinct that Savile was 'dangerous around children' and took her own children home from one Christmas party in the early 1970s as soon as she saw Savile there.⁶² Another nurse told us that she had let it be known through an associate of Savile's, Don Bennett, that Savile would not be welcome at a Christmas party for the children of staff. Savile did not attend.⁶³ Bennett told us that he had no recollection of the incident.⁶⁴

6.20. We were told that Savile organised and participated in several fundraising events on the Broadmoor estate or in conjunction with the Crowthorne village festival, and that staff joined in many of these events with him. There are many reports of these in the local press and in League of Friends papers. On the basis of these written reports and what we were told, it appears that some of the proceeds went to support the staff club, some the League of Friends, some the village festival, and some (perhaps most) went to Savile's charitable fund based at Stoke Mandeville Hospital (see chapter 8 for more detail on his fundraising).

Ward environment

6.21. The approach adopted by Broadmoor staff when Savile was first associated with the hospital has been characterised as custodial rather than therapeutic. Staff saw themselves as guarding prisoners, not caring for patients.⁶⁵ Staff wore a uniform similar to that of a prison warder, and this was described to us as a 'useful barrier' between patients and staff.⁶⁶ The closed culture of Broadmoor brought camaraderie, pride in the job and a low rate of sickness absence,⁶⁷ but it also brought remarkable resistance to change when ideas of forensic psychiatric care elsewhere began to evolve in a less custodial direction. From what we heard, much of the resistance to change centred on the local branch of the Prison Officers

⁶⁰ Former Broadmoor Hospital staff members (b), (c)

⁶¹ Former Broadmoor Hospital staff members (i), (n)

⁶² Former Broadmoor Hospital staff member (n)

⁶³ Former Broadmoor Hospital staff member (i)

⁶⁴ Don Bennett, former transport manager, Broadmoor Hospital

⁶⁵ Tony Backer-Holst, former head of forensic nursing, Department of Health

⁶⁶ Former Broadmoor Hospital staff member (a)

⁶⁷ Former Broadmoor Hospital staff members (b), (c)

Association (POA), a strong trade union presence within the hospital that was regarded by managers as very difficult to deal with.⁶⁸

6.22. It is clear to us from many interviews, from contemporary documentation and from reports into untoward incidents that the custodial approach within the three special hospitals (including Broadmoor) also implied a strong sense of ‘us and them’ on the part of staff, a detachment from ‘inmates’ and, in some, controlling and punitive attitudes. One former staff member said, in remarks he preferred not be attributed, that he doubted whether any staff member in the 1980s would have wanted to raise money for Broadmoor residents, ‘because they were scum’. Such attitudes, in a closed institutional culture, are just the kind that foster ill-treatment of patients by some. Previous reports have confirmed that there were many such instances at all the special hospitals, including Broadmoor. We were not at all surprised to hear certain examples concerning staff from previous years; but it was not the purpose of this investigation to examine individual complaints unrelated to Savile, and in any case we were not equipped to do so, especially after such a length of time.

6.23. Female patients described an initiation ceremony for new admissions which included having to take a bath naked in front of many staff, male and female, who would comment on their appearance and warn that they should not step out of line.⁶⁹ Others described staff reacting to a ‘troublemaker’, real or perceived, by dragging them the length of the ward, stripping them naked as they went, before propelling them into a seclusion room.⁷⁰ On other occasions, cold baths were used as punishment.⁷¹ These behaviours, and others, have been described in previous reports.⁷²

6.24. A solicitor who specialised in this field, Lucy Scott-Moncrieff, acted legally for, and was an advocate for, many Broadmoor patients. She was a frequent visitor to the hospital from 1979 until recently, and was in a good position to hear many patient accounts. She told us that, in her view, Broadmoor was an ‘extremely punitive place’,⁷³ where women in particular were ‘treated very badly’ in a ‘very, very regimented’ environment that was ‘very institutionalised’. Patients were ‘seen as the enemy’ in a ‘ruthlessly oppressive’ system that ‘was all about control, absolutely about control’. During the 1980s, she heard fairly regular complaints by female patients of being abused by male patients; these, she told us, were never properly investigated. Very few complaints were upheld, we heard, and complainants were seen as troublemakers, confined to ward and made to feel as though they were being punished. This view was reinforced by a later chief executive of the hospital, Dr Julie Hollyman, who reported that before she reformed the complaints system in about 1998 to bring it into line with the rest of the NHS, complaints ‘weren’t properly investigated. The [complaints] files came up with next to nothing in them.’⁷⁴

⁶⁸ Tony Backer-Holst, former head of forensic nursing, Department of Health

⁶⁹ Former Broadmoor Hospital female patients (l), (o)

⁷⁰ *ibid.*

⁷¹ *ibid.*

⁷² See papers for the social history and policy discussion event, referred to in paragraph 4.2 above

⁷³ This and the following six quotes are from Lucy Scott-Moncrieff

⁷⁴ Dr Julie Hollyman, former chief executive of Broadmoor Hospital, then of West London Mental Health NHS Trust

6.25. We regard this as vital context to understand the environment in Broadmoor through much of the period that Savile was present there. First, we believe it is likely that in at least some of the wards, staff with a hostile attitude to patients would have tolerated inappropriate behaviour from Savile, and some may even have regarded it as deserved by wrongdoers who merited punishment for criminal behaviour. Second, we believe it is likely to explain at least in part the apparent reluctance of patients to complain about any inappropriate behaviour, and may contribute to unwillingness even now on the part of former patients to revisit unpleasant episodes in order to report them.⁷⁵

Savile's personal conduct

6.26. It is clear from what many interviewees told us that Savile polarised attitudes among staff, and that many did not like him at all. Even those who did described to us some striking and unusual patterns of behaviour, which played an important part in how he was viewed and his influence in the hospital.⁷⁶

6.27. Savile could, we were told, undoubtedly be charming, persuasive and oddly charismatic, at least to some people, although others found him 'a showman',⁷⁷ 'bombastic',⁷⁸ 'charmless',⁷⁹ or 'arrogant'.⁸⁰ He was self-centred, narcissistic and grandiose, talking only about himself, his achievements (real or imagined) and the 'people in high places' he knew.⁸¹ He was described to us as extremely manipulative but lacking in human warmth and empathy, and he had no real friends. He was prone to bizarre exaggeration – for example even suggesting, we were told, that he had been the driving force behind the Major–Clinton Northern Ireland peace negotiations.⁸² We were also told that he was interested in 'juicy stories [about patients] which I would never tell him'.⁸³ He attended the funeral of a former director of nursing at Broadmoor dressed in a shell suit, and while there clowned around.⁸⁴ In the view of someone who worked closely with him, Savile 'couldn't care less about ... people ... never felt sorry for anybody'.⁸⁵ At least one psychiatrist at Broadmoor told us that she 'thought he had a major personality disorder',⁸⁶ and some nursing staff described him to us

⁷⁵ Lucy Scott-Moncrieff

⁷⁶ Former Broadmoor Hospital staff members (a), (f), (j), (p), Bob Barber, former head of security, Broadmoor Hospital

⁷⁷ Former Broadmoor Hospital staff member (z)

⁷⁸ Former Broadmoor Hospital staff member (p)

⁷⁹ Former Broadmoor Hospital staff member (f)

⁸⁰ Former Broadmoor Hospital staff member (a)

⁸¹ Former Broadmoor Hospital staff member (f); Bob Barber, former head of security, Broadmoor Hospital; Alan Franey, former general manager/chief executive, Broadmoor Hospital; Tony Backer-Holst, former head of forensic nursing, Department of Health

⁸² Bob Barber, former head of security, Broadmoor Hospital

⁸³ Harry Field, former director of nursing, Broadmoor Hospital

⁸⁴ *ibid.*

⁸⁵ Former member of mental health team, Department of Health (x)

⁸⁶ Dr Julie Hollyman, former chief executive of Broadmoor Hospital then of West London Mental Health NHS Trust

as ‘psychopathic’.⁸⁷ However, we found no evidence that staff regarded these concerns as sufficiently serious at the time to report them to others, and we believe it may be that they are being stated in stronger terms now than they were felt at the time, because of the inevitable re-evaluation that accompanies hindsight.

6.28. While some staff saw through these behaviours, it is clear from what we heard that many others tolerated them, and that Savile was able to exploit his ability to manipulate people and to create an aura of power and authority. On the basis of what we were told consistently, we conclude that he was particularly effective both at making staff believe that through his influence and ‘friends in high places’ he had the power to have them fired,⁸⁸ and at making patients believe that any complaint would only make their treatment worse.⁸⁹

Behaviour toward women

6.29. We heard a great many accounts, from both recipients and observers, of the way Savile would behave toward women from the first meeting. He would begin by kissing their hands and offering an extravagant greeting.⁹⁰ Depending on the reaction, this would typically progress to kissing up their arms to the neck, and even the lips. An informal note of a meeting attended by a Department of Health official concluded: ‘you might have warned me of [Savile’s] penchant for kissing ladies full on the lips’.⁹¹ We were told that the greeting might well include an inappropriate comment to the woman, for example that ‘many men in the hospital had been lusting after [her] body’.⁹²

6.30. Not surprisingly, many women told us that they were uncomfortable with this approach; but the almost universal reaction was that this was simply part of the ‘act’ he projected, that it was – in words that became depressingly familiar – ‘just Jimmy’.⁹³ In the light of subsequent knowledge, however, we believe that there is strong evidence that this approach was part of the way in which Savile ‘scoped’ the reactions of recipients and the degree of resistance that he might encounter. We heard that a strong reaction would cause him to stop at the hand-kissing stage,⁹⁴ while any lack of evident objection might cause him to try an embrace, as we heard from others and as he was seen to do with some female nurses.⁹⁵ Some on the receiving end of this behaviour told us that they found it ‘creepy’,⁹⁶ and

⁸⁷ Former Broadmoor Hospital staff members (b), (c); Bob Barber, former head of security, Broadmoor Hospital

⁸⁸ Former Broadmoor Hospital staff member (n)

⁸⁹ Former Broadmoor Hospital female patient (l)

⁹⁰ Former Broadmoor Hospital staff members (q), (r); Michael Morgan, former senior manager, Broadmoor Hospital; Dr Julie Hollyman, former chief executive, Broadmoor Hospital

⁹¹ Department of Health records Appendix 2A(iv)

⁹² Former Broadmoor Hospital staff member (q)

⁹³ Many interviewees, for example former Broadmoor Hospital staff member (q)

⁹⁴ Dr Julie Hollyman, former chief executive, Broadmoor Hospital

⁹⁵ Former Broadmoor Hospital staff member (k)

⁹⁶ Former Broadmoor Hospital staff member (i)

that it 'invaded personal space',⁹⁷ while at the same time noting that 'in those days culturally things were different'.⁹⁸

6.31. However creepy Savile's approach was perceived to be by the majority of women, it seems that there was a regular stream of visitors to his accommodation. In speaking to us, staff referred to his caravan and his flat⁹⁹ being used by young females, who would leave late in the evening; one described widespread gossip that he used it 'as a brothel',¹⁰⁰ although we heard no suggestion that other men were involved or that money changed hands. On the basis of what these staff told us, we conclude that the visitors to his accommodation probably included hospital staff, but not patients. An interviewee told us that, while a young nursing assistant, she had overheard conversations about Savile in the staff club, during which it was alleged that he would knock on nurses' bedroom doors and 'expect to be invited in to have sex'.¹⁰¹ Alan Franey, general manager of the hospital and a close acquaintance of Savile's,¹⁰² referred to a succession of women in their twenties; but, he said, there was no hint of anybody underage. Others, though, speculated to us about Savile's preference for younger girls: 'I'd say it was fairly widely commented that he had, if you like, a penchant for younger women'.¹⁰³ A former Broadmoor nurse said that nurses were warned by older colleagues to beware of allowing Savile near younger-looking females: 'don't leave young nurses alone with him, especially if they look about twelve years old'.¹⁰⁴ This suggests both a liking for younger women and a predatory aspect; but again, these accounts come with the benefit of hindsight, and are based on rumour and second-hand information. It seems clear from what we heard that no official reports or complaints were made (with the possible exception of the report we refer to in paragraph 6.42); certainly there is no surviving documentation of any, and we heard no direct evidence from anyone involved.

6.32. Nevertheless these concerns reached others outside Broadmoor, albeit as rumour and gossip. A Department of Health official in the team dealing with mental health policy in the 1980s told us that he had been aware of rumours of Savile's liking for 'maybe young ladies shall we say'.¹⁰⁵ He understood that the head of the team had challenged Savile for an assurance that, if he were nominated for a knighthood, there would be no embarrassing revelations. He apparently received a categorical assurance from Savile – but we found it instructive that he felt the need to issue the challenge.¹⁰⁶

6.33. It is important to be clear, however, that at this point there was no suspicion that the girls concerned were aged below 16, the legal age of consent. Another senior Department of Health official, James Collier, told the permanent secretary at the Department, Sir Kenneth

⁹⁷ *ibid.*

⁹⁸ *ibid.*

⁹⁹ Former Broadmoor Hospital staff member (h); Bob Barber, former head of security, Broadmoor Hospital

¹⁰⁰ Bob Barber, former nurse and head of security, Broadmoor Hospital

¹⁰¹ Former Broadmoor Hospital staff member (s)

¹⁰² Alan Franey, former general manager/chief executive, Broadmoor Hospital

¹⁰³ Former Broadmoor Hospital staff member (h)

¹⁰⁴ Former Broadmoor Hospital staff member (t)

¹⁰⁵ Alan Bacon, senior civil servant, mental health team, Department of Health

¹⁰⁶ *ibid.*

Stowe, that Savile had ‘got a reputation for picking up the girls. He goes around the country and it’s not very nice.’¹⁰⁷ In Sir Kenneth’s view, Savile was ‘a man of no repute whatsoever’, but ‘we had no indication whatsoever that he was in any way suspect of doubtful behaviour ... where he was involved in the National Health Service’.¹⁰⁸ There was ‘no reference at all’¹⁰⁹ that the girls may have been underage. We found no evidence, however, that either his reputation or his behaviour caused anyone at either Broadmoor or the Department of Health to question his suitability to be involved with the hospital.

Assaults

6.34. Fewer reports of sexual assaults have come to light at Broadmoor than in other spheres of Savile’s activity. We shall consider why this may be so later, but first we turn to those that were reported to us. We assured those who were assaulted that we would neither name them, nor provide information that could enable them to be identified, without their consent.

6.35. A male patient, A, aged 18 at the time, told us that he would regularly go to Savile’s flat to collect payment for washing cars. He said he was usually accompanied by the transport manager, Don Bennett, as he required an escort to go outside the secure perimeter. Bennett told us that he had no recollection of this. On one occasion Bennett was away, and A was encouraged by the staff member in charge to go to Savile’s accommodation alone, or he would miss his payment. He thought this must have been around March 1972. A described to us being coerced into giving Savile oral sex, recounting clearly the inner turmoil that this caused him, as well as the feeling that he had no alternative but to proceed, albeit unwillingly. Savile’s penis was not fully erect, and A kept stopping through fear of being caught. After some minutes, Savile said ‘ok’ and stopped him, without ejaculating. No physical force was used, and Savile did not touch him (Savile’s hands were behind his own head). A told us that he did not feel able either to say no at the time, or to complain afterwards, for fear of being labelled a troublemaker and because of Savile’s already considerable reputation around the hospital. This was a clear, detailed and convincing account.

6.36. A female patient, B, described to us an assault that took place in Broadmoor during a screening on television of *Top of the Pops* around 1971 or 1972. She said Savile regularly attended one of the wards in the Lancaster group on Thursday evenings at this time. Staff would be at the back of the day room, and patients and Savile would be toward the front. All would be watching the programme, which at that time was pre-recorded 24 hours in advance. Prior to redecoration in the late 1970s, the day room had a large sofa which blocked the view of those behind. This obstruction was regularly used by patients as a screen while they used a bucket kept in the day room as a makeshift toilet when access to toilet facilities was restricted. On this occasion, Savile sat out of view on the floor beside the sofa and assaulted B by placing his hand between her legs and groping her genitalia while she was watching the television. Staff could not see because the view was obstructed from the back of the room. He did not touch her elsewhere, no physical restraint was used, and he did not touch

¹⁰⁷ Sir Kenneth Stowe, former permanent secretary, Department of Health and Social Security

¹⁰⁸ *ibid.*

¹⁰⁹ *ibid.*

himself. The assault lasted two or three minutes. B did not feel able to complain, either then or later, for fear of being punished as a troublemaker. This was a clear, reasonably detailed and convincing account, and the method described fits with how Savile operated elsewhere.

6.37. A very young (pre-teen) boy visitor to Broadmoor, C, described to us how Savile exposed himself when they were alone in a League of Friends minibus in the mid-1970s. C rapidly made his escape and told nobody; but he felt that this experience may have contributed to his need for subsequent counselling. This was a brief incident, and there was little opportunity for C to provide detail, but his account was convincing.

6.38. Another female patient, D, gave an account of either four or five assaults by Savile on different days in 1987. She described him walking unaccompanied into the lounge area, where she was alone after having showered. D would habitually shower rapidly and return to the lounge while other patients were still bathing and while staff were either with them or having tea. Savile sat next to her and put his hand up her nightgown between her legs: 'he had his fingers inside of me'.¹¹⁰ At the same time, she said, 'he had his hands down his trousers and he was like playing with himself';¹¹¹ then he got up and walked out 'as if nothing had happened'.¹¹² There was no other contact and no physical restraint. The second occasion was 'exactly the same as the first time',¹¹³ as were the other two or three assaults. These accounts were colourless, and the exact repetition on several occasions, without any variation or further detail, is unconvincing. We believe, however, that this might, at least in part, reflect D's mental state at the time and the effect on it of an assault. D reported the first occasion to a member of staff and says that she was told to 'stop making things up or [she] would be in serious trouble'.¹¹⁴ She told us that as a result of this response she did not then report the subsequent incidents.

6.39. A third female patient, E, reported having been assaulted repeatedly in the early 1990s. She described Savile as regularly visiting wards where she was a patient, particularly Burnley and Sheffield wards. He was unaccompanied by staff and would sit in the day room and talk to patients while staff were elsewhere. While sitting with his back to other patients, Savile put his hand on E's leg and then, while still talking, proceeded to move it upwards and grope her genitalia. His clothes were shabby and dirty, unlike the image he projected on television. She was repelled but, because of her previous experience of being abused, 'froze' and felt guilty for allowing the assault to happen. Savile did not use restraint (but did not need to), and did not touch her elsewhere, or himself. E told a member of staff, who said she must have imagined it. Savile would assault her in the same way on several occasions over a period of weeks, before moving on to some other patient. Each time he arrived on the ward, she hoped he would not pick on her, but inevitably her turn would come around again. The cycle repeated itself several times. His approach to the other patients he assaulted – who, she said, tended to be the younger and more vulnerable women – was the same. E also described assaults on her and other patients, both physical and sexual, by male staff; these are the subject of separate police investigation. All these events caused significant distress to her and

¹¹⁰ Former Broadmoor Hospital patient

¹¹¹ *ibid.*

¹¹² *ibid.*

¹¹³ *ibid.*

¹¹⁴ *ibid.*

to others, and she attributes two patient suicides – one in Broadmoor and one later – in part to the effects of these events on vulnerable individuals. This was a clear, reasonably detailed and convincing account.

6.40. A fourth female patient, F, told a nurse at another hospital some time ago that she had been abused under the stage at Broadmoor, but neither the nurse nor anyone else at the other hospital could remember the name of the ex-Broadmoor patient. When we asked one of the people we interviewed about this, we were told that the account matched rumours going around among patients at the time. We have, unfortunately, been unable to interview the patient or even to discover who she was. However, the nurse's account of what the patient told her includes details both of Savile's access to wards, and of the perception current among patients that his acquaintance with senior staff rendered complaint pointless, that chime with what we heard from Broadmoor staff. The patient was reportedly at Broadmoor for 13 years.

6.41. A fifth female patient, G, told a journalist that she had been abused by Savile, had reported the attack to the charge nurse and had been placed in seclusion for speaking out. She also said that staff at Broadmoor during the 1970s and 1980s would, in effect, turn a blind eye to abuse claims and would often leave Savile alone with young girls. Unfortunately this patient did not wish to be interviewed.

6.42. We have an account from one ex-patient that in the mid-1990s he passed on to Franey complaints of sexual assault by Savile from three female patients, relating to a single day. He could not recall their names, and so we could not interview them. Neither Franey nor any of the Broadmoor staff involved with handling complaints in that period have any recollection of these complaints, and there is no extant record of them (we do not have a comprehensive archive for this period). The police have said that they fully investigated this allegation but could not identify the victims.

6.43. Two female members of staff described assaults. One, H, told us that in 1970 or 1971 she had been passing through the central hall when she was accosted by Savile, pushed up against a wall and embraced. Savile thrust his groin against hers through their clothing. She described the sexual nature of the contact as unmistakable and unwelcome. She struggled and he immediately released her. Patients and staff were present in the hall, as it was visiting time, and she felt embarrassed as well as angry at the assault. H did not feel this was worth reporting, given the climate at the time. Another staff member, J, told the police of an assault by Savile in 1999 or 2000. She did speak to us, but said she could add nothing: Savile had been rude and arrogant, wearing a Superman costume, and she described the assault as a brief 'groping', easily repulsed.

6.44. Broadmoor was indirectly associated with another assault, insofar as a member of staff was involved in the aftermath. A girl aged 14, K, whose mother knew Savile through his presence at Broadmoor (she knew some senior staff there) was invited to attend a television recording alone. She was assaulted in his flat in London by Savile, who asked if she liked it and desisted when she said no. K told us that when she got home she complained to her mother. A verbal message reached her mother through the transport manager at Broadmoor, Bennett, that Savile 'said to tell me that he was sorry',¹¹⁵ although there was no suggestion

¹¹⁵ Complainant

that Bennett knew to what the apology related. As the incident itself fell outside our remit, we did not seek further details of its nature.

6.45. Two other people, L and M, later reported to police that they had, on different occasions, been assaulted by Savile at Broadmoor. Both girls were 14 or 15 at the time, and were not patients. They did not tell anyone at the time of the assaults. They asked not to be interviewed by us.

6.46. A member of staff at another NHS hospital reported that Savile had told her that the happiest time he had ever had was with an unnamed 15-year-old against a wall at Broadmoor Hospital. This does not match any account that we have heard from a victim, and we believe it is most likely to have been a local resident and most unlikely to have been a patient. It is just possible that this person was M. Two additional second-hand reports were received by the police of unknown young females said to have had inappropriate contact with Savile; we have been unable to identify either, but we believe that they are most unlikely to have been patients.

6.47. In summary, leaving aside the indirectly associated incident (K) and the unnamed individual at paragraph 6.46, we have descriptions of serious assaults on six patients (A, B, D, E, F and G), two assaults on staff members (H and J), two assaults on minors (L and M), and one incident of indecent exposure to a minor (C). These are events which took place several decades ago and which, by their very nature, were unwitnessed. The six reported assaults on patients involved individuals whose mental health may have affected their interpretation or recall of events, and some did not wish to say more about what had happened. Nevertheless, we heard clear, strong, consistent and detailed accounts from five people (A, B, C, E and H), which lead us to conclude confidently that Savile abused them sexually. We heard one further account that was a little less convincing, perhaps reflecting the effect of the events described on a vulnerable individual (D). We conclude that it is more likely than not that this person was also sexually abused by Savile. In the case of two patients (D and E), these were repeated assaults. We were not able to test directly the strength and consistency of the accounts of the remaining five (F, G, J, L and M).

6.48. Our conclusions as to the veracity of these accounts are strengthened by the consistent nature of the descriptions we heard. These came from interviewees who, with very few exceptions, had no opportunity to collude: they were in Broadmoor at different times, had been admitted from different localities, and (so far as we were able to ascertain) their paths had not crossed following discharge. We tested each account by asking for details of time, place, surroundings and other circumstances, and received convincing and detailed responses, with the sole exception noted above. Where possible, we have checked times and locations with admission records and have verified what we heard.

6.49. In addition to these incidents, we heard convincing accounts of a pattern of inappropriate behaviour surrounding Savile's attendance on female wards at bath time and bedtime. Until at least the late 1980s, female patients would be obliged to strip while lined up in corridors – either where wardrobes held their clothing or outside bathroom areas. This would take place in view of staff, apparently for security reasons, before the patients could put on a nightdress or pass into the bathroom area.¹¹⁶ We heard that Savile followed a clear

¹¹⁶ Former Broadmoor female patients (I), (O); Alan Franey, former general manager/chief executive, Broadmoor Hospital

pattern of arriving on a female ward at just before this time, without using the ward front entrance. Unchallenged by staff, he would then watch from behind, as the row of female patients undressed. On occasion, according to several of those we spoke to, he would look in at the bathroom doorway and pass some crude comment, such as ‘you’ve got nice “Bristols”¹¹⁷ or ‘you don’t get many of those to the pound’.¹¹⁸ The behaviour of staff, who would watch patients change and bathe and who would pass derogatory comments, has also been described in previous reports as part of the institutional culture of high-security hospitals at the time.¹¹⁹

6.50. These accounts by patients may be doubted by those Broadmoor staff who resisted Savile’s attempts at persuasion and made sure that he was carefully escorted in patient areas. An important piece of corroboration came from a staff member who made a routine visit to Burnley Ward in 1990 or 1991, and, on leaving the ward, glanced into the day room. He was taken aback to see Savile sitting on a bench between two female patients. The room was otherwise unoccupied, but one staff member was standing outside the day room doorway, as if keeping watch. Both patients, Savile and the staff member jumped guiltily, as if surprised, and Savile challenged our interviewee, asking him what he was doing there. It may be significant that this staff member’s work clothes comprised a white shirt with epaulettes and dark serge trousers, an outfit not used by others, and he had previously been mistaken for a policeman. He did not witness any indecent behaviour, and thought no more of the incident at the time.¹²⁰

6.51. All of those we interviewed who had been involved with the official complaints system over the years confirmed to us that no complaint relating to Savile had reached them, and there is no surviving documentation to suggest that any did.¹²¹ Some staff suggested to us that this casts doubt on patient accounts,¹²² particularly as complaints about other matters were common, even if not always properly investigated.¹²³ We believe that this fails to take account of Savile’s ability to convince staff that he could have them dismissed, and patients that he had the power to make things worse for them, whether by increasing the harshness of the day-to-day regime or by hindering their discharge. One nurse put it graphically: ‘[staff] cannot go forward with any complaints, you had a tied house ... there is no question that [Savile] had the power to have you out, no question at all.’¹²⁴ We conclude that staff members’ perceptions of Savile’s power and influence within the hospital were a powerful incentive for them to discourage complaints from patients. This corresponds with the accounts given to us by several patients that they had been threatened with punishment for ‘troublemaking’ if they persisted.

¹¹⁷ Former Broadmoor Hospital female patient (l)

¹¹⁸ *ibid.*

¹¹⁹ Paper delivered at discussion event arranged by Kate Lampard, May 2013 (see paragraph 4.2 above)

¹²⁰ Former Broadmoor Hospital staff member (m)

¹²¹ Former Broadmoor Hospital staff members (e), (q), (u), (v); Harry Field, former director of nursing, Broadmoor Hospital; Alan Franey, former general manager/chief executive, Broadmoor Hospital

¹²² Former Broadmoor Hospital staff member (e)

¹²³ Dr Julie Hollyman, former chief executive, Broadmoor Hospital

¹²⁴ Former Broadmoor Hospital staff member (n)

6.52. Nevertheless, there were clearly rumours in the hothouse environment of Broadmoor. A former nursing assistant told us that he had heard rumours in the early 1980s that Savile molested patients, usually those whose mental state was affected by their condition.¹²⁵ From the accounts given to us, however, it seems clear that the rumours did not spread more widely at the time. The former chief executive of the High Security Psychiatric Services Commissioning Board, Ray Rowden, reported to us that he had been told by the chief executive of the hospital, Alan Franey, that Savile had a 'little secret',¹²⁶ a 'liking for young girls, the younger the better'.¹²⁷ This is strenuously denied by Franey,¹²⁸ and it is not clear whether 'the younger the better' was understood in any way to encompass those below the age of consent; but from other accounts we heard, it does not appear to us that, if the comment was made, it was considered sufficiently significant at the time to have been communicated to anyone else.¹²⁹ A nursing officer reported to the media that she had raised complaints about Savile at the time (in the late 1990s), but there is no record of any such complaints, and the human resources director at the time categorically denies that any adverse reports were made about Savile.¹³⁰ Franey does not recall being made aware of any complaints regarding Savile's behaviour, but would have expected any complaints to be dealt with by another member of the executive team.

6.53. We believe that the fact that fewer incidents have been reported from Broadmoor than from elsewhere reflects several important features of the hospital. First, people who have been patients in Broadmoor may not wish to recall their time there and may not want to risk others finding out that they were in the hospital. Second, some clearly recall being discouraged from reporting complaints or allegations, and may have no confidence that they will be listened to now.¹³¹ Some recall being treated harshly if they were seen as a 'troublemaker', and this may have left them disinclined to come forward now.¹³² Third, it seems that many of Savile's assaults took place opportunistically, and it may simply be that fewer opportunities presented themselves in the regimented and usually closely supervised environment of Broadmoor. Finally, patients stayed much longer in Broadmoor than in the great majority of hospitals, and many patients knew each other over a long period. The low turnover of patients reduced the number of potential victims, and the long patient stays increased the risk for Savile that two or more victims would compare notes if he were insufficiently cautious. Nevertheless, taking into account all that we have heard from staff and patients, we find no reason to doubt that Savile was an opportunistic sexual predator throughout the time of his association with Broadmoor Hospital, until he stopped visiting clinical areas around 2000.

¹²⁵ Former Broadmoor Hospital staff member (w)

¹²⁶ Ray Rowden, former chief executive, HSPSCB

¹²⁷ *ibid.*

¹²⁸ Alan Franey, former general manager/chief executive, Broadmoor Hospital

¹²⁹ Lady Anne-Marie Nelson, former chair of SHSA and later of the HSPSCB

¹³⁰ Kelvin Cheatle, former human resources director, Broadmoor Hospital

¹³¹ Some former patients subject to detention elsewhere may fear that if they are disbelieved this will be taken as evidence that they are not yet fit for discharge (Lucy Scott-Moncrieff; and former Broadmoor Hospital female patient (o))

¹³² Lucy Scott-Moncrieff

7. Savile's Involvement in the Management of Broadmoor

7.1. A unique feature of Savile's association with Broadmoor Hospital was his appointment to official positions in the management arrangements for the hospital, beginning in 1987. In order to understand the origin of this, it is necessary to consider briefly where responsibility for Broadmoor lay, as well as to return to the tension surrounding the need to introduce a more therapeutic and less custodial model of care.

7.2. Following the 1974 reorganisation of the NHS, Broadmoor and the other English special hospitals became the direct responsibility of the Department of Health and Social Security (DHSS). This was quite unlike the structure that applied to other NHS hospitals from 1974, which included an area or district health authority to manage the hospital, and a regional health authority to oversee the area or district health authority. Broadmoor's hospital management team, based on a medical director, nursing director and administrator, occupied the position of a district or area health authority in managing the hospital, but it had no health authority structure, board or membership, and lacked the administrative strength and capability to make decisions and tackle problems in the same way as a health authority. The oversight role that was undertaken by regional health authorities across the rest of the NHS fell to the DHSS, which was ill-equipped to carry out this task, since it lacked staff, expertise and experience to oversee hospital management directly (a function that it had only in relation to this one small part of the NHS). By the early 1980s, the Griffiths Report had replaced consensus administration with general management across the rest of the NHS,¹³³ throwing into sharper focus the lack of capability both within Broadmoor to manage services and within the DHSS to performance-manage the Broadmoor team.

7.3. Given the complex and challenging nature of Broadmoor and the other special hospitals, they would anyway have been left struggling in terms of management – even without the increasingly evident need for them to change their model of care. But the need for change, coupled with the strong and institutionalised reaction to it from the Prison Officers Association (POA), threatened to turn the lack of management capacity into a crisis, particularly at Broadmoor, where the union was at its strongest and most militant.

7.4. In 1986, when matters were beginning to come to a head, the senior civil servant in charge of mental health within the DHSS was Brian McGinnis. In his view, the DHSS could not hope to manage Broadmoor in any sense. He told us that it could '[keep] an eye on things, no doubt gave the Minister some kind of reassurance, would not have claimed to have been able to run the hospital and wrong that they should have attempted to try, it was not their job'.¹³⁴

¹³³ The Griffiths Report of 1983 led to the introduction of general managers with full individual managerial authority, accountable to their health authority

¹³⁴ Brian McGinnis, former head of mental health, Department of Health and Social Security

This might have sufficed had the hospital had a strong management team akin to a health authority, but it did not.

7.5. The initial DHSS response was to set up a hospital board in January 1987. This would incorporate the existing administrative team, with the addition of a chair, Sir David Brown, and some non-executives, one of whom was Savile. It is not clear now where the suggestion of a hospital board originated. We were unable to find any relevant papers; McGinnis told us that he now has no recollection, and in any case he delegated most operational matters to another member of his team, Margaret Edwards. Nor is it clear to us who proposed Savile. We heard that the other non-executives, including the chairman, were provided by ProNed, an organisation that was often used to find non-executives for NHS posts at the time. Ms Edwards told us that she recalled McGinnis meeting Savile at his office; McGinnis told us that this was at Stoke Mandeville, and recalled being impressed by Savile, who offered him a lift back to London, although he said that Savile talked of little else but himself on the drive.¹³⁵ Ms Edwards recalls McGinnis apparently considering that Savile would be an ‘unconventional’¹³⁶ appointment. It is important to recognise, however, that this was a non-executive position: the role would have involved contributing to board decisions and challenging hospital managers, but it was not itself a management role. The chairman, Sir David Brown, wrote to all board members, including Savile, allocating responsibilities. He did not offer Savile a policy role, but suggested that he ‘run a Christmas card competition ... for 1988’.¹³⁷ On the basis of this letter, it seems to us that Savile’s formal role on this board was limited.

7.6. By early 1987, however, McGinnis had left the DHSS. It must be noted that McGinnis has since been the subject of two allegations that have been made public. These allegations arose in the course of his voluntary sector work with disturbed and abused children, and both cases were dropped without charge. We regard any suggestion that McGinnis had some ulterior motive in regard to Savile’s Broadmoor role as highly unlikely, given that no interviewee reported any social contact or rapport between the two and they met only the once.

7.7. McGinnis’s replacement was another senior civil servant, Cliff Graham (now deceased), a central figure in the development of new management arrangements and Savile’s place within them. Graham had worked with Griffiths on the NHS Management Review, and took a much more entrepreneurial approach than the strategic and more traditional McGinnis.¹³⁸ Staff who knew and worked closely with him told us that he acted ‘shall we say less bureaucratically and more informally than other undersecretaries’,¹³⁹ and was not interested in details, but was a ‘big picture man’.¹⁴⁰ From the DHSS documents we have seen, Graham’s view was that none of the special hospitals was being run effectively, and that new management arrangements were required.¹⁴¹ Broadmoor was a particular problem because

¹³⁵ *ibid.*

¹³⁶ Margaret Edwards, senior civil servant, mental health team, Department of Health and Social Security

¹³⁷ Appendix 2A(ii)

¹³⁸ Former member of mental health team, Department of Health (x)

¹³⁹ Alan Bacon, senior civil servant, mental health team, Department of Health

¹⁴⁰ Margaret Edwards, senior civil servant, mental health team, Department of Health and Social Security

¹⁴¹ DHSS papers

of the degree of unrest surrounding the POA and overruns of time and cost with a major redevelopment, and required more urgent action.

7.8. It is clear to us from the surviving documents and from what members of the DHSS mental health team told us that Graham met Savile at this stage, probably in Broadmoor, and that Graham and Savile formed a close working relationship. Alan Bacon, a member of Graham's team, described the relationship: 'Cliff [Graham] found that [Savile] was a man of considerable understanding, insight and intelligence and actually developed quite a respect for him.'¹⁴² Graham 'was increasingly mentioning Jimmy Savile as someone who had an idea what was going on there and could make what Cliff [Graham] regarded as insightful comments'.¹⁴³ Graham would talk over issues with Savile – not just to do with hospitals – and Savile would 'cut to the chase'¹⁴⁴ and simplify problems. Graham would then be able to see his way to a solution. Increasingly, the solution did not include the existing Broadmoor board: Graham 'could be a thug when he wanted to be',¹⁴⁵ and Bacon told us that he did not think Graham 'got on terribly well with some of the people that managed Broadmoor at that time'.¹⁴⁶ Graham did, however, remain on very close terms with Savile, according to what we were told,¹⁴⁷ and we heard from one of Savile's personal assistants that Savile took Graham to Buckingham Palace when his knighthood was conferred.¹⁴⁸

7.9. As is clear from surviving documentation, Graham's solution to the management problems was to set up a new Special Hospitals Service Authority to stand over the three hospitals, Broadmoor, Rampton and Ashworth, each of which would have its own management team, headed by a general manager who reported to the SHSA. To address the urgent problems at Broadmoor, he established a task force to sweep away the previous board and take over running of the hospital. In the view of those members of the DHSS mental health team to whom we spoke, both the idea of the task force and the emergence of Savile as a leading member of it fitted with Graham's entrepreneurial approach and liking for unconventional solutions. 'Cliff [Graham] would have thought that [Savile] was exactly the sort of person who should be harnessed to get something changing',¹⁴⁹ particularly as he 'might be able to talk turkey with the POA'.¹⁵⁰

7.10. These changes crystallised over the summer of 1988, at a time when the DHSS was about to split into the separate Department of Social Security and Department of Health (the decision to separate them was announced in July). New ministerial responsibilities were being put in place for the start of parliamentary business in September. Because all the incoming ministers had pre-planned leave that summer (which disrupted the ministerial cover

¹⁴² Alan Bacon, senior civil servant, mental health team, Department of Health

¹⁴³ *ibid.*

¹⁴⁴ *ibid.*

¹⁴⁵ *ibid.*

¹⁴⁶ *ibid.*

¹⁴⁷ Tony Backer-Holst, former head of forensic nursing, Department of Health; Alan Franey, former general manager/chief executive, Broadmoor Hospital

¹⁴⁸ Janet Cope, Savile's Personal Assistant at Stoke Mandeville hospital until 1999

¹⁴⁹ Margaret Edwards, senior civil servant, mental health team, Department of Health and Social Security

¹⁵⁰ *ibid.*

arrangements planned by DHSS), during August all Department of Health business was the temporary responsibility of one minister, Edwina Currie, who described herself as being left as the sole minister ‘covering’, but doing a lot of it from Yorkshire; Broadmoor was just one issue among many.¹⁵¹ The senior civil servant to whom Graham reported was on leave in August.¹⁵²

7.11. Drawing on the accounts of those we spoke to in his former team, it seems to us that this situation would have suited Graham. He was a ‘highly political animal’¹⁵³ who liked to engage directly with ministers and tell them what he thought they should do. The Department of Health’s head of forensic nursing told us that he thought Graham ‘saw an opportunity’¹⁵⁴ that summer. Graham established the task force for Broadmoor, formally chaired by himself in London, but in practice to be run by Savile in Broadmoor, and briefed ministers retrospectively (on 30 August, ‘for their return after the [parliamentary] recess’¹⁵⁵) on the urgent need for the interim approach when Parliament resumed. Savile was now in a position to tell Broadmoor staff with some justification that he was running the hospital.

7.12. Mrs Currie then took on ministerial responsibility for mental health services, including the special hospitals, and inherited the changes that had been put in place. When she spoke to us, she was clear that Graham was ‘very much the lead on all of this’,¹⁵⁶ and that over the summer ‘[he] was just running things by himself for a couple of months’.¹⁵⁷ She was less clear on her understanding of Savile’s remit, but told us that, if he was more than a figurehead, it was only for a few months on an interim basis.

7.13. However, she then met Savile, at his request, at the end of a ministerial visit in September 1988. The site of the visit is not clear, but it was somewhere in either the Wessex or the Oxford region, as she was accompanied by the regional principal for those regions. It may have been at Stoke Mandeville, and the meeting with Savile appears to have been arranged at short notice, because she asked the official to accompany her as an afterthought. The note of the meeting confirms that the main topic of discussion was Broadmoor.¹⁵⁸ Savile claimed to have discovered widespread abuse of overtime by Broadmoor staff, and that families were occupying subsidised hospital accommodation, although they were no longer entitled to it. He also suggested that £5 million had ‘disappeared’ from the building programme. He intended to use this information to bring the POA to heel.

7.14. In Mrs Currie’s view, ‘he’d had a look at everything he could use to blackmail the POA ... I thought it was a pretty classy piece of operation. He knew how to pin people to the wall and get from them what he wanted ... hopefully that would mean that they would stop fiddling the overtime.’¹⁵⁹ The principal question was ‘how can [the government] break this hold that

¹⁵¹ Edwina Currie, former parliamentary under secretary of state for health

¹⁵² Sir Christopher France, permanent secretary, Department of Health; Strachan Heppell, senior civil servant, Department of Health

¹⁵³ Tony Backer-Holst, former head of forensic nursing, Department of Health

¹⁵⁴ *ibid.*

¹⁵⁵ Briefing document from Cliff Graham to ministers, Department of Health (see Appendix 2A(iii))

¹⁵⁶ Edwina Currie, former parliamentary under secretary of state for health

¹⁵⁷ *ibid.*

¹⁵⁸ Department of Health records Appendix 2A(iv)

¹⁵⁹ Edwina Currie, former parliamentary under secretary of state for health

POA has on the hospital?'¹⁶⁰ Government was determined to be 'tough in everything but at the same time we needed to come up with ideas of exactly how you would improve the lives of patients ... so this task force idea was dreamed up and seemed like a very good idea, and step forward Jimmy Savile who knew the place backwards and was more than happy to volunteer his time to do this. And we were happy to do it.'¹⁶¹

7.15. We have found no trace of any other papers that consider the benefits and drawbacks of giving Savile a management position in this way, or that consider alternatives, although that would have been usual at the time.¹⁶² In fact, there are few Department of Health policy papers on any of these changes, other than the retrospective briefing. A member of Graham's staff told us that she was confident that there had been no submission to ministers, and that this fitted with Graham's usual style of working.¹⁶³ Other interviewees commented to us on Graham's impatience with process, and his habit of retaining few papers. His successor, Clive Wilson, told us that he questioned the lack of surviving paperwork with the policy team in the Department, and was told that 'Cliff [Graham] tends to do that [pass on few papers] when he leaves a job'.¹⁶⁴

7.16. We found no official papers suggesting any allegations of sexual abuse by Savile, and we found no evidence to suppose that ministers or officials may have suspected it. In our view, Savile's appointment to the task force was strikingly unusual because of his background, but not because any suspicion of sexual abuse was ignored or overlooked.

7.17. One curious feature of the paperwork that does exist suggests to us that Graham felt some concern over how the appointment of Savile to a significant management position in the hospital would be perceived within the Department of Health: almost always when he mentioned Savile, Graham was careful to refer to him as 'Dr Savile'.¹⁶⁵ Savile's degree was an honorary one, an LLD (honoris causa) from Leeds University, and, as Graham must have been aware, recipients of honorary degrees are advised that they do not confer use of a title such as 'doctor'.

Savile's management role in Broadmoor

7.18. The role of the task force was, we were told, not well communicated or understood within Broadmoor,¹⁶⁶ although Savile himself was quick to claim through the press that he was in charge of the hospital.¹⁶⁷ In keeping with his previous approach to staff at the hospital, he used the position to strengthen the impression that he was close to government ministers and

¹⁶⁰ *ibid.*

¹⁶¹ *ibid.*

¹⁶² Former member of ministerial private office staff, Department of Health (y)

¹⁶³ Former member of mental health team, Department of Health (x)

¹⁶⁴ Clive Wilson, former head of mental health, Department of Health

¹⁶⁵ Department of Health records

¹⁶⁶ Former Broadmoor Hospital staff members (b), (c)

¹⁶⁷ Contemporaneous press articles

Department of Health officials, and was therefore in a position of authority.¹⁶⁸ The familiarity and close contacts that he claimed with senior members of the government were, we were told, seen by those within Broadmoor as ‘conferring power on him’.¹⁶⁹ He may have had some justification for this: one surviving piece of briefing prepared in October 1988 by Cliff Graham, headed ‘For the PERSONAL attention of Mrs Currie’, was in preparation for a private meeting between himself, the minister and Savile, reporting on the task force’s first month of progress and setting out a list of points which ‘Dr Savile will raise for further action’.¹⁷⁰ In November 1988, Mrs Currie said in a press release ‘Under Jimmy Savile’s guidance, shifts in attitude and pattern and delivery of service have already been achieved. He is an amazing man and has my full confidence.’¹⁷¹

7.19. We were told that Savile boasted that he had got rid of ‘a few troublemakers’¹⁷² during this period. However, the only evidence we could find for his role in any staff changes is in an annex to a brief for ministers in February 1989: ‘... as a direct result of Mr Savile’s determined, and at times ruthless, leadership ... 15 militant senior nurse managers are set to leave the hospital’.¹⁷³ This may simply have reflected the way in which Savile presented the changes to Graham. There were certainly changes to senior staff, with the removal of the previous hospital management team from their roles, but these were handled by Graham, as they would have to have been.¹⁷⁴ It is not clear from what we heard how far Savile was able to influence Graham in these changes.

7.20. Interviewees told us consistently that Savile’s appointment to the task force was based in large part on his perceived usefulness in being able to resolve what was described to us as the ‘festering sore’¹⁷⁵ of the POA’s obstruction of change within Broadmoor. At the meeting in September 1988 between Savile and Mrs Currie, documented by the official she co-opted to accompany her, Savile had suggested that he would do this by confronting POA members with knowledge of fraudulent overtime claims and inappropriate occupation of hospital accommodation.¹⁷⁶ Mrs Currie said that accommodation being ‘illegally occupied by what amounted to a racket run by the union was like manna from heaven’,¹⁷⁷ and Savile ‘warned them [he] would go to the *Sun* and tell them about it if they don’t do as we wanted’.¹⁷⁸ Yet staff at the time painted a different picture to us when they were interviewed. Savile, they said, took no action in response to issues raised by POA members. One senior manager who worked with Savile on the task force, Mick Morgan, described Savile’s relationship with the POA

¹⁶⁸ Former Broadmoor Hospital staff members (b), (c); Michael Morgan, former senior manager, Broadmoor Hospital; David Lee, former security manager, Broadmoor Hospital

¹⁶⁹ David Lee, former security manager, Broadmoor Hospital

¹⁷⁰ Department of Health records

¹⁷¹ Department of Health records

¹⁷² Savile’s PA

¹⁷³ Briefing by Cliff Graham to ministers, Department of Health records Appendix 2A(vi)

¹⁷⁴ John Roberts, former administrator, Broadmoor Hospital

¹⁷⁵ Tony Backer-Holst, former head of forensic nursing, Department of Health

¹⁷⁶ Department of Health records Appendix 2A(iv)

¹⁷⁷ Edwina Currie, former parliamentary under secretary of state for health

¹⁷⁸ *ibid.*

in terms of listening to them but doing nothing.¹⁷⁹ When we interviewed POA officials from the time, they told us that Savile had not used threats, and that he had not brought about a change of approach by the POA.¹⁸⁰ A disruptive work to rule was ended shortly after the task force was established, though POA officials told us that this was because a significant offer had been made by the Department of Health (which we know that Graham negotiated with the Treasury¹⁸¹) on allowances, and a compromise had been reached on a new and less warder-style uniform, which former POA officials said was their suggestion.¹⁸² On the other hand, we did hear an account that the Department of Health's head of forensic nursing was summoned to an urgent meeting with the POA at Broadmoor one Saturday, only to arrive and find Savile having a private meeting with some of the management participants. It then transpired that the official's presence was no longer required at the meeting with the union – a meeting at which agreement with the POA was quickly reached. When he telephoned Graham to report what had occurred, Savile took the phone and also reported to Graham in a manner that reinforced the impression that Savile and Graham were on very close terms: 'they were obviously very great chums ... no question about it from the dialogue I was privy to obviously'.¹⁸³

7.21. Newspapers reported in early 1989 that Savile was 'masterminding the release' of 60 patients.¹⁸⁴ In fact, this would have meant their transfer to lower-security hospitals or hostels. The difficulty of finding places in lower-security units for Broadmoor patients who, psychiatrists judged, no longer required high-security is a recurring theme in documents from the time. We found no evidence, however, from staff we interviewed or from documents, that Savile had any role in such transfers at that time.

7.22. We find it impossible to assess after this length of time (and the death of several key participants) whether Savile really did have any effect on relationships with the POA, or whether he attempted to make use of the supposed information that he had concerning fraud within the hospital. It is certain that any lull in union activity was only temporary, as poor industrial relations continued to plague the hospital for some time to come. The suggestion that Savile did have knowledge of fraud and may have sought to use it in this way does, however, raise a question concerning the appropriateness of this approach and its implicit sanctioning by a government minister. In effect, it was based on tolerating fraudulent and possibly illegal activity in exchange for greater compliance from the POA, when the activity should have been investigated and dealt with properly. Mrs Currie told us that this was how it was done at the time,¹⁸⁵ but when we asked the then secretary of state for health, Kenneth Clarke, he told us that he doubted that this was a defensible approach at any time.¹⁸⁶ If true, it would, of course, have given Savile a hold over staff that he could have misused in other ways.

¹⁷⁹ Michael Morgan, former senior manager, Broadmoor Hospital

¹⁸⁰ Former Broadmoor Hospital staff members (b), (c)

¹⁸¹ Department of Health records

¹⁸² Former Broadmoor Hospital staff members (b), (c)

¹⁸³ Tony Backer-Holst, former head of forensic nursing, Department of Health

¹⁸⁴ Contemporaneous press articles

¹⁸⁵ Edwina Currie, former parliamentary under secretary of state for health

¹⁸⁶ Kenneth Clarke, former secretary of state for health

Appointment of a general manager

7.23. As the previous hospital management team had been stood down, Cliff Graham sought to identify replacements, initially as part of the task force. The key post was the hospital administrator position. As surviving documents make clear, Graham envisaged the hospital administrator becoming a general manager leading the management team, in line with changes that the rest of the NHS had introduced in 1984, following the Griffiths Report. We believe it is inconceivable that Graham would not have discussed this with Savile, given their close working over Broadmoor and Savile's role on the task force, and an acquaintance of Savile's emerged for this position, Alan Franey. Franey had been a deputy house governor at Leeds General Infirmary,¹⁸⁷ where he had met Savile and done charity runs with him, and a hospital secretary in London.¹⁸⁸ He was currently the deputy secretary to the board of the National Institute for Biological Standards and Control.¹⁸⁹ We believe that, by most standards, this was not a recent career that demonstrated immediate suitability to run a large and complex hospital, let alone one with as challenging a set of problems as Broadmoor at that time: a general manager position is a considerable step up from deputy administrator. Franey's reference from his employer included the observation that 'Franey is friendly and in touch with Mr JS ... [the referee and his superior] think Franey could do a good job with guidance, e.g. from Mr JS'.¹⁹⁰ We found it surprising that the general manager of Broadmoor would be expected to rely on guidance from Savile.

7.24. Surviving documents make it clear that Franey was invited to meet Graham, Savile and another senior civil servant, James Collier, to discuss the general manager position. The meeting took place at the Athenaeum Club in London, and Franey was offered the post on an interim basis, initially on a six-week secondment,¹⁹¹ with a brief to 'change [Broadmoor] or close it'.¹⁹² Another member of the Department of Health staff suggested to us that Savile also met the minister, Mrs Currie, at the Department of Health at this time,¹⁹³ but Mrs Currie told us she had no recollection of this meeting and we could find no record of it.

7.25. Subsequently a selection process was undertaken to make substantive appointments to the general manager positions at all three high-security hospitals. In a submission dated 29 June 1989, Graham briefed the responsible minister, by now Roger Freeman, on candidates for all 3 hospitals. His brief said that Franey was the only candidate that the Special Hospitals Service Authority could shortlist for the Broadmoor position, and that 'Mr Savile will press for Mr Franey' to be appointed at Broadmoor.¹⁹⁴ Five months earlier, in January 1989, Savile had already written to Graham before the selection process describing

¹⁸⁷ Alan Franey, former general manager/chief executive, Broadmoor Hospital; Alan Bacon, senior civil servant, mental health team, Department of Health

¹⁸⁸ Alan Franey, former general manager/chief executive, Broadmoor Hospital

¹⁸⁹ Department of Health records

¹⁹⁰ Department of Health records

¹⁹¹ Department of Health records

¹⁹² A Franey, *Managing High Security Psychiatric Care*, 1998, p35

¹⁹³ Former member of mental health team, Department of Health (x)

¹⁹⁴ Cliff Graham submission to Roger Freeman, 29 June 1989 (see Appendix 2A(vii))

Franey as 'General Manager, designate, to be confirmed'.¹⁹⁵ Franey's position was then made substantive.

7.26. Senior staff at the hospital were in no doubt about what had happened. Franey, we were told, 'was brought in by Jimmy [Savile] and effectively rubber stamped into a formal position'.¹⁹⁶ The selection process may have crossed the responsible minister's desk, as is suggested by surviving Department of Health reports,¹⁹⁷ but it is clear that Graham took the lead responsibility, and the prevailing view was that 'politicians should not interfere in appointing people'.¹⁹⁸ We conclude that, through Graham, Savile significantly influenced the selection of Franey for the post of general manager.

7.27. Although some interviewees suggested to us that the relationship later cooled,¹⁹⁹ Franey and Savile clearly worked together closely at first,²⁰⁰ and we believe, on the basis of the majority of the accounts we heard, that they remained close acquaintances throughout. We were told that staff who were close to Savile used him to pass things on to Franey about how the hospital operated, as well as gossip.²⁰¹ Franey rang Savile regularly when he was at Stoke Mandeville, asking for 'the godfather'.²⁰² Savile would 'hold court' in his accommodation for staff who wanted to talk to him about work²⁰³ and their personal problems,²⁰⁴ and it seems very likely to us that all of this played straight into Savile's hands as an extremely effective manipulator of people. Staff told us that they believed he had a significant role in running the hospital.

7.28. As far as we are able to tell, Savile seems to have had no hand in guiding the direction of the hospital, and no view on what that direction should be, so his motives in behaving in this way are difficult to understand. It is clear from several accounts that process bored Savile. We were told that, in the brief period in which the hospital board operated before the task force replaced it, Savile would attend meetings only reluctantly and would remain detached, facing away from other members, not engaging with them or the chairman,²⁰⁵ and often feigning sleep.²⁰⁶ We were told that he 'never ever wrote a letter'²⁰⁷ and any he signed had been written by somebody else.²⁰⁸ What he did do, we heard, was to intervene selectively from time to time on single issues, usually of a rather trivial or localised nature that for some

¹⁹⁵ Department of Health records Appendix 2A(v)

¹⁹⁶ Michael Morgan, former senior manager, Broadmoor Hospital

¹⁹⁷ Department of Health records Appendix 2A(v)

¹⁹⁸ Edwina Currie, former parliamentary under secretary of state for health

¹⁹⁹ Former member of mental health team, Department of Health (x)

²⁰⁰ Jim Finney, external member of Hospital Advisory Committee, Broadmoor Hospital

²⁰¹ Bob Barber, former nurse and head of security, Broadmoor Hospital

²⁰² Janet Cope, Savile's Personal Assistant at Stoke Mandeville hospital until 1999

²⁰³ Alan Franey, former general manager/chief executive, Broadmoor Hospital

²⁰⁴ Former member of mental health team, Department of Health (x)

²⁰⁵ Margaret Edwards, senior civil servant, mental health team, Department of Health

²⁰⁶ Former Broadmoor Hospital staff member (aa)

²⁰⁷ Former member of mental health team, Department of Health (x)

²⁰⁸ *ibid.*

reason interested him. We were told, for example, of how he championed fridges for wards and managers' offices, and became involved in individual personnel disputes.²⁰⁹

7.29. To the outside world, however, Savile continued to present himself as an important part of the management arrangements at Broadmoor.²¹⁰ Once the Special Hospitals Service Authority began to operate effectively, and once Franey was confirmed as general manager of Broadmoor, the task force was wound up. At Graham's insistence,²¹¹ Savile was given a new role as chairman of the Hospital Advisory Committee (HAC), set up in October 1989 as a sub-committee of the SHSA. This committee was unusual in combining roles liaising between patients, management and the local community, 'counter-acting any tendency towards the hospital becoming institutionalised and introspective',²¹² with a statutory responsibility as 'hospital manager' for certain categories of detained patients. This raises the alarming prospect that Savile, with no relevant experience, expertise or training, was chairing the body responsible for the discharge of patients from Broadmoor. In light of this concern, we were careful to question those interviewees who had direct knowledge of the HAC about its function, and searched for relevant documentation among the records. Although we could find nothing relevant among remaining documents, interviewees told us clearly that the HAC regarded its role as purely advisory, making recommendations to the responsible medical officer, who had the final say on discharge.²¹³ We also heard that Savile would take little interest in the meetings and would only rarely express an opinion.²¹⁴

General management of Broadmoor

7.30. In our view, it is impossible to examine Savile's position in the hospital and his ability to exploit it without understanding Franey's role in the management of the hospital. The two were close associates, Savile was influential in Franey's appointment, and Franey was in overall charge of the hospital and its policies and procedures from 1989 to 1997.

7.31. There is widespread agreement among those we spoke to that setting up the SHSA and appointing general managers was a necessary step in improving the running of the special hospitals and moving to a more therapeutic approach to care. Initial reports from Broadmoor suggested progress, and indicated that Savile had played a significant part. According to Mrs Currie, '[w]e had nothing from Broadmoor except positive feedback. Admittedly much of that positive feedback came from Jimmy himself.'²¹⁵ On the basis of the evidence that we saw and heard, however, there is an obvious discrepancy between the picture that Savile presented to the outside world of his involvement with the task force and what he actually did. Although we were told repeatedly that Savile represented himself to staff as an important member of the task force, interviewees with knowledge of how it

²⁰⁹ Harry Field, former director of nursing, Broadmoor Hospital

²¹⁰ Contemporaneous press articles

²¹¹ Department of Health records Appendix 2A(vi)

²¹² Department of Health records

²¹³ Tony Backer-Holst, former head of forensic nursing, Department of Health; Lucy Scott Moncrieff; Finney, external member of Hospital Advisory Committee, Broadmoor Hospital

²¹⁴ Former member of mental health team, Department of Health (x)

²¹⁵ Edwina Currie, former parliamentary under secretary of state for health

worked told us that, with only a few exceptions, he left the running of the hospital to others, particularly Franey.²¹⁶ Some outside the hospital were also sceptical about Savile's role. A former permanent secretary who had retired some years before the task force was set up, Sir Kenneth Stowe, said that 'it would not have occurred to me then nor did it occur to me subsequently that Jimmy Savile was the kind of person you wanted to be there'.²¹⁷

7.32. From the evidence we heard, it seems to us that, despite initial enthusiasm from some both inside and outside the hospital about Franey's approach,²¹⁸ there was a lack of sustained progress at Broadmoor. We were told that the closed institutional culture proved as hard to change as ever, and resistance grew to the changes that Franey was trying to make. Staff told us that they doubted his credentials to run a hospital such as Broadmoor.²¹⁹ During this period in the early 1990s, Savile remained a significant presence for staff in the hospital, although Franey himself told us that he doubted whether Savile did anything but 'hold court' in his accommodation, and denied that he consulted Savile, although he said he was aware that staff visited him to 'yakk'.²²⁰

7.33. Nevertheless, we were told that Savile 'had been given huge power and credence at some point along the way ... quite a lot of the staff knew him quite well',²²¹ and it seems clear to us that he continued to be perceived as influential. The then head of security, Bob Barber, told us that he was asked at short notice to take over a major exercise on nurse re-grading that all hospitals were required to carry out, and found himself struggling to cope with the additional workload. He spoke to Savile, who instructed him to stop the work; then, following a visit from two Department of Health officials, Broadmoor was temporarily exempted from the national requirement to re-grade nursing staff.²²² Whether or not this was a direct result of Savile's intervention, staff certainly believed it to be so, no doubt encouraged by Savile himself, and we found it significant that a senior member of staff accepted an instruction of this nature from Savile. This constitutes one of the very few examples we were told about where Savile appears to have intervened directly in the running of the hospital. However, he also continued to use his position to take part in some surprising events, including, we were told, the pre-interview reception for a new director of nursing,²²³ ward case conferences,²²⁴ a staff briefing before a night drugs search of the hospital,²²⁵ and Christmas ward rounds²²⁶ (following one of which he was criticised for supplying alcohol to patients on one ward).

²¹⁶ Former Broadmoor Hospital staff members (b), (c); Bob Barber, former head of security, Broadmoor Hospital; Alan Franey, former general manager/chief executive, Broadmoor Hospital

²¹⁷ Sir Kenneth Stowe, former permanent secretary, Department of Health and Social Security

²¹⁸ Lucy Scott-Moncrieff

²¹⁹ Former Broadmoor Hospital staff members (b), (c)

²²⁰ Alan Franey, former general manager/chief executive, Broadmoor Hospital

²²¹ Dr Julie Hollyman, former chief executive, Broadmoor Hospital

²²² Bob Barber, former head of security, Broadmoor Hospital

²²³ Harry Field, former director of nursing, Broadmoor Hospital

²²⁴ Former Broadmoor Hospital staff member (k)

²²⁵ Former Broadmoor Hospital staff member (bb)

²²⁶ David Lee, former security manager, Broadmoor Hospital

7.34. Savile continued to command some respect in Department of Health circles, and any knowledge that Broadmoor staff may have had of this would have reinforced his credibility within Broadmoor. For example, Savile was an adviser to the NHS Chief Executive’s Award Scheme in the early 1990s; and Graham recommended him for a role in Ashworth in late 1988, similar to the role he then had Broadmoor, as well as for appointment as chairman of the new Stoke Mandeville NHS Trust in 1993.²²⁷

7.35. The newly appointed director of nursing at this time, Harry Field, said that he found Savile ‘a very strange man’,²²⁸ and was concerned at his continued role in the hospital: ‘[He] used to say to [Franey] what is [Savile] doing, he is going round pretending that he is in charge of the whole shop talking to patients and staff in a way like he is in charge.’²²⁹

7.36. It was clear to us from what we were told that frustration continued to grow on the part of the overseeing bodies, the Department of Health, the SHSA, and then the High Security Psychiatric Services Commissioning Board that followed it, concerning the approach adopted by many staff to patients.²³⁰ Staff at this time were described to us as wearing ‘black prison officers uniform and also the staff had watched too many American movies because their hair was all cropped and [they] had mirrored sunglasses on with all their tattoos showing’.²³¹ This strongly custodial approach, which focused on guarding prisoners rather than caring for patients, is evident in contemporary reports on special hospitals, including Broadmoor – in particular in reports by Boynton,²³² Fallon,²³³ the Health Advisory Service²³⁴ and Blom-Cooper.²³⁵

7.37. Moreover, Franey’s conduct in the hospital was, we were told, giving rise to concern. He occupied hospital accommodation during the week, returning home on a Friday afternoon. Stories began to circulate widely in the hospital, as we heard from many interviewees, that during the week female members of staff visited his house after hours, often for prolonged periods.²³⁶ We were told, for example, that Franey had ‘quite a life with some of our staff’,²³⁷ and that he ‘put it about a bit’ and was using his accommodation for ‘inappropriate activities’.²³⁸ Staff told us that the circulation of these stories repeatedly over time was

²²⁷ Department of Health records

²²⁸ Harry Field, former director of nursing, Broadmoor Hospital

²²⁹ *ibid.*

²³⁰ Lady Anne-Marie Nelson, former chair of SHSA and later of the HSPSCB ; Ray Rowden, former chief executive, HSPSCB

²³¹ Former Broadmoor Hospital staff member (x)

²³² Sir John Boynton, *Report of the Review of Rampton Hospital*, 1980, Cm 8073

²³³ P Fallon, R Bluglass, B Edwards and G Daniels, *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*, 1999, Cm 4194-ii

²³⁴ NHS Health Advisory Service/DHSS Social Services Inspectorate, *Report on the Services Provided by Broadmoor Hospital*, 1998

²³⁵ Sir Louis Blom-Cooper, *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*, 1992, Cm 2028

²³⁶ Former Broadmoor Hospital staff members (j), (aa), (cc); Kelvin Cheatle, former human resources director, Broadmoor Hospital

²³⁷ Former member of staff, Broadmoor Hospital (j)

²³⁸ Kelvin Cheatle, former human resources director, Broadmoor Hospital

disruptive, and we heard that some nurses would discuss sexual liaisons as if these gave them an advantage over other staff.²³⁹

7.38. Franey denied these allegations to us, and claimed that the various stories of 'about fifty' affairs were attempts by those opposed to change to discredit him.²⁴⁰ We are in no doubt that Broadmoor could be a hostile environment for someone perceived as an outsider, such as Franey, and we heard reports of damage to his car. It is clear to us on the basis of several accounts, however, that staff criticism of Franey's personal behaviour reached senior members of the management team, who told us that they gave it credence.²⁴¹ Stories of Franey's behaviour also spread outside Broadmoor: Department of Health officials recorded the accounts and their concern over the effect on the hospital in a written briefing,²⁴² as did a senior member of staff at the High Security Psychiatric Services Commissioning Board, Dr Dilys Jones, in a letter to her chief executive.²⁴³

7.39. It is not necessary for us to form a view on whether there is any substance to these stories or not, and there is only second-hand evidence to suggest that there may be. What is important, however, is that many staff, at all levels of the organisation, thought that there was substance to them, and regarded this as damaging to Franey's stature and credibility. We believe, on the basis of what we heard and the documentary evidence of concern outside the hospital, that there is a strong probability that this perception impaired the general manager's ability to lead the organisation and generate much needed improvement in the institutional culture. We also conclude on the basis of the evidence we heard from staff that it encouraged the view among some staff that inappropriate sexual behaviour could be tolerated, and that there was no point in reporting it to the management team.²⁴⁴ One particular case was to prove far reaching.

The Hill case

7.40. Elizabeth Ann (Liz) Hill was, we were told by former staff,²⁴⁵ regarded as a good nurse and had been promoted to nursing officer. This was, according to what we were told, despite her history of having had lesbian relationships with women in her care. Her former ward sister when she was a staff nurse described this to us as a recurring pattern of behaviour, leading on one occasion to a fight outside the main entrance, involving the enraged husband of the patient concerned. This ward sister felt unable to report Ms Hill's behaviour, but 'walked away from it'.²⁴⁶ She believed not only that nobody would pay any attention to her, but also that she would suffer a reaction from other staff, since she was regarded as being from outside

²³⁹ Former Broadmoor Hospital staff member (j)

²⁴⁰ Alan Franey, former general manager/chief executive, Broadmoor Hospital

²⁴¹ Kelvin Cheatle, former human resources director, Broadmoor Hospital; Harry Field, former director of nursing, Broadmoor Hospital

²⁴² Department of Health records

²⁴³ Department of Health records

²⁴⁴ Former Broadmoor Hospital staff member (i)

²⁴⁵ Former Broadmoor Hospital staff member (j)

²⁴⁶ *ibid.*

Broadmoor (“this is a very closed shop”²⁴⁷). She was relieved to be moved away from the ward when she was promoted. We believe that this reaction is understandable in light of the evidence we heard that Hill was subsequently regarded within Broadmoor as suitable for promotion, despite her unprofessional behaviour.

7.41. This account, together with various other reported cases of staff–patient sexual relationships over the years,²⁴⁸ suggests to us that at ward level the institutional culture in Broadmoor was, in some parts of the hospital, not only tolerant of such relationships, but hostile to anyone who tried to report a member of staff involved in one. Although inappropriate attractions between staff and patients may occur in such an intense and introspective environment, it should not need to be emphasised that yielding to temptation to allow this to develop into an emotional or sexual relationship constitutes exploitation of a vulnerable patient and entails serious risks to security and staff safety.

7.42. Subsequent events, however, brought Hill to attention in a way that could not be ignored. Another female patient, now dead, told her ward sister that she had been involved in a sexual liaison with Hill. She had decided to bring the affair to light because she was dismayed when Hill ended it. Hill was by now a nurse manager. The ward sister, who told us that she would not tolerate such relationships and regarded them as ‘serious, serious stuff’,²⁴⁹ ascertained further details, including an allegation by the patient that Hill had continued the affair when the patient was moved to Springfield Hospital (she later returned to Broadmoor), and that when Hill visited her there, allegedly for further sexual liaisons, she had been accompanied by Franey.²⁵⁰ We have no evidence that Franey was aware of the alleged purpose of Hill’s visit.

7.43. The ward sister told us that she then reported this to her superior, who took no action. The superior cannot recall any such report.²⁵¹ Indeed, no action was taken, we were told, until the patient, believing that Hill had embarked on a relationship with another nurse manager, went on the rampage with a knife.

7.44. Franey denied the allegation strenuously when we interviewed him, but there is certainly evidence that he had a close relationship with Hill, who spoke to other staff about partying and holidaying with Franey.²⁵² We were told that she was observed by a member of the hospital management team socialising with Franey in his house,²⁵³ and Franey himself admitted that he took Hill out for meals.²⁵⁴ The then director of nursing described to us how Hill, one of his senior officers, used the liaison to influence Franey for her own ends.²⁵⁵

²⁴⁷ *ibid.*

²⁴⁸ Leeanne McGee, director of high secure services, West London Mental Health NHS Trust

²⁴⁹ Former Broadmoor Hospital staff member (i)

²⁵⁰ *ibid.*

²⁵¹ Former Broadmoor Hospital staff member (dd)

²⁵² Former Broadmoor Hospital staff member (j)

²⁵³ Manager, Broadmoor Hospital

²⁵⁴ Alan Franey, former general manager/chief executive, Broadmoor Hospital

²⁵⁵ Harry Field, director of nursing, Broadmoor Hospital

A staff member told us that Hill visited the patient mentioned above along with Franey (paragraph 7.40).²⁵⁶

7.45. A disciplinary panel was convened to hear the case against Hill. We were told that, contrary to usual practice in a case of this seriousness, the panel was not chaired by Franey, who said to us that he 'honestly can't remember what it was about'.²⁵⁷ Others, including the chair of the newly constituted Broadmoor Special Health Authority were clear to us that this was because Franey was implicated in the case.²⁵⁸ Interviewees agreed that the panel was chaired by Jo Sheehan, the director of finance, and in March 1996, Hill was dismissed. She appealed, and we heard that in June 1996 an appeal panel chaired by the chair of the Broadmoor Special Health Authority (which had come into existence on 1 April 1996) upheld the dismissal.²⁵⁹ Ms Sheehan told us that she could not recall that the allegation involved Franey, but agreed that it would have been usual for Franey to have chaired the initial panel. When we challenged her that the reason for his withdrawal had been the allegation in which he himself was involved, she replied 'I vaguely remember that, I don't know.'²⁶⁰

7.46. As was reported in the national media at the time, Hill then lodged an industrial tribunal (now employment tribunal) case, and a date was set for a hearing in September 1997. The hearing did not take place, which can only mean that Hill withdrew her case. Hill is now also dead. One of the most unsatisfactory elements of this whole sorry saga is that none of those who were in a position to know said they could remember what lay behind that outcome.

7.47. There was national publicity and much speculation surrounding the impending case and what might lie behind it.²⁶¹ Surviving documents show that the Department of Health was concerned about the reputational damage likely to arise from lurid press reports of what Hill was threatening to reveal at the tribunal hearing: a civil service briefing for a ministerial visit in July 1997 said 'Ms Hill will allege that she had a relationship with Broadmoor's chief executive, Alan Franey.'²⁶² Dr Dilys Jones of the High Security Psychiatric Services Commissioning Board briefed her chief executive that Hill would allege that Franey was in relationships with Hill herself, with the director of finance, and with another senior member of staff at Broadmoor.²⁶³

7.48. This was by no means the sort of case that a hospital, even Broadmoor, would deal with every day – or even every year – and yet none of the board members we were able to interview, including Franey, could recall for us how it ended,²⁶⁴ or even whether it was discussed with the board of the Broadmoor Special Health Authority. There is no record in

²⁵⁶ Former Broadmoor Hospital staff member (b)

²⁵⁷ Alan Franey, former general manager/chief executive, Broadmoor Hospital

²⁵⁸ Sheila Drew-Smith, chair, Broadmoor Special Health Authority

²⁵⁹ *ibid.*

²⁶⁰ Jo Sheehan, former director of finance, Broadmoor Hospital

²⁶¹ Contemporaneous press articles; Department of Health records

²⁶² Department of Health records

²⁶³ Department of Health records

²⁶⁴ Sheila Drew-Smith, chair, Broadmoor Special Health Authority; Alan Franey, former general manager/chief executive, Broadmoor Hospital; Jo Sheehan, former director of finance, Broadmoor Hospital; Lezli Boswell, former director of nursing, Broadmoor Hospital; Gary Hoyte and Kelvin Cheatle, former Directors of Human Resources, Broadmoor Hospital.

those few board papers that could be traced of any consideration of the matter after Hill's dismissal. Nor could the board members we interviewed confirm whether Hill had been referred to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), the nursing registration body at the time, as would have been standard practice when professional misconduct had occurred. In fact, we found that Hill had allowed her registration to lapse some years previously, which the then director of nursing told us he had discovered during a routine check of registration; he regarded it as inappropriate that she was no longer registered, but told us that Franey had discouraged him from challenging her about it.²⁶⁵ The director of nursing at the time of the dismissal told us that she had little knowledge of the case, and from what she told us, we believe it is likely that she was excluded from discussions in the Trust.²⁶⁶ When we asked Franey directly about the outcome of the Hill case, he first suggested to us that there had been a tribunal hearing; then he indicated that compromise agreements were relatively commonplace at the time.²⁶⁷ Given the evidence that he had been in a close relationship with Hill – including, by his own account, dining with her – we found his inability to recall the case or its outcome remarkable.

7.49. Other Broadmoor staff told us that they believed Hill had been in discussions concerning a financial settlement, in return for which she would withdraw the case and drop attempts to generate embarrassing publicity. The ward sister who heard the initial allegations told us that she had been informed by a senior manager that Hill would potentially receive a settlement, and was 'disgusted'.²⁶⁸ The *Health Service Journal* reported that the hospital was in discussions with Hill about a compromise agreement. We asked the director of finance about this report. She did not know why the tribunal case had been withdrawn. When asked whether it was because compensation had been paid, she said 'I can't remember, I do not recall it.'²⁶⁹ We find it surprising that the person statutorily accountable for the hospital's finances was unable to say whether a payment had or had not been made in a case as high profile and inherently memorable as this.

7.50. It seems to us that there are only three possibilities. First, Hill may have decided to withdraw the tribunal case, without compensation, for her own reasons. This may be what happened, but it seems to us unusual that, if this was the case, there appears to have been no knowledge of it among the board members; none of the more junior staff we spoke to who knew Hill believe this to have been the case.²⁷⁰ Second, the Broadmoor Special Health Authority board may have discussed the options in light of the impending tribunal, decided to offer a sufficiently large compensatory payment in settlement, in order to avoid the serious reputational damage that would have ensued, and gained the necessary approval to make the payment. It may have been possible to make such a case, depending on the sum involved and the likely cost of the tribunal. Again, however, it seems to us unusual that nobody who would have been involved can remember any such discussions or decision, and there is no

²⁶⁵ Harry Field, former director of nursing, Broadmoor Hospital

²⁶⁶ Lezli Boswell, former director of nursing, Broadmoor Hospital

²⁶⁷ Alan Franey, former general manager/chief executive, Broadmoor Hospital

²⁶⁸ Former Broadmoor Hospital staff member (i)

²⁶⁹ Jo Sheehan, former director of finance, Broadmoor Hospital

²⁷⁰ Former Broadmoor Hospital staff members (b), (c), (i), (j)

record of a payment requiring special approval being seen by the Department of Health.²⁷¹ Third, and of most concern, we cannot entirely discount the possibility that an irregular payment may have been made to Hill to settle the case, which therefore requires appropriate investigation.

7.51. We believe that this case is important on various levels. Not only did it shed light on compliance with policies and procedures (including those on inappropriate contact with patients), it also signalled to staff, who clearly followed it closely, that grossly inappropriate sexual behaviour was not dealt with immediately, and that when it was addressed, the outcome was ambiguous or (as was widely believed by staff, whether correctly or not) involved payment of compensation. This was hardly likely to foster the development of an atmosphere that discouraged inappropriate behaviour and encouraged reporting. That the principal protagonist was a close associate of Franey's would only have reinforced staff perceptions of how any concern over the conduct of another close associate, Savile, would have been regarded.

Further management changes

7.52. It is clear to us on the basis of what we heard from many of those concerned that members of the Broadmoor Special Health Authority board lost confidence in the chief executive (as Franey was now designated) not long afterwards. To some extent, this was a result of continued frustration over the lack of progress toward a more therapeutic model of care,²⁷² and to some extent it was due to a growing realisation on the part of the Broadmoor Special Health Authority board,²⁷³ the High Security Psychiatric Services Commissioning Board²⁷⁴ and the Department of Health that Franey was not the right person for the job. He had, in any case, served nine years in an arduous post. The chair of the High Security Psychiatric Services Commissioning Board and former chair of the SHSA described Franey to us as 'not a good manager for Broadmoor'.²⁷⁵ The new director of human resources for the hospital told us that, at the request of the chair of the Broadmoor Special Health Authority, he opened discussions with Franey, who took early retirement in July 1997.²⁷⁶ It is not certain to what extent the stories about Franey's activities in his hospital accommodation, as clearly revealed by the Hill case, contributed to the view that he was not good for Broadmoor; but given the disruption that, as we heard, was caused within the hospital, it would be surprising if it played no part.

7.53. Ms Sheehan then became interim chief executive before a substantive appointment was made in 1998. The new chief executive was Julie Hollyman, who clearly strove to overcome the resistant culture and the damage done to staff morale by the Franey years, to some effect. Dr Hollyman also proved resistant to Savile's attempts at manipulation, and told

²⁷¹ Department of Health records

²⁷² Dr Julie Hollyman, former chief executive, Broadmoor Hospital

²⁷³ Sheila Drew-Smith, chair, Broadmoor Special Health Authority

²⁷⁴ Lady Anne-Marie Nelson, former chair of SHSA and later of the HSPSCB; Ray Rowden, former chief executive, HSPSCB

²⁷⁵ Lady Anne-Marie Nelson, former chair of SHSA and later of the HSPSCB

²⁷⁶ Kelvin Cheatle, former human resources director, Broadmoor Hospital

us she had concluded that ‘actually the hospital was doing something for him [not the other way round] and that that wasn’t right’.²⁷⁷ She removed Savile’s access to accommodation (bar one room).²⁷⁸ From the evidence that we heard from many interviewees, we conclude that changes to patient care took some time to take effect, and work remained to be done when the hospital was transferred to the West London Mental Health NHS Trust. But we believe the important factor was the establishment for the first time of an effective board and management team that could set a clear direction for the hospital and ensure that it began to be put into practice. However, by then Savile’s involvement with the hospital had, for all practical purposes, come to an end.

²⁷⁷ Dr Julie Hollyman, former chief executive, Broadmoor Hospital

²⁷⁸ Department of Health records

8. Savile's Celebrity Status and Fundraising

8.1. The investigators were asked to consider the part played by Jimmy Savile's celebrity status and his fundraising role in relation to the matters dealt with above.

8.2. The investigators were also asked to review Jimmy Savile's fundraising activities associated with Broadmoor Hospital, and any issues that arose in relation to governance, accountability and use of the funds.

Fundraising activities

Charitable funds

8.3. Broadmoor Hospital's finance department administered bank accounts (one current, one deposit) for a 'Jimmy Savile Broadmoor Hospital Fund'. The finance department's operational procedures (dated 1988) described these as 'subsidiary accounts'. The accounts typically held less than £10,000.²⁷⁹

8.4. The Fund was not registered with the Charity Commission – unlike at least two other charitable funds (unconnected with Savile) that were administered by Broadmoor Hospital's finance department – and is not mentioned in those minutes we have seen of the Broadmoor Hospital Authority Charitable Funds Panel. Eventually (we have no date), possibly after the Charity Commission initiated a general review of all funds, the hospital closed these accounts and transferred the balances to the Jimmy Savile Charitable Fund at Stoke Mandeville.

8.5. Deposits came principally from two sources: small donations by people in response to Savile-promoted activities or appeals, e.g. a sponsored walk; and the Argos scheme.

8.6. Savile and Don Bennett, the hospital's transport manager and de facto driver for Savile, negotiated with the general-goods catalogue retailer Argos a discount on its normal prices. Orders would then be collected from patients, who would pay the full list price. The balance would be deposited in the Jimmy Savile Broadmoor Hospital Fund. The collection of orders, delivery of goods and deposit of proceeds was up to Mr Bennett. In 1988, auditors found the scheme unorthodox, but not improper.²⁸⁰

8.7. Signatories for the accounts were the same as for Broadmoor's own accounts: that is, the finance department. Savile was not a signatory, but his approval was normally sought for any withdrawal.²⁸¹

²⁷⁹ Broadmoor Hospital papers

²⁸⁰ Broadmoor Hospital papers

²⁸¹ Example in Broadmoor hospital papers

8.8. Uses to which money withdrawn was put include: prizes (for example – all from 1994 – £316 for two mini-cruises for a Broadmoor staff draw; four prizes of £25 for the Crowthorne village festival; and £200 for the Sandhurst Ward bazaar); £500 to support a production of *Macbeth* by the Royal Shakespeare Company; £250 to support a football tournament; £70 for prizes for the best ward Christmas decorations; trips for patients outside Broadmoor; and equipment (e.g. a running machine for staff and patients). Money was also withdrawn to pay the telephone bill and TV licence at Savile’s own Broadmoor accommodation, which is unlikely to have been regarded as its purpose by those participating in the scheme.

The Friends of Broadmoor

8.9. In 1971, Savile became a vice-president of the Friends of Broadmoor. In 1973 he donated a minibus to help with the transport of patients’ relatives, and soon after he agreed to meet its running costs. Savile participated in, and presented prizes for, many sponsored walks. Prizes were typically donated by others, e.g. the Crowthorne Businessmen’s Association. Beneficiaries varied, but proceeds typically were split between the Friends of Broadmoor (in 1982 the National Association of Leagues of Hospital Friends) and the Jimmy Savile Broadmoor Hospital Fund. In a typical year (1983) the Friends’ accounts show income of £642 from Savile walks.

Direct donations

8.10. On several occasions, Savile arranged the provision for the hospital of equipment. Examples include a discotheque, washing machines and a hairdressing salon (which was reserved for his own use on Friday afternoons, when Don Bennett’s wife dyed his hair).²⁸² These came at no cost to the hospital (other than running costs) but we do not know the extent to which the costs of provision were met by Savile or by the manufacturers or retailers.

8.11. On many occasions Savile arranged trips outside the hospital for staff and their children (e.g. to Thorpe Park),²⁸³ and on some occasions for patients. Again, these were at no or minimal cost to the hospital or staff, but we do not know whether Savile met the costs himself or if the money came from his charitable funds. Several ex-staff commented that Savile appeared never to pay for anything himself, or indeed to carry cash, but expected either that the bill would be waived or that they should pay for him.²⁸⁴

8.12. On at least one occasion, Savile gave a cheque drawn on a personal account (for £1,825, payable to the staff club to settle the tug-of-war account).

External beneficiaries

8.13. Some fundraising sponsored by Savile in or around Broadmoor was for beneficiaries other than Broadmoor. These included the Crowthorne Festival, for which Savile lent one of his Rolls-Royces every year and occasionally donated and presented prizes; and Stoke Mandeville appeals.

8.14. We have no evidence that Savile himself benefited financially from any of his fundraising activities at Broadmoor (other than his telephone bills and TV licence, mentioned at paragraph

²⁸² Former Broadmoor Hospital staff member (j)

²⁸³ David Lee, former security manager, Broadmoor Hospital

²⁸⁴ Savile’s PA

8.8 above, and use of the hairdressing salon). Several people we interviewed commented that Savile was widely perceived as benefiting more, in public relations terms, from the publicity that his fundraising generated than did the ostensible beneficiaries, either financially or from the publicity.

Savile's celebrity status

8.15. It was Savile's celebrity that led Dr McGrath to believe, in 1968, that he should welcome Savile as someone who could help improve public perceptions of the hospital (see paragraph 6.3). He could also, as a disc jockey, provide some entertainment for patients and staff, and, more importantly, he proved in due course that his celebrity could attract other well-known entertainers and celebrities to Broadmoor.

Other celebrity visitors

8.16. Other celebrities did visit Broadmoor from time to time. We consider this briefly, as it is relevant to the part that celebrity played in Savile's access to the hospital. Some were there as a result of Savile's involvement, including the acts that he brought to entertain patients, particularly early on in his association with the hospital. Later, Savile brought Frank Bruno to the opening of the gymnasium, toward which he had provided charitable funds, and a photograph was published showing Bruno shaking hands with a patient, Peter Sutcliffe.²⁸⁵ Another visitor brought by Savile was Rolf Harris, who visited Broadmoor on one occasion in 1973. All of these visitors were escorted, and we heard no suggestion of any inappropriate behaviour or access to patients.

8.17. HRH Diana, Princess of Wales visited the hospital on several occasions.²⁸⁶ Although some staff believed that Savile was in some way behind these visits, there is little evidence to suggest this, though it would be typical of Savile to claim a link. Two were official visits, and several were less-formal visits, arranged at shorter notice,²⁸⁷ when the princess would spend time talking to patients, sometimes in private conversations, but always with appropriate security in place.²⁸⁸ When a documentary programme was mooted, however, Special Hospitals Service Authority (SHSA) board members became concerned that patients' interests would not be best served by this, and took action to discourage it.²⁸⁹

Savile's honours

8.18. Savile's celebrity was, in the eyes of both the public and Broadmoor, confirmed by the honours bestowed on him.

²⁸⁵ Former Broadmoor Hospital staff member (p)

²⁸⁶ Lady Anne-Marie Nelson, former chair of Special Hospitals Service Authority and later of the High Security Psychiatric Services Commissioning Board; Alan Franey, former general manager/chief executive, Broadmoor Hospital; Bob Barber, former head of security, Broadmoor Hospital; David Lee, former security manager, Broadmoor Hospital

²⁸⁷ Bob Barber, former head of security, Broadmoor Hospital

²⁸⁸ David Lee, former security manager, Broadmoor Hospital

²⁸⁹ Lady Anne-Marie Nelson, former chair of SHSA and later of the HSPSCB

8.19. In 1972, Savile was awarded the OBE for his charity work, with particular reference to his work as a porter at Leeds General Infirmary. The Department of Health and Social Security added support, mentioning his work at Broadmoor and Rampton.

8.20. In 1982, his name was put forward for a knighthood.²⁹⁰ At this stage, the main focus was on his fundraising for Stoke Mandeville, but his contribution at Broadmoor was also acknowledged. Originally, officials advised that the knighthood be held over until the Stoke Mandeville work was complete, but in April 1983 the *Sun* newspaper printed articles in which Savile boasted of his promiscuous lifestyle. Under the headline ‘My violent world, by Jim the Godfather’, it also provided an account of the violent way in which he had maintained order when running dancehalls. As the Department of Health was, at the time, concentrating on the HIV/AIDS campaign, it was the promiscuity which rendered it impossible to consider him for a further honour at the time.²⁹¹ However, his name continued to be put forward year after year, endorsed by then Prime Minister Margaret Thatcher, and in 1990 it was decided that the 1983 article was far enough in the past to be forgotten.²⁹²

8.21. Unusually, Graham, the under secretary responsible for mental health, showed Savile the citation that the Department of Health had prepared, and told him that if there had been any embarrassing incidents that might subsequently come to light, it would be in his own interests to stop the submission now, the implication being that senior honours submissions routinely prompted checks. Savile denied that there were any such incidents.²⁹³

Summary

8.22. Savile’s fundraising for Broadmoor was negligible. His relatively small donations of prizes and equipment were valued by staff, as was his ability to persuade well-known entertainers to come to Broadmoor. His celebrity was seen as being of value to Broadmoor, although it is possible that his association with the hospital brought more benefit to him than to it. There is no evidence that he made any material difference to the public’s perception of the hospital.

²⁹⁰ Cabinet Office records

²⁹¹ Cabinet Office records

²⁹² Cabinet Office records

²⁹³ Alan Bacon, senior civil servant, mental health team, Department of Health

9. Current Policies, Practices and Procedures

Introduction

9.1. The investigators were asked to ‘review the adequacy of current complaints, safeguarding, whistleblowing and other relevant policies, practices and procedures relating to the matters mentioned above relevant to the [Department of Health] and Broadmoor Hospital’.

9.2. Our approach was to identify weaknesses in practice during Savile’s time at Broadmoor; then to review present policies and procedures, and the extent to which these were being put into practice; and finally to consider whether the past weaknesses have been adequately addressed.

9.3. We interviewed staff from the Trust, from the London Borough of Ealing social work department, and from Bracknell Forest Borough Council. The Bracknell Forest safeguarding lead selected for us a stratified random sample of recent safeguarding incidents at Broadmoor.

9.4. Past weaknesses in practice are discussed in the preceding chapters. Some staff had a hostile attitude toward patients, which may have led them to tolerate inappropriate behaviour by colleagues and to deter patients from complaining. As a result, patients abused by Savile were reluctant even to inform staff, much less formally to complain: of the four patients we were able to interview who had told us of abuse, only two had informed staff at the time. One had been ordered to ‘stop making it up’ and the other had been told that she ‘must be imagining it’ (see paragraphs 6.38 and 6.39).

Safeguarding: policies and procedures

9.5. Present policies and procedures relevant to safeguarding and patient safety are available on the Trust’s website,²⁹⁴ and we do not attempt to precis them here.

9.6. The policies appear to be consistent with national guidance, although much of that is not aimed at secure mental health hospitals.

9.7. The Bracknell Forest safeguarding lead,²⁹⁵ who is a member of the Safeguarding Adults Partnership board, told us that Broadmoor’s policies and procedures on safeguarding are ‘as good as can be expected’. The Partnership board’s position is that ‘[it] is satisfied that the safeguarding procedures set out by the Trust and Social Work Department are fit for purpose’.

²⁹⁴ <http://www.wlmht.nhs.uk/publications/policies-and-procedures/clinical-practice/>

²⁹⁵ Zoe Johnstone, who is also a member of this investigation’s Local Oversight Panel (see Appendix A)

After careful (albeit non-specialist) consideration of these policies and procedures, we concur with this expert judgement.

9.8. The Trust also participates annually in external validation and benchmarking within London by submitting a return, using the Safeguarding Adults At Risk Self-Assessment Assurance Framework tool (primarily about strategy and systems), one of which is specifically for Broadmoor. The last review, in 2012, cited the Trust’s systems for auditing, monitoring and reporting safeguarding incidents as an example of good practice.²⁹⁶

9.9. In 2013, the Trust’s adult safeguarding was audited independently as part of its application for Foundation Trust status.

Safeguarding: practices

9.10. Practices are inherently more difficult to judge than policies. Good practice is likely to flow from good policies and procedures, combined with adequate internal monitoring of the implementation of procedures (see paragraphs 9.14 to 9.17 below); but there is no substitute for independent observation of practice (which is difficult to achieve in any high-security facility) or for external inspection.

9.11. We note that a Care Quality Commission team, which included a Mental Health Act commissioner, inspected Broadmoor in June 2013, when it met 25 service users, six relatives or representatives, and 43 staff on nine wards and in other centres. It found Broadmoor compliant with government standards on safety and quality, including ‘safeguarding people who use services from abuse’ (as it had been on the Commission’s February 2012 inspection); the inspection report, published in August 2013, is on the Care Quality Commission website.²⁹⁷

9.12. We did not attempt either first-hand observation of practice or a full inspection, but the current patients and staff we met were mostly supportive of the Trust’s endeavours to raise standards and develop a more open culture; from our discussions with senior managers, we believe the weaknesses in past practice to be well recognised within the Trust. We reviewed a stratified random sample of incidents, selected for us by the Bracknell Forest safeguarding lead, and found that Broadmoor’s response to all these had been appropriate.

9.13. The Bracknell Forest safeguarding lead also told us that ‘we do have evidence that they [Broadmoor] are much more robust in their response in recognising when an issue is a safeguarding issue and dealing with it appropriately and training their staff’, that they have ‘a much more open culture’, and that ‘they are going in the right direction but it still needs to permeate right the way through’.

Safeguarding: monitoring

9.14. Culture is even less susceptible than practice to quantitative measurement. The Trust’s director of safeguarding helpfully described the metrics he is developing as intended to ‘take

²⁹⁶ London-wide Overview report, NHS London, March 2013. The next review was due in May/June 2014.

²⁹⁷ www.cqc.org.uk/location/RKL51

the temperature' of the organisation. At present, the principal metric for adult safeguarding at Broadmoor is the number of safeguarding referrals; other relevant metrics are for untoward incidents, allegations against staff, training and Criminal Records Bureau (now Disclosure and Barring Service) checks. Data has been collected in a way that readily lends itself to detailed analysis only since summer 2013, and so trends cannot yet be analysed; nor can the data yet be compared with that from other high-security hospitals. It can, however, enhance the ability of managers to identify 'hot spots' (e.g. wards) requiring closer investigation. The development of safeguarding metrics has been a priority for the Trust.

9.15. The number of referrals and their analysis form the subject of regular reports to the Trust's management and others. A good example of this is the information in the annual reports on safeguarding²⁹⁸ Investigation and analysis should be assisted by the appointment of a professional adult safeguarding lead (NHS grade 8B), which we understand was approved by the Trust in early 2014.

9.16. We were briefed by Broadmoor managers on incidents in recent years where there have been unacceptable interactions between staff and patients outside the normal therapeutic relationships, as well as on an independent thematic review in 2011 of such interactions. Incidents considered by that review included 42 cases over the previous five years (in what is described as a sample), of which 11 cases were of sexual and/or unprofessional behaviour. These led to disciplinary action – up to and including dismissal – against nine staff. The Trust is to be commended for identifying and acting on these incidents, including commissioning a review and acting on its recommendations. Although comparable records are not available for Savile's time, we have reason to believe that the frequency of what are now called 'boundary violations' would have been much higher, and significantly fewer would have been brought to the attention of managers.

9.17. On the basis of the evidence we heard, we believe there was, until relatively recently, a culture at ward level in Broadmoor that tolerated boundary violations, including those of a sexual nature, and discouraged reporting – 'keep your eyes and ears open and your mouth shut'.²⁹⁹ This is being appropriately addressed, in particular by encouraging reporting; but changing the underlying culture of any hospital takes significant time. Some level of incidents may be considered inevitable, and indeed indicates that possible poor practice is being identified; but the numbers do suggest that Broadmoor cannot yet provide complete assurance that its practices match its policies and procedures.

Safeguarding: oversight

9.18. Responsibility for safeguarding patients rests with the provider organisation: in Broadmoor's case, that is the West London Mental Health NHS Trust. As with all NHS trusts for all patient services, it is accountable to its commissioners (for Broadmoor this is now NHS England) and is regulated by the Care Quality Commission. These are the only bodies with ready access to sanctions if providers do not respond to concerns about standards.

²⁹⁸ The report for 2013/14 was expected to be on the Trust's website as a Board paper in June 2014.

²⁹⁹ Member of staff, (hh) Broadmoor Hospital

9.19. Local oversight of, and expertise in, safeguarding is located in local government authorities; in Broadmoor's case this is Bracknell Forest. Other of the Trust's functions and services are the responsibility of various London local authorities, led by Ealing, where the Trust's headquarters is located. Ealing social services have developed expertise in forensic social work that is normally found only in local authorities in which secure hospitals are located. Since the 1990s, NHS providers have asked their local authorities to provide social work services (rather than employ social workers directly); since the Broadmoor Health Authority merged with the West London Mental Health NHS Trust in 2001, Broadmoor's 'local' authority for the purposes of the provision of social work services has been the London Borough of Ealing, while its 'local' authority for safeguarding purposes remains Bracknell Forest. We understand this arrangement to be unique.

9.20. It may well be that this arrangement has come about for historical reasons, rather than as the result of a considered assessment of the advantages and disadvantages of the various options. But that does not matter if it works. And we believe it does – in part because all the stakeholders recognise its complexities. The Trust and both Ealing and Bracknell Forest councils have (in 2013) reached a formal tripartite agreement. All the main stakeholders are represented on the Bracknell Forest Safeguarding Adults Partnership board, which meets every two months. They will, however, need to remain alert to the potential dangers of such divided responsibilities, and we believe it would be prudent to conduct a risk assessment of the present divided arrangement and to appraise the alternative options.

9.21. There is a National Oversight Group for all three secure hospitals, and a Clinical Secure Practice Forum which meets quarterly.

Complaints

9.22. Broadmoor's present policies and procedures on complaints seem consistent with NHS guidance. We have no reason to doubt that the present complaints procedures are, in practice, followed scrupulously once a complaint has been made. We have no evidence of staff attempting to deter patients from complaining, as seems to have happened in Savile's time. Indeed, the Trust is developing a protocol for the handling of excessive and possibly malicious complaints against staff by patients, which would suggest that staff either do not attempt to deter or do not succeed in deterring complaints made against them by patients.

9.23. In addition to the ability to complain, patients can speak to various people: their primary nurse during regular one-to-one conversations; the independent advocacy team; their solicitors; the Care Quality Commission on a direct line; or the chaplains and other relevant spiritual staff. Each ward has recently identified an anti-bullying champion; and clinical team meeting agendas include a standing item on bullying and harassment. All wards are now inspected within an internal peer-review process, which focuses on what patients think of their care (quarterly visits by two members of staff to each ward, open to all patients, with no ward staff present). Patients are also encouraged to speak out at regular 'community meetings' within the Trust's Healthy Communities programme; patient representatives attend the monthly meetings of the Clinical Improvement Group; and a senior social worker recently briefed the patients' forum on safeguarding.

9.24. No procedure can, however, guarantee that staff will never attempt to deter patients from complaining. Such prevention must depend on wider measures to develop a more open culture.

Training

9.25. Training is an important element in the Trust's strategy to continue to improve the culture within Broadmoor. All staff are trained in safeguarding at the time of their induction, and there are refresher courses every three years: Broadmoor achieves consistently high proportions of its staff with up-to-date training (93% as at March 2014). For some years, all patients at Broadmoor have been adults, with children entering only as visitors; nevertheless, as was noted by the Care Quality Commission, staff receive one-and-a-half days' training to Level 2 in safeguarding children, and 2–3 hours' training to Level 1 in safeguarding adults. The Care Quality Commission investigators nevertheless found that the breadth and content of the present induction training in adult safeguarding was excellent, in particular its encouragement of staff to report anything untoward, even if it might not meet the threshold for treatment as a safeguarding incident.

9.26. Some 95% of nurses also attend monthly clinical supervision 'to improve therapeutic skills, the transmission of knowledge and the facilitation of reflective practice'.³⁰⁰

9.27. Staff we interviewed referred to the frequency of training and the importance attached to it, even when it conflicted with operational requirements.

Recruitment

9.28. We have not considered present recruitment policies in detail, but we do note that different policies were in force when many of the staff members were recruited. This reinforces the importance of achieving cultural change.

9.29. Since 2002, like all employers, Broadmoor has been able to check staff (present and prospective) against national lists of people deemed unsuitable to work with vulnerable people. Originally maintained by the Criminal Records Bureau and the Independent Safeguarding Authority, since 2012 these lists have been the responsibility of the Disclosure and Barring Service (DBS). We observe, however, that Savile did not appear on any of those lists. Today, anyone with safeguarding concerns about staff can refer to the DBS; on the basis of the accounts we heard, however, we believe it is unlikely that Savile would have been so referred by anyone then at Broadmoor.

Whistleblowing

9.30. The Trust has recently revised its whistleblowing policy, and it appears to be consistent with policies brought in throughout the NHS. Its procedures can protect whistleblowers from formal sanctions by senior managers, but not from the sort of informal sanctions (e.g.

³⁰⁰ Winstanley J, White E (2003) Clinical Supervision: Models, measures and best practice. *Nurse researcher*; 10:4, 7.3 8

ostracism) that – so we were told – were likely in the past to have been imposed by junior staff on any colleague who blew the whistle on others.³⁰¹ In Savile’s time, when (as we described in chapter 5) Broadmoor was more of a closed and introspective institution with several generations of staff from the same local families, some staff appear to have placed loyalty to colleagues above concerns for the rights and interests of patients. Broadmoor needs to be unusually sensitive to the need to encourage and protect those who speak out about abuse. Its ‘Rat on a Rat’ campaign in 2010, though prompted by concerns that staff were selling stories to the media, is indicative that it is. Nevertheless, a member of staff told us, commenting on a recent report of an inappropriate relationship between another member of staff and a patient, ‘it is part of people turning a blind eye to their colleagues behaving badly for whatever reason’.³⁰²

Security

9.31. Security is significantly tighter now than in Savile’s time. Changes since Savile’s time are described in paragraphs 5.13 to 5.20. Broadmoor now has a protocol for visitors, including VIPs and celebrities. Most of the improvements would have made little difference to someone such as Savile, who had been given the access privileges of a staff member; but some would surely have helped deter him, not least the widespread CCTV cameras. Intelligence gathering and collation by security staff is an important component of monitoring what goes on in practice.

Summary

9.32. Policies, procedures and practices seem to us to minimise the probability of a recurrence of the sort of abuse seen in Savile’s time. But no suite of documents can ensure this. There is some formal monitoring of practice, but this in itself would not necessarily have detected the activities of someone with the sort of free access to ward areas that Savile had. Prevention at ward level relies on a change of culture, which we recognise takes time in any institution. We believe that considerable progress has been achieved at Broadmoor, but that more remains to be done. We believe that the most effective single measure to prevent any recurrence is to ensure that people, whether staff or visitors, are not granted access to clinical areas except under close supervision, no matter how well meaning they appear to be or how famous they are.

³⁰¹ Member of staff, Broadmoor Hospital (ff)

³⁰² Member of staff, Broadmoor Hospital (gg)

10. Recommendations

10.1. Our analysis of Savile's time at Broadmoor reveals significant shortcomings in systems, processes, hospital culture, Department of Health practice, and the response to celebrity. Many aspects have improved since the time of Savile's active association with Broadmoor – in some cases almost beyond recognition. However, we identify here a complete set of recommendations to address these shortcomings, together with an indication of the extent to which we believe that these have been taken forward in the intervening period.

- (1) Many celebrities make a significant contribution to improving patient wellbeing and help to raise charitable funds, but that does not imply that they should be exempt from standard procedures governing access to NHS patients. NHS bodies should ensure that any celebrity they may consider appointing should be subject to the suitability checks appropriate to their contact with the NHS facility and its patients, and should not be given privileged access under any circumstances.
- (2) Some celebrities may have the necessary qualities and the desire to contribute to the NHS in a non-executive capacity, but they should not be exempt from the usual selection process, which would include careful consideration of the benefits and risks. Celebrities should not be considered for operational or executive NHS roles – not even on a voluntary basis.
- (3) Security systems at Broadmoor were underdeveloped and potentially ineffective for much of Savile's active involvement with the hospital, and were sometimes poorly applied in practice. Nobody but a properly trained and appropriately qualified member of staff should be in a clinical area without supervision. We believe that the much-needed overhaul has been effectively implemented, but we recommend that the way theory is put into practice should be reviewed regularly by West London Mental Health NHS Trust.
- (4) Procedures to safeguard vulnerable patients were poorly developed during Savile's active involvement with Broadmoor, including the reporting and proper investigation of complaints. We believe that safeguarding has been greatly improved and that procedures are appropriate and effective, but we recommend that the way theory is put into practice should be reviewed regularly. We also recommend that the arrangement that separates local authority responsibility for safeguarding from the provision of social workers should be reviewed within the next year, and that a risk assessment and appraisal of alternative options should be carried out.
- (5) The closed and introspective institutional culture of Broadmoor failed to prevent some instances of psychological, physical and sexual abuse of patients, including those committed by Savile, and discouraged staff from reporting or taking effective

action. We believe that the much-needed improvement has been achieved, principally through recruitment, induction, training, continuing education and disciplinary policies. We recommend that the effectiveness of these policies continues to be monitored regularly by the Trust's board and by the Care Quality Commission.

- (6) In order to improve the review and monitoring of security systems, safeguarding and organisational culture, we recommend that service commissioners should review how all three high-security hospitals share relevant comparative information.
- (7) Department of Health procedures proved inadequate in ensuring that the decision to give Savile a managerial role in 1988 was thoroughly evaluated and subject to proper scrutiny. In part, this was due to a combination of circumstances at the time that is unlikely to be repeated. We recommend that any decision to have the Department of Health directly manage an operational service should be exceptional and subject to thorough risk assessment.
- (8) Public officials, including senior civil servants, who are responsible for recommending the appointment of someone with whom they have a close personal relationship should generally withdraw from the appointment process. At the very least, they must ensure that their judgement is subject to independent verification. We recommend that the Department of Health and NHS organisations review the relevant policies to ensure that this is made explicit.
- (9) We believe that stories of multiple sexual relationships between senior and junior staff circulated widely within and outside Broadmoor, and were particularly corrosive. We believe this contributed to an atmosphere that was unusually tolerant of sexual relationships between staff and patients in some parts of the hospital. We recommend that NHS boards ensure that policies and systems are in place to encourage staff to report such behaviour, and make sure that the organisation can act to eradicate it.
- (10) We are particularly concerned that we cannot confidently exclude the possibility that an irregular payment was made to settle an impending tribunal case at which embarrassing personal allegations would have become public. We recommend that NHS Protect and the police investigate this possibility.

Glossary

Department of Health

Ministry of Health: 1968 – the government department responsible for Broadmoor until the creation of the DHSS

Department of Health and Social Security (DHSS): 1968–1988 – replaced the Ministry of Health

Department of Health (DH): 1988–present – replaced the DHSS

Secretary of state for health: the most senior minister in the DH or DHSS

Minister of state: a second-ranking minister, in this case in the DH or DHSS

Parliamentary under secretary of state: a third-ranking minister, in the case of the DH or DHSS usually with responsibility for specific services, e.g. mental health

Permanent secretary: the most senior grade of civil servant, in this case in the DH (grade 1)

Deputy secretary: the second grade of civil servant (grade 2), usually in charge of a group of divisions; often now a director-general

Under secretary: the grade of civil servant (grade 3) usually in charge of a division, e.g. mental health and learning disabilities; often now a director

Assistant secretary: the grade of civil servant (grade 5) usually in charge of a branch, e.g. secure mental health hospitals; often now a deputy director

Principal: civil service grade 7; examples: regional principal (managed DH liaison with one or more NHS regions); the administrator at Broadmoor until 1988

Private secretary: managed the office of a minister or permanent secretary

Personal secretary: managed the office of a senior civil servant

Special Hospitals Services Board: previously the Special Hospitals Office Committee; a committee of DHSS officials, chaired by an under secretary, which managed the secure hospitals, including Broadmoor, until the SHSA was created in 1989

NHS

Regional health authority (RHA): 1974–1996 – responsible to DH for the 14 English health regions to 1994, 8 regions 1994–2002; regional offices of the NHS Executive within DH 1996–2002; excluded special health authorities; replaced by strategic health authorities

Strategic health authority (SHA): 2002–2013 – responsible for NHS trusts in English health regions (28 regions 2002–2006; 10 regions 2006–2013)

District health authorities (DHA): 1982–1996 – reported to RHAs

Area health authorities (AHA): 1974–1982 – reported to RHAs; replaced by DHAs

Broadmoor Hospital Board: 1987–1988 – reported to the Special Hospitals Services Board in DHSS

Special Hospitals Service Authority (SHSA): 1989–1996 – reported direct to DH; responsible for all three high-security mental health special health authorities, including Broadmoor

Hospital Advisory Committee (HAC): 1989–1996 – a sub-committee of the SHSA for each of the three high-security hospitals, including one for Broadmoor (chaired by Savile 1989–1992)

Special health authority: reported direct to DH; included Broadmoor Special Health Authority 1996–2001

High Security Psychiatric Services Commissioning Board (HSPSCB): 1996–2013 – commissioned services from the special health authorities responsible for the three high-security mental health hospitals, including Broadmoor; this commissioning function now lies with NHS England

West London Mental Health NHS Trust (WLMHT): took over responsibility for Broadmoor when Broadmoor Special Health Authority was abolished in 2001

Broadmoor staff

Hospital management team: tripartite management of the hospital by an administrator (a civil service principal at Broadmoor in the 1980s), senior doctor and senior nurse; reported to the Special Hospitals Services Board

Medical (or physician) superintendent: top manager at Broadmoor until 1981; replaced by medical director as chair of the hospital management team; reported to the Special Hospitals Services Board

General manager: post introduced in the late 1980s as leader of a hospital management team; reported to a board, e.g. the SHSA for Broadmoor

Chief executive: superseded general managers in the mid-1990s

Responsible medical officer (now responsible clinician): each patient at Broadmoor was the responsibility of one primary doctor (now any clinician)

Other health-related bodies

Mental Health Act Commission (MHAC): a special health authority that protected the rights of patients detained under the Mental Health Act between 1983 and 2009; subsumed under the Care Quality Commission

Care Quality Commission (CQC): a non-departmental public body that checks on all services for NHS patients, including detained mental health patients (2009–present)

NHS Counter-Fraud and Security Management: a division of the NHS Business Services Authority; its operating name is NHS Protect

Disclosure and Barring Service (DBS): replaced the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) in 2012

Third parties mentioned in the report

National Society for the Prevention of Cruelty to Children (NSPCC): collaborated with the Metropolitan Police service on the Operation Yewtree investigation of 2012–2013 into Savile’s activities; helpline telephone number 0808 800 5000

National Association for People Abused in Childhood (NAPAC): provides support and information for people abused in childhood; helpline telephone number 0800 085 3330

Prison Officers Association (POA): trade union for prison staff and some special hospitals staff

Royal College of Nursing (RCN): trade union representing nurses and nursing under a Royal Charter

BIOGRAPHIES OF INDEPENDENT INVESTIGATORS

BILL KIRKUP, CBE

Bill qualified in medicine at the University of Oxford in 1974, and practised as an obstetrician and gynaecologist until 1982. Following posts in public health and NHS management, he was appointed as an executive director of Northern and Yorkshire regional health authority in 1994, and became regional director of public health in 1999. After a period as acting deputy chief medical officer in the Department of Health in 2005, he became associate chief medical officer, retiring at the end of 2009.

In addition to these posts at local, regional and national level, Bill worked and advised on public health and health reconstruction in Kosovo (1999), Iraq (2003, 2005) and Afghanistan (2007, 2008). He also carried out investigations into serious adverse NHS incidents in Leeds, Middlesbrough and Warrington.

Since standing down as associate chief medical officer, Bill has led an investigation into children’s heart surgery services in Oxford, and served as medical member of the Hillsborough Independent Panel. He agreed to chair the Morecambe Bay Investigation in 2013, and became a non-executive director of Leeds Teaching Hospitals Trust in May 2014.

PAUL MARSHALL

Paul was educated at Harrow and Oxford, where he read history then philosophy and politics.

Following posts in banking and the Department of Energy, he worked in the Department of Health from 1985 to 2004. Roles there included cancer policy; liaison with the NHS in the West Midlands and the South West eg performance management and ministerial intelligence; secretary to the statutory professional advisory committees, eg the UK-wide Clinical Standards Advisory Group, where he helped prepare more than 30 published reports; and public health.

Since 2004 he has worked independently with several Primary Care Trusts and Strategic Health Authorities, lastly on the Oxford Radcliffe paediatric cardiac surgery review.

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Appendix 1: Membership of the local oversight panel

The Local Oversight Panel was intended to:

- provide local oversight of the joint investigation, providing local reassurance on the process followed
- monitor the progress of the investigation
- provide challenge to ensure the procedures being followed are thorough and robust

The panel did not have a role in producing or commenting on the content of the Independent Investigator's report.

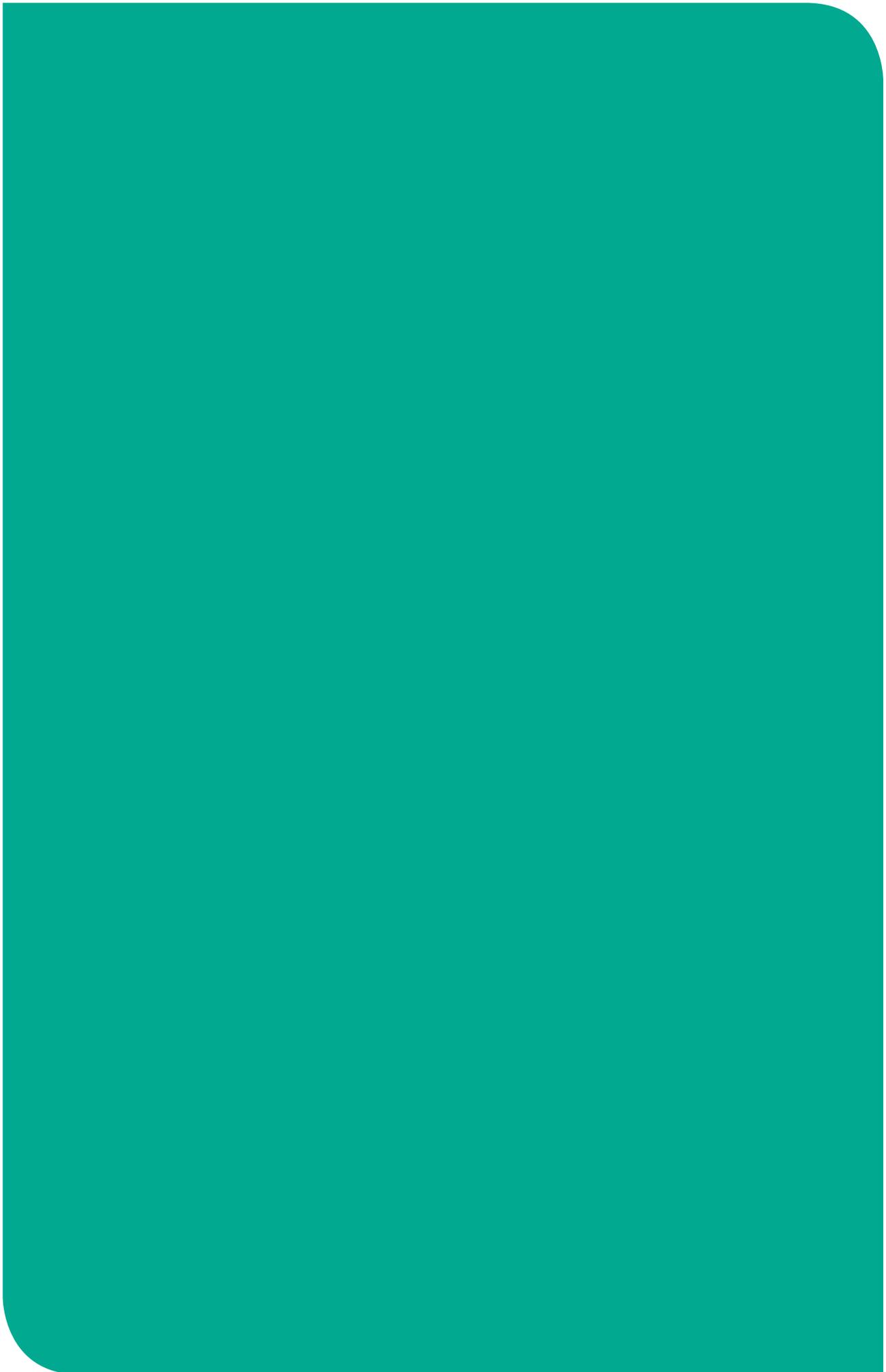
Membership

The oversight panel consisted of seven members with expertise in mental health services and safeguarding:

- Chairman – Nigel McCorkell, Chairman of West London Mental Health NHS Trust
- Vice-chairman – Bruce Calderwood, succeeded by Karen Turner and then Sarah McClinton, Directors of Mental Health Policy DH
- Independent non-executive director – John Bacon, Chairman Sussex Partnership NHS Foundation Trust
- NHS England/National Trust Development Authority – Victoria Man
- Safeguarding lead – Zoë Johnston, Bracknell Forest Local Authority
- Representing service users – Paul Jenkins, CEO Rethink
- Independent secure services expert – Granville Daniels

The following people supported the oversight panel:

- Leeanne McGee – Executive Director of High Secure Services, West London Mental Health NHS Trust (Leeanne will act as the Trust main contact point and coordinate support for Dr Kirkup)
- Gwen Nightingale, succeeded by Tessa Ing – Deputy Director, Department of Health (In attendance as the main Departmental contact point for the investigation)
- Helene Feger – Director of Communications, West London Mental Health NHS Trust
- Gerard Hanratty – Partner, Capsticks
- Isabel Letwin, DH Legal Services



Appendix 2: Sources

Documentary Evidence

Sources

1. Berkshire Record Office
2. Broadmoor Hospital
3. Cabinet Office
4. Care Quality Commission (successor body to Health Care Commission)
5. Department for Education
6. Department for Work and Pensions
7. Department of Health archives
8. Hansard
9. Home Office
10. London Strategic Health Authority
11. Ministry of Justice
12. National Offender Management Service
13. Royal household
14. The Charities Commission
15. The Metropolitan Police Service
16. The National Archive
17. West London Mental Health Trust

Search criteria

- Jimmy Savile (in all possible forms, eg James Savile, Jimmy Saville, and for any date)
- Broadmoor hospital
- Broadmoor task force
- Special hospital service authority / special hospital / special health authority
- high secure hospitals/ high secure psychiatric hospitals
- Fallon inquiry

- appointments (1986-1989)
- press notices, particularly 1987-1989
- Private Office files / corporate management meeting files
- Stoke Mandeville Rebuild in 1979
- Ministerial weekly meeting
- Ashworth (1971)
- Rampton (1971-1973)

As well as reviewing formal files, the Investigation Team visited Broadmoor to review unsorted papers from the 1960s stored in a decommissioned ward.

These searches produced over 1000 extant files potentially containing relevant information, with the earliest papers dating from 1966. The Investigation Team read all of these, identifying in particular material related to the Terms of Reference covering

Appointments

- a) Honorary Entertainments Assistant / Activities Committee
- b) Taskforce / Hospital Board (Chair or member)
- c) Hospital Advisory Committee
- d) Decision makers, (Ministers, senior officials)
- dd) Honours

Access and privileges

- e) Keys
- f) Flat/House/Garage/Office space
- g) Dedicated support
- h) Salary

Complaints

- i) Any complaint against Jimmy Savile
- j) Complaints handling

Charity and fundraising

- k) Jimmy Savile fund (Broadmoor)
- l) Use of charitable fund money
- m) Governance of fund

Celebrity Status

- n) Public relations
- o) Broadmoor redevelopment project

Policies and procedures

- p) Significant policies & changes to practices
- q) Safeguarding
- r) Child protection
- s) Security
- t) Visiting & trips policy

Contextual

- u) Committee structures/ ToR/ Membership
- v) Key staff changes particularly decision makers

Other Jimmy Savile Investigations

- w) Information relevant to the other investigation teams
- x) Information for the Police

Press Allegations

- y) Members of Broadmoor attending BBC Programmes
- z) Members of the public invited to attend parties at staff bar

This analysis was incorporated into an electronic documents management system (Lextranet) to facilitate further researches.

Information from individuals

All present Broadmoor staff and patients, and all previous staff, who had been there in Savile's time were invited to offer information. Key individuals were identified from the documentary sources. Individual contacts frequently suggested others who were then followed up. (Chapter 3, paragraphs 3.11 et seq)

In addition people were invited for interview, even if they had not responded to the more general invitation above, who had

- Held key positions during the period under review, and especially at dates when Savile acquired formal roles within Broadmoor
- Made allegations about Savile's activities

The Investigation was in direct contact with over 300 individuals; over 200 from Broadmoor and over 100 from the Department of Health. Of those, 101 were interviewed, 70 in person and 31 by telephone. Those interviewed in person were:

8 ex-patients

42 current and former Broadmoor staff

5 former Ministers

9 former Department of health civil servants

6 third parties

Each individual was sent a short, friendly letter asking them to contact the investigation if they had any relevant information; and those who responded were sent a fuller information note before an appointment was made. Each interview began with, broadly, the same introduction. Interviewees were subsequently sent a transcript and asked to confirm its accuracy. Proforma invitation letters, the information note and transcript letter are at Appendix 2B

Appendix 2A (i)

27 September 1968

Letter from Dr Patrick McGrath, Physician Superintendent at Broadmoor, to Mr R Bolton, Ministry of Health, setting out the origin of Jimmy Savile's association with the hospital.

Mr R. Bolton,ⁱ

Divn. H.S.2.C.,

Ministry of Health

Jimmy Savile has been written to by two or three of our patients through the medium of some 'Pop' magazine over the last few months. About a month ago he rang the Entertainments Officer, Mr Britton, offering to come down to visit those patients in particular, and other patients in the hospital. The Entertainments Officer, as he normally does, accepted this invitation from a celebrity whose visit he knew would give pleasure to very many patients. He told me about it, and I endorsed his action. It is, therefore, true that Savile came to the hospital "at the invitation of the Hospital Authorities".

Near the day of the visit, which was on Friday, 13 September, Mr. Savile again rang and asked if, on his arrival, he could be photographed talking to myself; this suggestion I rejected, and in the event Mr. Savile turned up at the hospital, after I had left for my Out-Patient Clinic. He had not indicated in previous discussion that he had intended to publicise the visit, but when he turned up he had a photographer and an associate with a tape recorder. He was told that photography in the hospital was not permissible, and contented himself with the photograph later published in 'The People'. I understand that some photographs were also taken at the invitation of various members of the hospital staff of Mr. Saville with those staff members. The photographer did not come into the hospital and took no photographs of patients.

Mr. Savile's visit was a riotous success and gave a great deal of pleasure to a large number of patients and to staff. He asked if he might stay on to visit the Staff Club in the evening and then stay overnight before returning to his ordinary work. In my absence on the Friday afternoon this permission was given – permission which I endorsed on my return.

I met Mr. Savile that evening when he was insistent on his sincerity of offering help for fund raising activities for the League of Friends. I gave him a short and innocuous interview which he recorded. He told me that he had a column in the 'People' and proposed writing up his visit. I asked that the copy should be submitted to me. On the following Thursday, in a programme "Top of the Pops", I am told that Mr. Savile, without mentioning the word 'Broadmoor', greeted by a code phrase and signal, some of the patients whom he had met here. This also gave a great deal of pleasure to these patients. I understand that he will make a similar reference to his visit in the programme "Savile's Travels" on Radio 1 on the 29th September.

On Thursday, 18th September the Features Editor of the 'People' rang me and read the text of Mr. Savile's article. I found nothing in it to object to, conscious of the fact that the style, grammar and syntax were aimed at

readers of the 'People' and not at readers of the 'Observer'. The article is certainly not worse than the series of articles in 'Tit Bits' which appeared five years ago, and has not caused the protests of offence which those articles did. You will remember that the writer of the 'Tit Bits' articles was "sold" to me by the Department.

I rang xxxxxx, who was the only official of the Department who I could readily contact, and told her of the forthcoming publication; expressed my personal feeling of nausea but also my view that no patient would come to any harm from the article – in fact many patients, friends and relatives would derive pleasure from it. I should add that I am not the "doc" referred to in Mr. Savile's article.

On the question of visits to the hospital, every week outside entertainers visit the hospital – cricket teams, bowls teams, football teams, concert parties, solo artists, dancing instructors, chess players, philatelic experts, etc. etc. Very rarely, unless the timing or other circumstances of the visit are out of the ordinary, am I concerned with these visits, and it had not occurred to me to consult the Department about any of them. Anyone of the many friends of the hospital could write about their experiences on their visit, and we would have no means whatsoever of preventing them so doing.

PATRICK G. MCGRATH
Physician Superintendent

27th September, 1968

ⁱ This letter has been transcribed owing to the poor quality of the original. The name of one junior official has been removed.

Appendix 2A (ii)

23 December 1987

Letter from Sir David Brown, Chairman of Broadmoor Hospital Board, to Jimmy Savile, allocating responsibilities to Board members.

Broadmoor Hospital

Crowthorne, Berks. RG11 7EG

Telephone: 0344 773111



Sir David Brown, K.C.B.
Chairman
Broadmoor Hospital Board

PERSONAL
MANAGEMENT IN CONFIDENCE

23 December 1987

Dr J Savile OBE KCSG LLD
C/o Broadmoor Hospital
CROWTHORNE
Berkshire

Dear Jimmy,

INFORMATION BRIEF

During our consideration of the 'Information Brief' issued by Cliff Graham, Under Secretary, concern was expressed over the lack of clarity and precise definition of responsibilities. In particular the insertion of the word 'Management' in the Board's title, since the laying before Parliament of Statutory Instrument 1986(2005), had added to the confusion.

We agreed our best way forward would be for individual members to speak on behalf of the Board on specific topics. This should avoid fundamental disagreements between Board members and leave the Chairman properly free to manage the meeting on 19 January 1988.

The Secretary will contact each Board member individually on or before 6 January 1988 to establish areas of particular interest and concern. However, the following topics may be appropriate and likely Board members names have been inserted in brackets as suggested speakers:-

- (a) The feasibility of a Board entirely made up of part time members to be held responsible for day to day management. Perhaps a General Manager is what is really needed? (Flather/Morgan).
- (b) The lack of the Employment Function considerably limits 'management' responsibilities including:
 - Discipline
 - Inefficiency
 - Disputes and Grievances
 - Promotion
 - Appointment and dismissal of staff (Dancy/Jones).
- (c) The exclusion of overall Financial Accountability because of the exclusion of the Employment Function, which represents some 75% of the annual budget (Secretary/Emerson).

- (d) The lack of flexibility arising from the present accounting systems with no 'carry over' facility from one financial year to another (Young/Jones)
- (e) Financial and Manpower Resource Allocation (Young/Emerson)
- (f) Complaints Procedure (Emerson/Lillington).
- (g) Admission of patients, without regard to resource implications (Dick/Secretary).
- (h) Financial control of Capital Building Projects (Jones/Emerson).

It would be helpful to Mr Roberts if you could marshal your thoughts on the subjects listed before he telephones.

Finally, a response should be prepared to the question of what should be our function and responsibility if a General Manager is introduced. To whom should the General Manager be responsible?

May I wish you a Happy Christmas and Prosperous New Year.

*Yours sincerely,
David*

Sir David Brown

c.c. Medical Director
Chief Nursing Officer
Administrator

I have not suggested you as a spokesman but to help everyone 'pull together', you might give a thought to a Broadmoor Christmas, Competition, Printout, Prize for winner and programme for 1988.

DLB.

Appendix 2A (iii)

30 August 1988

Submission from Cliff Graham to Department of Health Ministers, setting out the management position in relation to the special hospitals with particular reference to Broadmoor.

Perm Sec

RF 9/9
Broadmoor

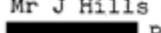
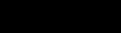
RF 14/9
15 records



From C Graham, PC Div

30 August 1988

c.c.

-  PS/MS(H)
-  PS/PS(H)
- Mr J Hills - Special Adviser
-  PS/Perm Sec
- CMO
- Mr Utting
- CNO
- Dr Abrams, DCMO
- Mr Heppell, HPSS PG
- SHSB Members
-  PC4

SPECIAL HOSPITALS SERVICE

SUMMARY

1. This submission informs Ministers about decisions, about the future management of the Special Hospitals Service (SHS), taken, in March 1988, by the Secretaries of State for Social Services, the Home Department and the Territorial Departments; reports on management action taken to date under the auspices of the Department's Special Hospitals Service Board (SHSB); and, seeks the views of Ministers on remaining action in the light of current events.

MANAGEMENT ARRANGEMENTS

2. A copy of Mr Moore's letter dated 30 March 1988 to Cabinet colleagues with an interest in the Special Hospitals Service is at Annex A. This proposes the creation of a Special Health Authority for the SHS; the appointment of a General Manager in Broadmoor Hospital, in Rampton Hospital, and a single manager for the two hospitals at Park Lane and Moss Side outside Liverpool, who will be accountable to the General Manager of the SHA; and, the replacement of the existing three Local Hospital Boards by hospital "House Committees" operating on the lines of the original "Boynton Review Team" at Rampton.

POLICY

3. The SHSB is developing, for the approval of Ministers, a national policy for the future of the SHS. This will include a survey of the

dependency of all existing patients of the SHS, and clear guidelines on the criteria Ministers wish to see applied to future SHS patients on admission, continued detention, length of stay, transfer, treatment, rehabilitation and discharge (to prisons, NHS or community care provision and the general public). The overriding aim is to concentrate the SHS on those people who need the full security and treatment facilities of a special hospital. The national policy would also take account of the developing management arrangements. A note of some of the policy issues at present under consideration by the SHSB is at Annex B.

CONSULTATION

4. In May 1968, Ministers decisions were communicated to all staff, and all other interests, including the media, in the form of the note at Annex C.

5. In general, there has been good support for these proposals, except for the following two points:

- 5.1 the Civil Service Unions reject the case for change, even though it has been accepted by members of the management teams at all the hospitals; and, more important, they wish to be clearer about the balance of advantage for their members if the special hospitals were to become part of the NHS in 3-5 years time as suggested in Annex C;
- 5.2 two of the three Chairmen of the existing Local Hospital Boards, Sir David Brown at Broadmoor and Mr Robert McConnell at Park Lane/Moss Side lobbied Lord Skelmersdale for the retention of their Boards broadly as constituted at present: Dr David Edmond, the longest serving Chairman of the longest running Board at Rampton, disagreed with his colleague Chairmen and has given strong support to the concept of the central SHA; and, all Board Members have accepted the need to develop a new role for the "House Committees", which are intended to replace the Local Boards next year, and that these new "Committees" should not form part of the general management line.

BROADMOOR

6. Following the announcement of Ministerial changes and the creation of the Department of Health, the SHSB put the arrangements in Annex C "on hold" until the views of new Ministers could be established.

7. The developing situation at Broadmoor Hospital required some interim activity by the SHSB, pending clarification of the views of Ministers, for the following main reasons:

- 7.1 HAS REPORT: the Secretary of State has received a report from the Director of the Health Advisory Service which will be read as containing a frontal assault on the medical and nursing regimes at the hospital and calling for significant improvements to be made urgently for the treatment and care of patients: it refers to a similarly worded, unpublished, HAS report almost 15 years ago which has not resulted in any effective action to date. The SHSB have discussed the HAS Report and will be recommending that Ministers should publish the Report without further delay, together with an action programme in support of the HAS recommendations. The SHSB are preparing a separate submission for Ministers;
- 7.2 REBUILDING OF BROADMOOR HOSPITAL: the rebuilding scheme, which results from almost 20 years of planning, is running about 3 years late on a 2 year construction contract, which itself started 2 years late, and the, almost completed, Stage I of the rebuilding is likely to cost £32m-£35m against an original budget estimate of £13.5m. PSA acted as the client for DHSS. The Chief Secretary has been informed and the Accounting Officers for DHSS and PSA have agreed an urgent programme of action to get the scheme back on track; but no further work has been, or will be, authorised until the results of the SHSB's post-contract audit has been received, hopefully in November, and proposals for re-shaping the scheme, have been drawn up. The SHSB is preparing a separate submission for Ministers;
- 7.3 INDUSTRIAL RELATIONS: Broadmoor nurses have threatened, and taken, much industrial action over the past year, culminating in their present ban on overtime working at the hospital. Four issues lie behind the current industrial action: the shortage of nurses and general difficulties of recruitment; an unmet claim for a "location allowance", to compensate nurses for the high cost of housing in Berkshire; a refusal to co-operate in the commissioning of the new hospital building until the unions' financial claim is met; and, the absence of firm and inspired professional and management leadership at the hospital - where, at present, the Union is forced to deal with the Hospital Management Team (HMT), the Local Board and the Department of Health. The SHSB has responded by authorising the recruitment of 25 more Nursing Assistants (the number of professional nurses has increased even though patient numbers have fallen); by indicating that Treasury might be prepared to offer £200 "location allowance" as an addition to the existing Special Hospitals lead payment of £2,000 plus; and by replacing the HMT and Board by a task

force, representing central and local management, committed to improving management and taking charge of the new building as soon as possible. The SHSB are preparing a separate submission for Ministers.

- 7.4 MANAGEMENT ARRANGEMENTS: the HMT comprises a Medical Director (Dr Hamilton), Chief Nursing Officer (Mr Clarke) and Administrator (Mr Roberts). The Local Board comprises Vice Admiral Sir David Brown plus a doctor, a nurse, a retired social worker, a retired civil servant and 3 lay members: the Board's functions are difficult to work out in practice; but it has no effective role in terms of finance, personnel and employment and patient admissions and transfer. The HMT acknowledge, as is evident from the strong language in the HAS Report, that they have not been able to provide the necessary degree of corporate leadership and, on a more fundamental level, to operate as a "team". As a result the hospital lacks comprehensive management oversight and a sense of dynamic, day-to-day, direction. The presence of the Local Board, for most of the past year, and particularly the interventionist role of the Chairman, appears to have added to these difficulties of local management. The SHSB have, therefore, taken action as described in Annex D; essentially to replace the management team, pending new appointments (including that of a General Manager for the Hospital), and to suspend the activities of the Local Board, pending Ministers' decisions on management arrangements for the SHS in keeping with Annex C. This has attracted, essentially favourable; press interest, on which Ministers have been advised separately by ID.

ACTION

8. The SHSB (Dr Reed, SPMO, Mr Tait, PNO, Mr Smith ACI/SSI, Miss Edwards A/S PC4 and myself) stand ready to discuss the above with Ministers, in terms of both responding to immediate events and continuing action on the longer term changes outlined in Annex C. Mr Heppell will be available to join in such a discussion on his return from leave on 5 September; and Mr France may wish to join in, as Accounting Officer for the rebuilding scheme expenditure as well as generally.



CLIFF GRAHAM

2.20
1/4

ANNEX A

Mr Heppell

Mr Graham P

Dr Reed

Mr Tait

Mr Smith - SS1



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Social Services

The Rt Hon Douglas Hurd CBE MP
Secretary of State for the Home Department
50 Queen Anne's Gate
LONDON
SW1H 9AT

30 March 1988

I am writing to seek your views on changes I propose in the management of the four special hospitals.

I have been reviewing the current management arrangements to decide whether any changes are needed to meet management and policy objectives for the special hospitals service and to provide stronger management and policy links with psychiatric provision elsewhere in the National Health Service and with the Prison Service and the Prison Medical Service. We have concluded that changes are needed, and our proposals are set out in the annex to this letter.

I am conscious of your responsibilities for the powers of the courts and the treatment of prisoners, and your concern that there should be appropriate hospital resources available for the treatment of mentally disordered offenders. It is my intention to pay full regard to these issues in developing my plans. To give effect to this, I would propose that officials in your Department should be represented on the proposed Special Hospitals Service SHA, both in its shadow and final form.

I shall be informing interested colleagues of my proposals, but I wished to give you a first opportunity to comment in view of your particular responsibilities and interests.

JOHN MOORE

Annex B

MANAGEMENT IN CONFIDENCE

POLICY AND MANAGEMENT OF THE SPECIAL HOSPITALS SERVICE (SHS): POLICY REVIEW

Issues for policy review

1. It is proposed that the following issues be addressed and proposals for future policy be formulated as a result.

Patients

2. The appropriateness of the workload of the SHS should be reviewed. There should be a census and review of the patient population, to determine who needs the SHS level of security, who should be treated elsewhere on security or other grounds (Regional Secure Unit (RSU), other hospital psychiatric provision, community psychiatric or other provision) and who does not need treatment at all (transferred prisoners, psychopaths considered no longer treatable). The current criteria for admission to the SHS should be examined as part of this review.

Services

3. The provision for SHS patients and staff should be reviewed, to determine the services to be provided for the future and to form the basis of central and local objectives for service development and measurement of quality and value for money.

4. The provision for patients should be designed to provide comprehensive assessment on admission (based wherever possible on a pre-admission plan reflecting history, source of referral, diagnosis); individual treatment programmes, regularly reviewed, with patient participation; rehabilitation; preparation for transfer or discharge; and post-transfer/discharge monitoring. Because of the deprivation of liberty and as part of the treatment and rehabilitation process, the service organisation and environment should maximise patient participation in the life of the hospital, contact with the outside world and opportunity for self-development and fulfilment (through treatment, creative work and other activity and recreation). Account should be taken of quality assessment work done elsewhere in the NHS and abroad (eg McColl report on the organisation of the in-patient day).

5. The provision for staff should be designed to provide support: to minimise isolation (within the hospital and surrounding community and from the rest of the NHS); and to promote a therapeutic and positive relationship with patients. There should be provision for personal development; post-qualification training and development; and encouragement of an atmosphere that expects education, training and continuing development. Full multi-disciplinary team working should be established. To meet these requirements, the review and subsequent operation of the SHS should draw on experience and skills elsewhere in the NHS and other services, including the prison service. Professional assessments of manpower requirements (eg Joint Planning Advisory Committee for medical manpower) in all disciplines should be applied, and there should be consideration of further joint training arrangements and appointments, two-way secondments of management and staff with other hospitals, and more links with academic institutions. There should be encouragement of research and an enquiring attitude.

6. In reviewing services and keeping them under review centrally and locally, the views should be obtained of patients, staff and other interested parties (eg patients' relatives and friends, Leagues of Friends, the Mental Health Act Commission, staff associations and unions).

Security

7. The nature and organisation of the SHS security requirement should be reviewed. Within the context of informed perimeter security, consideration should be given to decreasing the individual elements of security within the hospital, to provide a freer, more therapeutic, environment for patients and reduce the custodial element in the staff input and manpower requirement. The review should encompass the security requirement for SHS patients moving outside temporarily, eg on escorted individual and group outings, trial leave or for acute hospital treatment.

Quality of service/value for money

8. Performance indicators should be developed, to measure output and performance in relation to input and provide a means of monitoring quality of care and value for money. They should be developed for use within the SHS itself and for comparison with relevant provision elsewhere.

Amount and location of SHS provision

9. The future amount of SHS provision should reflect the assessment of need for SHS treatment at any one time. Other issues to be addressed, taking account of service, security and quality of care/value for money considerations, are the optimum size of a special hospital; whether there should be 'specialisation' according to patient diagnosis; the optimum location, taking account of the value of the SHS estate and options for maximising it, the location of other psychiatric provision (RSU, hospital and other psychiatric provision) and prison provision; and economic factors such as cost of living and alternative employment opportunities affecting staff recruitment.

Alternatives to SHS provision

10. Alternatives to SHS provision for patients needing treatment but not the SHS level of security should be considered with the NHS hospital and community health services, the family practitioner services, the social services and the probation service. All those services should be invited to consider the amount of provision needed for such patients, taking account of the likely range of security requirements; and the training and support needs of staff treatment and caring for them and of families and others providing care in the community. Health authorities, in particular, should be actively involved in reviewing the service needs of such patients. The Department should consider with all authorities concerned the best application of available funding to meet the identified needs.

Post-SHS provision

11. To ensure provision for patients admitted to the SHS but no longer needing treatment there, all concerned centrally and locally should be required to facilitate or provide alternative care from the time the patient was ready for transfer or discharge. This would require liaison with NHS and other authorities (as in the 'Difficult to Place Patients' initiative and SHS transfer list arrangements with RHAs) and with the Home Office on movement of SHS patients under restriction orders.

SHS management and funding

12. The long-term management arrangements for the SHS should be addressed as part of the policy assessment. The option of full absorption into the rest of the NHS should be examined on the basis of a full assessment of the policy

requirements of the SHS, in relation in particular to security, staffing, and patient management. Funding arrangements should be addressed, taking account of developments in NHS funding policy and the scope for extending the present charging arrangements for SHS services.

Sources and inputs

13. The review should draw on previous and current reviews of SHS provision (eg Boynton Committee report on Rampton Hospital; the current Park Lane review) and reviews set in a broader context (eg Butler Committee report on Mentally Abnormal Offenders; Royal College of Psychiatrists report on Secure Facilities for Psychiatric Patients; and the recent DHSS/HO reports on Offenders Suffering from Psychopathic Disorder and Mentally Disordered Offenders in the Prison System). On the management and professional requirement, it should draw on reviews of NHS management and services; the Griffiths report on Community Care; and reports and developments in professional and training requirements in the psychiatric field. It should also consider provision for psychiatric treatment in a secure setting in other countries.

ANNEX C

POLICY AND MANAGEMENT OF THE SPECIAL HOSPITALS SERVICE

The Secretaries of State for Social Services and the Home Department have decided that the arrangements for policy formulation and implementation, management and operation of the Special Hospitals Service should be changed over the course of the next year. To assist and control the management of these changes on their behalf, Ministers have decided to create a "shadow" Special Health Authority at the centre and to appoint General Managers in each of the Special Hospitals (counting Park Lane and Moss Side Hospitals as one hospital for this purpose):

It will be for the "shadow" SHA to advise on the implementation of the programme of action Ministers have in mind. Ministers aim to appoint General Managers by Autumn 1988 and have a central SHA in place by 1 April 1989, or as soon as possible thereafter. Members of the "shadow" SHA will be appointed by the Special Hospitals Service Board and membership of the "shadow" SHA, and its executive support staff, will reflect all the many existing interests involved in the central and local management of the Special Hospitals Service.

Before General Managers are appointed by the Special Hospitals Service Board, advised by the "shadow" SHA, Ministers intend to promulgate their national policy for the future of the Special Hospitals Service. The aim will be, so far as possible, to minimise the existing geographical, professional and service isolation of the Special Hospitals Service; by emphasising and strengthening the existing vital links to the full range of psychiatric services provided by the Hospital and Community Health Services, the Family Practitioner Service and the social services, and to HM Prison Service and the Prison Medical Service and the Courts.

Once the central SHA is in place and General Managers are working within a national policy for the Special Hospitals Service, hopefully by 1 April 1989, Ministers intend to abolish the Special Hospitals Services Board within DHSS and to re-adjust the role, functions and organisation of the existing Special Health Authorities at Broadmoor, Rampton and Park Lane/Moss Side Special Hospitals. Ministers intend also to give consideration to placing a time limit on the operation of the central SHA, say three or five years, in an endeavour to forge even stronger links between the National Health Service and HM Prison Service and the Special Hospitals Service, especially for those patients requiring the maximum security of detention during the period of their hospital treatment. This will also allow Ministers to evaluate the full process of change before settling the final policy and management arrangements at the end of this 3-5 year period.

In re-adjusting the role and functions of the Local Management Boards, in keeping with these central and local changes, Ministers will wish to remove the status and functions of a "Special Health Authority" from the Boards and yet strengthen the local accountability of the hospitals in terms of the professional requirements of national policy and local community perceptions of the most appropriate balance between the treatment and security of individual patients. This may point to the need for some form of "House Committee" in each of the special hospitals, operating locally and

outside the new management arrangements for the Special Hospitals Service. At that point, each Special Hospital might then fall naturally within the area of management responsibility of identified regions and districts of the National Health Service, in keeping with the national policy for the Special Hospitals Service agreed by the Secretaries of State for Social Services and the Home Department.

All these changes are designed to continue and build on the evolutionary process of management change and development within the Special Hospitals Service, which has been given a major impetus in recent years by the work undertaken by the Local Management Boards over the 6 years since the establishment of the Rampton Review Board.

SUS

4 Nov 1986

MANAGEMENT IN CONFIDENCE

THE SPECIAL HOSPITALS SERVICE

Hospitals

1. The Secretary of State for Social Services is responsible for providing the Special Hospitals Service through four hospitals - Broadmoor, Moss Side, Park Lane and Rampton. The hospitals have been managed directly by the Ministry of Health and DHSS since the Home Office Board of Control was replaced by the Special Hospitals Service in preparation for the Mental Health Act 1959. Under Section 4 of the National Health Service Act 1977, the Secretary of State is required "to provide and maintain establishments (referred to as "special hospitals") for persons detained under the Mental Health Act"... "who in his opinion require treatment under conditions of special security on account of their dangerous, violent and criminal propensities".

Patients

2. The hospitals form a single national service and provide treatment for nearly 1,700 patients. Patients are admitted direct from the courts or transferred from prisons or other hospitals. Admissions are determined centrally by the DHSS, through a multi-disciplinary Admissions Panel.

Management

3. The Secretary of State for Social Services is responsible ultimately for the management of the hospitals and the care of the patients. He is advised on all matters pertaining to the Special Hospitals Service by a multi-disciplinary group of DHSS officials comprising the Special Hospitals Service Board (SHSB).

4. Local management boards have been established for the hospitals, and all management functions have been delegated to them except patient admissions, employment and the allocation of resources. The local management boards are special health authorities (SHAs). There is one each for Broadmoor and Rampton, and a combined one for Moss Side and Park Lane which share a single site. The local management boards are supported by Hospital Management Teams (HMTs) comprising a Medical Director, Chief Nursing Officer and Administrator. The HMTs are led by the Medical Director. They are accountable to DHSS for

the exercise of the HMT management responsibilities which DHSS still discharge directly. They are accountable to the local management boards for the exercise of the functions for which the local management boards have delegated responsibility.

Need for change

5. There is an urgent need to develop a coherent policy for the Special Hospitals Service, in itself and in relation to other services on which it has a direct bearing - the hospital and community psychiatric services; the prison service and the prison medical service. There is a need to end the geographical, service and professional isolation of the Special Hospitals Service and ensure that the hospitals are regarded as part of the spectrum of psychiatric treatment. Unless the present management weaknesses are corrected, this policy requirement will not be met.

Proposals for change

6. The following changes are proposed to correct the existing management weaknesses and more effectively meet the policy requirement:

(a) create Special Hospitals Service SHA: create a shadow SHA, drawing on the SHSB, local management boards and DHSS staff, pending the necessary legislative change, to be responsible for overseeing the necessary management of change at all levels;

(b) abolish local management boards: as soon as possible, supersede the existing local SHAs by the proposed central SHA, if necessary in shadow form;

(c) appoint General Managers: in each of the special hospitals, counting Moss Side and Park Lane as one hospital for this purpose, following open advertisement along NHS lines;

(d) develop a national policy: for the future of the Special Hospitals Service, which is flexible enough to be implemented either through a central SHA or as part of the NHS, or both. This would require an appropriate budget, which would be managed by the central SHA through the General Managers in the hospitals.

7. The key elements are to establish a central SHA and to appoint General Managers in the hospitals. By establishing a central SHA, the Special Hospitals Service would be given the strengthened management and policy advice which it needs. The objective would be to link the Special Hospitals Service more closely to the NHS, either through complete integration over time or through a preferably time-limited central body which could consider and recommend long-term policy and management arrangements. By appointing General Managers, the Special Hospitals Service would be brought into line with the rest of the NHS and provided with a function which is necessary for effective decentralisation of day-to-day management of the hospitals and delivery of central management/^{and} policy requirements.

Resource consequences

8. It is not envisaged that the proposed changes would make additional demands on resources, the aim being to introduce tighter and more effective control of existing resources. The proposals are designed to be met from the present revenue budget of the Special Hospitals Service (£59m for 1988/89). They should produce a long-term savings, as the three local management boards are superseded by a single SHA and consensus management teams at hospital level are drawn together by a General Manager. Better use of resources, particularly capital resources (£12m for 1988/89) and manpower (3318 staff at 1.4.89) should produce either further savings over the longer term or an improved quality and quantity of service.

Consequences of change

9. The process of change will not be easy, especially in the present political and industrial relations climate, and senior officials and Ministers can expect to be lobbied by the various interest groups. The local management boards will need careful handling if they are to be convinced of the need to sacrifice their only recently created local position in favour of more effective national action. The process will be tightly controlled, and it is the intention to include as many as possible of the key local figures in the early membership of or support staff for the shadow, if not the final, SHA.

Timing

10. There is a strong operational and policy requirement for early strengthening of the management arrangements, and it is proposed that the changes be brought about before the existing SHAs become further established. The aim is therefore to appoint General Managers in the hospitals by the autumn of this year and supersede the local management boards by the Special Hospitals Service SHA by 1 April next year. Work on a national policy paper to guide the future direction of the Special Hospitals Service will be carried forward in parallel.

ANNEX D

TOP MANAGEMENT OF BROADMOOR HOSPITAL WITH EFFECT FROM 1 SEPTEMBER 1988 UNTIL FURTHER NOTICE

With effect from 1 September 1988 the following management arrangements will be put into effect by the SHSB:

- Broadmoor Hospital Task Force: the task force will be reconstituted, to take full management responsibility for Broadmoor Hospital, under the Chairmanship of the Chairman of the Special Hospitals Service Board. It will include in its new membership, Mr John Tait, Principal Nursing Officer, and Dr Louis Warnants, Senior Medical Officer for the Department of Health and Dr Dick, Professor Morgan and Dr Savile as representatives of the Broadmoor Hospital Board;

- Medical Director: the SHSB has agreed to Dr Hamilton's request to be seconded to the Department of Health, to work on the patient dependency survey the Department is commissioning from the Institute of Psychiatry as part of its formulation of a national policy for the Special Hospitals Service. Dr Louis Warnants, Senior Medical Officer, will be seconded from the Department to Broadmoor Hospital to take on Dr Hamilton's management responsibilities, pending the appointment of an acting Medical Director. Dr John Reed will agree with Consultant Medical Staff at the hospital interim arrangements for handling Dr Hamilton's clinical responsibilities, pending the appointment of an acting Medical Director;

- Chief Nursing Officer: the SHSB has agreed to Mr Clarke's request to be granted premature retirement with effect from 14 October: Mr Clarke's last day on duty in Broadmoor Hospital will be 31 August 1988. Mr John Tait, Principal Nursing Officer, will be assuming responsibility for the nursing management at Broadmoor Hospital, he will be supported by the acting Chief Nursing Officer, Mr Colin Webster, pending the appointment of a new Chief Nursing Officer following the recent advertisement of the CNO post.

- The Broadmoor Hospital Board : in consequence, all the activities of the Broadmoor Hospital Board will be put into suspense with effect from 31 August 1988 until a new management team is in place and essential management action has been agreed in keeping with the Secretary of State's requirements for the Special Hospital Service.

Appendix 2A (iv)

15 September 1988

Note of a meeting between Edwina Currie and Jimmy Savile

Perm [Signature]
*This is the background
to J. Savile's invitation
to tea.*
BS 16/9,

B.F. 28/9

Mr C Graham PC

From: [Redacted] RL1B

Date: 15 September 1988

cc. [Redacted] PS to PS(H)
PS to Perm Secy ✓

PS(H) Meeting with Dr. J Savile 13 September 1988.

1. I have already reported back orally and fully on the meeting; this note records the main points and uses slightly less earthy language!
2. The conversation centred entirely on Broadmoor, and what Dr Savile would like to do if PS(H) would "press the button".
3. Having established that PS(H) was now the Minister i/c Broadmoor and therefore had full authority for button-pressing, Dr Savile gave a quick resume.
 - 3.1 The patients he believes behave in an exemplary fashion, but their goodwill is being stretched by the behavior of some of the staff.
 - 3.2 The staff fall into 3 categories - those who want to turn Broadmoor into a prison, those who want to behave as a caring profession and those who would go either way.
 - 3.3 The rebuilding programme has now been stopped by him. He turned down PS(H)'s suggestion of more money to get it finished saying that rebuilding was not a priority and was not necessarily the answer to Broadmoor's ills.
 - 3.4 The result of the ballot does not worry him - he has (unspecified) ways of dealing with it whichever way it goes.
4. He is convinced he can sort Broadmoor out but needs to be able to tell the media (when the time comes) that he was able to do so because he had the full backing of the Minister. PS(H) promised to give him her full support so long as
 - the public were fully protected
 - the inmates' lives were improved

She also suggested forensic psychiatry could play a greater part. Dr Savile gave her his total assurance on these and promised he could improve Broadmoor beyond recognition within 8 weeks if he got the go ahead. He did warn however that there would be several sorts of mess on the walls but good news at the end of it.

5. PS(H) raised the question of the high housing costs for Broadmoor staff. Dr Savile told her that there were currently 30 staff houses occupied by ex-wives of Broadmoor staff, or persons no longer employed at Broadmoor. He intends to get these people out to free the houses for Broadmoor staff, but promised PS(H) that he would not evict elderly or infirm occupants.

6. Dr Savile also said that officials at the Department were getting very worried because he was moving so fast, and he was worried he was causing you so much hassle. We reassured him that you were more than able to cope with hassle.

7. Finally he said he wanted to meet the "top guy" and take him to the Athenaeum. I promised to pass on the message to Mr Frances' private secretary.

8. If you would like a purely personal point of view I would say he was 100% sincere and committed in his desire to improve the management of Broadmoor and the lives of its patients, and it is his burning ambition to do so. But I doubt he will let anyone stand in his way and he clearly doesn't mind how many people get trampled underfoot in the process if, in his opinion, they deserve it.

9. You might have warned me of his penchant for kissing ladies full on the mouth.....



G31 Richmond House
210-5638

Appendix 2A (v)

28 January 1989

Letter from Jimmy Savile to Cliff Graham, copied to Department of Health Ministers, the Prime Minister and others, setting out the management arrangements for Broadmoor following the Task Force.

National Spinal Injuries Centre

Jimmy Savile Stoke Mandeville
Hospital Trust, No. 283127
Jimmy Savile Charitable Trust,
No. 326970

at Stoke Mandeville Hospital

Mandeville Road Aylesbury Bucks HP21 8AL

Tel: Aylesbury (0296) 84111

Date 28.1.89

Please reply to:-

Mr. Cliff Graham
Under Secretary,
Department of Health,
Priority Care Division
Alexander Fleming House,
Elephant & Castle,
London SE1

On October 19th 1988, I agreed to resolve the long term problems at Broadmoor Hospital. We saw this as an on-site one man band situation with yourself back at the Department making it all work. This arrangement we envisaged going on until a Special Health Authority was set up in April, 1989.

I tell you now, with some pleasure, that my end of things is completed.

Broadmoor Hospital is now effectively controlled by the following:+

Alan Franey
General Manager, designate, to be confirmed.

Mick Morgan
Administrator. Confirmed.

Colin Webster
Boss Nurse. To be confirmed.

Harvey Gordon
Boss doctor. To be confirmed.

This quartet can do the job. I guarantee.

I understand that back in the Wonderful World of Whitehall, April completion became July, then October. So be it.

- 2 -

Here is my diagnosis, from up at the sharp end.

- (1) Confirm all the positions, somehow, like now.
- (2) I will still be on-site Task Force Chairman but the boys will do the work. A fine arrangement.

That way the hospital will run like a Rolls and finally allow us to look at the hopeless inheritance of the rebuild.

My Stoke Mandeville architects, builders et al, are ready and waiting.

On a personal note, as follows.

Even by my standards, you have been terrific. There is no way I would have got near the finish line without your strong man act.

Its now only January 28th so it didn't take us long, did it. The vulgarity of success could make us both not flavour-of-the-month.

In total appreciation,

DR. JIMMY SAVILE, O.B.E., K.C.S.G., LL.D

PS. Let it be known that if anybody tries to mess the place up, after all this hard work, they can expect a slap in the mouth.

Copy to:: Kenneth Clark
Roger Freeman
Sir Christopher France
Sir Gordon Roberts
Robert Tinston (Leeds Infirmary)
Roger Titley (Stoke Mandeville)
All J.S. Trust Trustees
and
10 Downing Street.

Appendix 2A (vi)

20 February 1989

Submission from Cliff Graham to the Permanent Secretary (Sir Christopher France) setting out the context to Jimmy Savile's letter to him [Appendix 2a (v)] and recommending that a further role be found for Savile at Broadmoor.

Perm Sec

Plan B 3/1/2

Pharmaceutical Co 3 cars in
word with 1/2 freedom, etc.

Arranged 28/2 @ 9.00

d

MANAGEMENT : IN CONFIDENCE

PS/Perm Sec

From: C Graham, PC Div

Date: 20 February 1989

c.c.

Mr McKeon PS/SofS
PS/PS(H)

c.c. With copy of JS
Letter

Mr Heppell HPSS PG
Dr Abrams DCMO
Mr Utting CI/SSI
CNO
SHSB Members

1. In your manuscript minute dated 1 February you told me that the Permanent Secretary would like me to let the DH recipients, of Jimmy Savile's letter to me dated 28 January, have a note of the long term improvements that have resulted from Mr Savile's "Task Force" activity at Broadmoor Hospital from 1 September 1988 to date. I am sorry that other work pressures have delayed my reply.
2. In case there is any doubt, I start by declaring that I had no hand in, nor warning of, the drafting or circulation of Mr Savile's letter. I attempt an explanation of his possible reasoning below.
3. I have summarised the longer term improvements which, in my opinion, have resulted from Mr Savile's, generously given, time at Broadmoor Hospital, in the attached note at Annex 1.
4. If I were to guess at the reason why Mr Savile has written in this, his usually flamboyant, way at this moment, I would say that it was in response to my "disciplining" of him over recent Press attention and as a signal that he is ready to write his farewell speech ("I was quite happy, for 25 years, to act as 'Honorary Assistant Camp Entertainments Officer'; and, I am quite happy to return to that position now that I have put the hospital straight at the request of "the boss" and I can rest content that the hospital is in good management hands again and is about to become a 'centre of excellence'" is roughly what he said when I had "disciplined" him).

5. If he is set to step down, I do hope that Ministers and Senior Officials will find time to thank Jimmy Savile for his human interest, concern and management skill. Without him, we could not possibly have achieved all or most of what has been achieved over the last 100 plus days. Whatever his present plans, I would intend to suggest that Mr Savile should become Chairman of whatever "watchdog body" Ministers decide to set up at Broadmoor Hospital once the central SHA is in place and has appointed a General Manager and a supporting management team.

6. I understand from Mr Savile that he has received a message from No 10 that the Prime Minister has noted with interest the contents of his letter and intends to continue to keep an eye on Broadmoor. I gather from James Collier that, at a No 10 reception for the Stoke Mandeville Trustees early last December, the Prime Minister spoke effusively about Mr Savile's apparent success at Broadmoor, particularly on the industrial relations front.

A handwritten signature in black ink, appearing to read 'CLIFF GRAHAM', with a stylized, cursive script.

CLIFF GRAHAM

MANAGEMENT IN CONFIDENCE

ANNEX 1

BROADMOOR LOCAL MANAGEMENT : SEPTEMBER 1988 TO DATE

1.1 HOSPITAL STAFF : just over 100 days ago the nurses were on strike and patients were being confined to their rooms for almost 23 hours a day; local POA representatives were appearing on TV and in the Press warning of life threatening danger to staff, patients and the public; and, local management was in disarray - the Hospital Management Team and Local Board had lost management control of the situation and broken down and the Chairman of the Broadmoor Hospital Board had appeared on "prime-time" TV news declaring full support for the POA and castigating Ministers and the Department. As a direct result of Mr Savile's determined, and at times ruthless, leadership, effective management control has been re-established; 200 nurses are now members of the RCN (and 15 "militant" senior nurse managers are set to leave the hospital); the local POA Secretary formerly a "militant" oponent of all management proposals is now ready to lead 180 POA members into the RCN; and, we have established a Staff Liaison Committee at the hospital which will allow the RCN to negotiate with local and central management on behalf of its members. This, quite remarkable, turn around in management's relationship with hospital staff can best be summarised by reference to two key events which occurred in the last few weeks:

- the Secretary of the Local POA has spoken freely and openly to the local and national Press about her good relations with local management and her wish for "custodial" nurses to give way to "therapeutic nurses" and the local POA Executive Committee has refused to allow the Chairman of the National POA (Mr Bartell) to use a local committee meeting to incite Broadmoor members to take industrial action in response to the Nurse Regrading exercise;

- staff at the hospital are now actively seeking, from ward level upwards, every effort to demonstrate, often in their own free time, their developing interest in the therapeutic aspects of their profession at the expense of the "Prison Officer" image and outlook which was apparent just a few months ago - for example the re-introduction of, secure, arrangements for, highly selected, patients to work outside the hospital and take part in patients' outings for the first time in almost a decade;

1.2 HOSPITAL MANAGEMENT : 100 days ago the Hospital Management Team (Medical Director, CNO and Hospital Administrator) was in complete disarray: they could not work as a team and each member of the team tended to blame the other members for the staff and service difficulties facing the hospital. The Medical Director (Dr Hamilton) has been seconded to the Institute of Psychiatry to work on the census and treatment and security classification of all the Special Hospitals Service patients under the research direction of Professor Gunn and the supervision of Dr Reed. The Chief Nursing Officer (Mr Clark) has been granted early retirement on grounds of limited efficiency. The Hospital Administrator (Mr Roberts) is in the final stages of accepting flexible

early retirement. Four acting appointments have

been made, to hold the local management position stable, and build on the improving relationship with the staff, described above: pending the establishment of an SHA for the SHS, probably in July 1989, and the appointment of a General Manager for Broadmoor plus a new top management structure. The "acting" appointments are as follows:

- Mr Alan Franey - Manager (General Tasks) (pending the appointment of a General Manager)
- Mr Michael Morgan - Acting Hospital Administrator) pending a new
- Mr Colin Webster - Acting Chief Nursing Officer) "SHA"
- Dr Harvey Gordon - Acting Medical Administrator) management structure

All these posts, or their equivalent in a new management structure, will be the subject of some process of "NHS competition" after the SHA is established; but, in the interests of stability, continuity and, most important, local teamwork, it may be that Ministers will decide to let the posts continue as at present for about a year, to let the improved management at Broadmoor develop a more secure foundation and let the SHA bed itself down before it is required to make substantive appointments. The SHSB are clear that the "acting" Hospital Management Team have performed admirably, and to a very high standard, over the last, most difficult, six months.

【For the record, Mr Franey is a Principal, seconded from the National Biological Standards Institution on the recommendation of Mr Savile (who worked with him as Deputy Administrator at Leeds) and with the approval of its Chairman - Dr John Evans ex DCMO. Mr Webster was deputy CNO at the hospital. Mr Morgan is a Principal from the Department - ex Management Services - who had already been out-posted to Broadmoor as its Finance Officer. Dr Harvey Gordon was, and is still, the elected Chairman of the Medical Staff Committee at the hospital.】

1.3 HOSPITAL BOARD : the local hospital board had an unclear function, inadequate management skill and lacked the confidence of central and local management and staff. The Board Chairman (Vice Admiral Sir David Brown ex-Devonport Dockyard) had stated that he, and his Board, could not engage in effective local management unless he had the power to "hire and fire" staff, deal with the admission and discharge of patients and handle all aspects of personnel, finance and the budget without intervention from the Department. The Chairman was "at war" with his HMT - particularly with the Medical Director. He also lacked skill in dealing with PR and the media on behalf of Ministers - see 1.1 above. With the agreement of the Chairman and Board Members, and in keeping with the law, the SHSB suspended the activities of the Broadmoor Hospital Board pending the establishment of an SHA for the SHS, the substantive appointment of a General Manager and the introduction of a new local management arrangement. The Board's remaining activities, principally dealing with the renewal and detention of patients, have been assumed pro tem by the Broadmoor Hospital Task Force which is essentially a combination of the SHSB, the HMT and three Board Members -

Mr Savile, Dr Dick and Professor Morgan. The Chairman of the SHSB is Chairman of the Task Force and Mr Savile has been given responsibility for leading the on-site activities of the Task Force on behalf of PS(H) (with the full agreement of Mrs Currie, and now Mr Freeman). There were five main reasons for making the change: the breakdown in the local management arrangements; the rapidly deteriorating industrial relations climate; the long delays and overspend on the Broadmoor rebuilding scheme; an impending overspend on the hospital budget; and, severe problems on nurse manpower where the POA were demanding 100 extra nurses plus a £3,000 allowance to offset high housing costs. The Task Force has now settled all these matters apart from the hospital rebuilding (see further below); and the POA have settled for the recruitment of 25 extra nursing assistants plus a £200 location allowance pending examination of their claim by the Pay Review Body;

1.4 HOSPITAL ESTATE : in April 1988 the Department assumed full responsibility for the rebuilding of Broadmoor, which hitherto had been the "client" responsibility of PSA acting on behalf of the Department. In preparation for the handover, PSA had reported to the Chief Secretary that the scheme, which had started 2 years late and was now running a further 3 years late on the 2 year contract for Stage I, was facing Stage I expenditure of approximately £35m against an original PSA budget estimate of £13.5m. With the help of Mr Savile and his building team from the Stoke Mandeville Spinal Injuries Centre, which he claims as the only hospital building scheme which has been completed before time and for less than the original budget estimate, the Permanent Secretaries of DH and PSA have been provided with a joint PSA/DH report which pinpoints the Stage I problems and suggests a way of avoiding them in future. A joint DH/PSA post contract audit of Stage I expenditure points to the fact that £11m could have been saved if the scheme had been started, properly pre-planned, 1 year later and finished on time. The same DH/PSA team are now starting to examine what would be necessary - in terms of change of use of new buildings, upgrading some existing buildings, and providing more new building - to make the maximum use of present and future capital investment for the benefit of patients, staff and the taxpayer. Mr Savile continues to provide valuable, street-wise, help to the team which will assist the Task Force to advise Permanent Secretaries and Ministers on the best way to finish this difficult job. It will probably fall to the SHA to finish the rebuilding of Broadmoor in the context of Ministerial guidelines on service provision for the Special Hospitals Service as a whole; but Mr Savile has greatly helped us to get this far so successfully and will provide valuable on-site presence and control when decisions are taken on the completion of the rebuilding of Broadmoor, one way or another. As a footnote to this matter, it should also be recorded that Mr Savile has been instrumental in significantly improving the hospital's management of the existing estate: for example, he has arranged the eviction of 11 illegal tenants of residential accommodation, without any fuss; speeded up the housing repair and modernisation programme, which was a major POA grievance; encouraged staff to enter the housing market through beneficial mortgage arrangements with the "Prudential"; and, he is clearing up the grounds and gardens with the help of outside working parties and, free, help from local contractors.

1.5 HOSPITAL SERVICE : the future of the hospital, in terms of improved treatment and therapy without lessening essential security or threatening public safety, lies in the speedy and successful implementation of the recommendations in the, recent, Health Advisory Service Report at Broadmoor. Under the driving force of Mr Franey, Manager (General Tasks), and with the on-site advice and support of Mr Savile, within 1 month the HMT produced an action plan and timetable which was approved by the SHSB and Mrs Currie in December. Since then, local progress has kept pace with the plan and, in many cases, local action has been completed ahead of the agreed timetable. In addition, the HMT will shortly let the SHSB have their local vision of the clinical, caring and therapeutic requirements of the Broadmoor Hospital of the future, which will guide the completion of the Broadmoor rebuilding scheme and will inform the SHS policy and service requirements of the SHA. The long term effect of all this is to create in the "hearts and minds" of staff, patients and the public a vision of a therapeutic and caring institution which is drawing ever closer to similar, long stay, institutions in the NHS and the private sector (eg British Airways have purchased the control and restraint procedures pioneered in Broadmoor) and yet one which is not visibly less secure in the interests of the safety of the public. All this appears in stark contrast to the reality of industrial strife, management weakness and public distrust which pervades the Park Lane/Moss Side campus in Liverpool, pending the establishment of the SHA and general management in a few months time.

CLIFF GRAHAM
PC DIVISION

2 FEBRUARY 1989

Appendix 2A (vii)

29 June 1989

Submission from Cliff Graham to Roger Freeman, Parliamentary Under Secretary of State for Health, about the process of appointing the Chief Executive for the new Special Hospitals Service Authority and General Managers for each of the Special Hospitals

SENIOR STAFF : IN CONFIDENCE

PS/PS(H)

From: C Graham, PC
Date: 29 June 1989

copies: Dr Reed MEDMHI
 Mr Tait NUR
 Mr Smith SSI
 PC3
 PC3G

SPECIAL HOSPITALS : GENERAL MANAGERS

1. We have today completed the shortlisting process for the posts of Chief Executive of the SHSA and three General Managers for the Special Hospitals.

2. The results are as follows:

CHIEF EXECUTIVE

15 Applicants : see Annex A

6 Candidates shortlisted for psychometric and medical tests, references and interviews see Annex B:

Likely outcome : Mr Charles Kaye or, as is rather less likely, [redacted] - CVs attached at Annex C. For the reasons underlying PS(H)'s exchanges with Mr Hogg, we have shortlisted the only "Home Office" candidate; but we doubt that she will be appointed.

3. Mr Kaye was the sole DGM applicant, and the one that, in the view of PA Consultants, the others should be matched against. If he is appointed following the interviews on 11 and 12 July, and PS(H)'s meeting with the recommended candidate, we might have to consider appointing [redacted] or someone similar, following the outcome of the "Head Doctor" interviews on 14 August, to provide the Special Hospitals/Forensic Psychiatry experience that Mr Kaye lacks. [redacted] was identified as a possible front runner mainly because of his long and well known association with the development of the specialty. But he has little or no general management experience.

4. The field was nowhere near as wide and as strong as we would have wished. PA advise that we would have to increase the salary to £45,000, "jazz up" the job description accordingly and engage in, highly selective, "head hunting" if we wish to stand any chance of improving on the present position through re-advertisement. This would take time and additional expense and would probably take us beyond even the 1 October start date for the SHSA, all with no real guarantee of any improvement. In particular, we would still be in competition with the attractive job opportunities emerging within the NHS following publication of the White Paper, as well as the outside market.

5. Does PS(H) wish us to proceed to interview the 6 shortlisted candidates on 11/12 July as planned or to start again on the lines suggested by PA?

HOSPITAL GENERAL MANAGERS

6. The position is even more gloomy, in response to our advertisement for general managers for the special hospitals at Broadmoor, Rampton and Liverpool. We have had over 60 applicants - see Annex D for details. They are mainly at, or below, UGM level in the NHS plus a few from inside the special hospitals service.

7. Following our shortlisting meeting, we could, just about, select enough candidates to go ahead with the interviews planned in each hospital - see Annex E for details.

8. In reality, we only have three credible candidates:

Mr Franey - Manager (General Tasks) Broadmoor

Dr Dickens - Medical Director Rampton

Mr Selby - Governor Grendon (Psychiatric) Prison.

There are no credible candidates for the Liverpool campus: Mr Selby, the only "Home Office" candidate (apart from a Principal in the Home Office, who was ruled out on almost every ground), has applied only for Broadmoor.

9. The likely outcome is therefore that Dr Edmonds will press for Dr Dickens, Mr Savile will press for Mr Franey, and that we will have to set up a Task Force, under a new Chairman, to hold the fort at Liverpool pro tem.

10. Does PS(H) wish us to go ahead on this basis, or to start again following the advice of PA? In any event, we will not need to go ahead, if PS(H) decided to appoint a Chief Executive after interview.

11. Would PS(H) like to discuss this with us before proceeding further? For obvious reasons, we need to inform the candidates, and the interview panels, what is going on by this weekend at the latest.



CLIFF GRAHAM

Appendix 2B

Proforma letter of invitation to staff

Private & Confidential – Addressee Only
Broadmoor Hospital
Crowthorne
Berkshire
RG45 7EG
Tel: 01344 75 4122

Dear

Re: Jimmy Savile investigation Broadmoor Hospital / Department of Health

I am undertaking an independent investigation for the Department of Health and West London Mental Health Trust into allegations made about Jimmy Savile's conduct when he was at Broadmoor hospital.

As I'm sure you are aware there have been reports in the media that Jimmy Savile abused patients and others. The Trust and the Department are keen that any staff who had contact or interaction with Jimmy Savile take the time to speak to us. I enclose a copy of the terms of reference for your information.

I should be delighted to meet you to discuss any information you may have about Jimmy Savile. You can of course be accompanied at the interview; and you may wish to give us a written statement in advance.

Interviews will be recorded and may be transcribed if required. If the interview is transcribed a copy will be sent to you for approval and factual accuracy.

Any information you give us will be treated sensitively. However any allegation of a criminal offence will need to be passed to the relevant authorities.

I should be grateful if you could get in touch, if possible within a fortnight, with the investigation office at Broadmoor (01344 754122) to arrange a convenient time to speak; or email any questions or a statement (to [email address redacted]).

Yours sincerely

Dr Bill Kirkup

Attach: Terms of reference

PROFORMA LETTER OF INVITATION TO PATIENTS

Private & Confidential – Addressee Only

Sent by recorded delivery
High Secure Services

Dear

Re: Jimmy Savile investigation Broadmoor Hospital / Department of Health

I am writing to you to let you know that Dr Bill Kirkup and I are undertaking an independent investigation into allegations made about Jimmy Savile's conduct when he was working at Broadmoor hospital. I understand that you were a patient in the hospital at the time he worked there.

As I'm sure you are aware there have been reports in the media that Jimmy Savile abused patients and others. We want to check that if you had contact with him during his time in the hospital you did not come to any harm, and to ensure that we can take steps to guard against a repetition of these events happening in the future.

We would be delighted to meet with you to discuss any contact or interaction that you may have had with Jimmy Savile.

You can of course bring a member of your clinical team, an advocate or your solicitor with you when we meet.

Interviews will be recorded and may be transcribed if required. If the interview is transcribed a copy will be sent to you for approval and factual accuracy.

Your interview will be treated in confidence except as agreed with you. However any allegation of a criminal offence will need to be passed to the relevant authorities.

Yours sincerely

Paul Marshall

JSI Independent Investigation Team

INDEPENDENT INVESTIGATION – BROADMOOR HOSPITAL

INTERVIEWEE INFORMATION (STAFF)

Introduction

1. The independently led investigation was set up by the West London Mental Health NHS Trust and Department of Health following allegations of misconduct including sexual abuse by Jimmy Savile during his activities at Broadmoor Hospital.
2. The objective is to investigate the allegations made against Jimmy Savile concerning the time that he was involved with the hospital, to understand how this could have happened and to establish what must be done to stop this happening again. This includes examining fully what happened, establishing what procedures and safeguards were in place then and whether current policies and procedures are adequate to ensure that these events cannot happen again. Further details are set out in the Terms of Reference.
3. An independent investigator, Dr Bill Kirkup CBE will lead the investigation, assisted by Paul Marshall. The investigation is subject to local scrutiny by a Local Oversight Panel and national oversight from Kate Lampard, who was appointed by the Secretary of State for Health to ensure that the NHS investigations into Jimmy Savile's conduct at Stoke Mandeville, Broadmoor and Leeds General Infirmary are comprehensive and follow good practice.
4. The investigation will be conducted in private. This means that only members of the investigation team and interviewees will be present at the interviews. The media and public will not be allowed to attend.
5. Information will be sought from anyone with relevant information about Jimmy Savile's association with or activities at Broadmoor Hospital. In particular, the investigation team is keen to hear from anyone who:
 - (a) was the subject of misconduct including inappropriate sexual behaviour by Jimmy Savile at Broadmoor Hospital or in connection with his involvement there;
 - (b) knew of or suspected misconduct including inappropriate sexual behaviour by Jimmy Savile at Broadmoor Hospital or in connection with his involvement there;
 - (c) raised concerns about Jimmy Savile's conduct with a member of staff at Broadmoor Hospital or elsewhere in the local NHS or Department of Health/Department of Health and Social Security (DHSS), whether formally or informally;
 - (d) worked at Broadmoor Hospital (or the Department of Health/DHSS branch who were responsible for its management) during the time that Jimmy Savile was involved there and had contact with him; this is whether or not you were aware of any inappropriate behaviour;
 - (e) worked with or for Jimmy Savile in relation to his involvement at Broadmoor Hospital or elsewhere in the local NHS;
 - (f) was familiar with the culture or practices of Broadmoor Hospital during that time;

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

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

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

How can you help?

8. You are encouraged to contribute by:

(a) sending relevant documentation

– for example, a letter of complaint or policies and procedures in place at that time;

(b) providing a written account of what you know.

– guidance on what to include or assistance with preparing the account, if required, will be provided by the investigation team;

(c) attending an interview with the investigation team.

Interviews

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

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

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

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

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

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

12. Interviews will last as long as necessary to clarify information, but are unlikely to last more than two hours.
13. All interviewees and persons accompanying them will be expected to keep confidential any information disclosed to them.
14. The information given at interview will be recorded (either digitally or by a stenographer) and, at the request of the interviewee or the investigators, may be transcribed; in which case the interviewee will be sent the record of the interview to check for accuracy and to sign.

Anonymity and publication

15. The investigation will not publish the name of anyone who was the subject of inappropriate sexual conduct without their consent. If we need to give details of your identity to anyone else (such as the police) this will be done in confidence. Other interviewees can ask to remain anonymous and we will consider these requests, especially for junior staff.
16. The information given will be used for the purpose of preparing the report of the investigation. The report will be made public and information from written accounts and interviews may be included. At this stage, it is not the intention to publish the evidence in its entirety but it is possible that some or all of the information you provide may be made public in due course.
17. The main objective of the investigation is as set out in paragraph 2 above and the investigation team has formed no view, provisional or otherwise, as to whether it is necessary to make any criticism of any individual or organisation. Should any points of potential criticism arise, the person or organisation concerned will be informed of them, either orally, when they are interviewed, or in writing. Before receiving written notice of the detail of any potential criticism, the recipient may be required to give an undertaking to keep the written notice and the information contained in it confidential, except for the purpose of taking advice or preparing a response.

Information sharing

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

Support

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

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

[for victims, and for other patients and staff on request: specialist support is also available under a contract for the investigation with the Tavistock and Portman NHS Trust]

Contacts

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

Paul Marshall 01344 754122 (at Broadmoor, room 1.37 admin building)



West London Mental Health 
NHS Trust

Private & Confidential
Addressee Only

Broadmoor Hospital
Crowthorne
Berkshire
RG45 7EG
Tel: 01344 75 4122

Dear

Re: Savile Investigation – Broadmoor Hospital / Department of Health

Thank you very much for giving us your time and for telling us what you know about Jimmy Savile in Broadmoor.

As promised, I enclose a transcript of what you said.

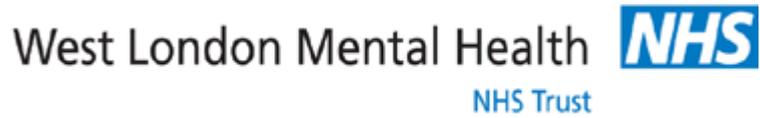
As mentioned when we saw you, we may share the transcript with others we if we think it necessary and appropriate. For example, we may share it with Kate Lampard and her support team, with legal advisers and within our own investigation team. It may also be necessary to share the information in it with others. This may include (but not be limited to):

- (a) The police
- (b) Professional regulatory bodies
- (c) Other investigations into the conduct of Jimmy Savile
- (d) The Dame Janet Smith review into the conduct of Savile and the BBC
- (e) The NHS Litigation Authority or insurers
- (f) Officials and Ministers at the Department of Health

I also enclose a form for you to sign and return to me if you are content that the transcript is accurate; with a space for any other information that may have occurred to you since we met.

Yours sincerely

Paul Marshall



Savile Investigation - Broadmoor Hospital / Department of Health

RETURN TO PAUL MARSHALL

Room 1.37, Administration Building, Broadmoor Hospital

I confirm that the transcript of my interview, which I have retained, is an accurate record.

I confirm that I agree to us sharing it and/or the information in it as we have described to you and that you agree to the “processing” of the information by us and by any recipients

SIGNED:

NAME:

Date:

Appendix 3:

Principal national policies and legislation

The core legislation relevant to the secure hospitals is

- Mental Health Act (1983) with Mental Health Act Amended (2007)
- Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (DoLS)
- Children Visiting Directions, 1999 – specific to Secure Hospitals
- Safeguarding Vulnerable Groups Act, 2006

Child protection and safeguarding

1. NHS bodies have a **statutory duty** to make arrangements to safeguard and promote the welfare of children, under section 11 of the Children Act 2004. They are statutory members of Local Safeguarding Children Boards (LSCBs) under section 13 of that Act.
2. In response to a recommendation of the Munro review of child protection, the Department for Education published revised inter-agency **statutory guidance**, *Working Together to Safeguard Children* on 21 March 2013, which came into effect on 15 April 2013 <http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/protection/a00210235/consultation>.
3. In parallel, the NHS CB (now NHS England) published *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework*, also on 21 March 2013 – at <http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf>

Secure Hospitals

4. The “Visits by Children to Ashworth, Broadmoor and Rampton Hospitals Directions” (1999) was the first legislation to govern child visits across the three hospitals. These Directions were published in 1999 by the Department of Health and NHS in response to findings from the Fallon report. Up until this time visits had been governed by local policies.

The child visiting directions were updated in 2013

<https://www.gov.uk/government/publications/high-security-psychiatric-services-directions>

Adult safeguarding

- The Safeguarding Vulnerable Groups Act 2006 (Controlled Activity and Prescribed Criteria) Regulations 2012
<http://www.legislation.gov.uk/ukxi/2012/2160/contents/made>

5. The Mental Health Act Commission (MHAC) was an NHS special health authority providing a safeguard for people detained in hospital under the powers of the Mental Health Act 1983 in England and Wales. The Commission was abolished on 31 March 2009.
6. The Commission consisted of some 100 members (Commissioners), including laypersons, lawyers, doctors, nurses, social workers, psychologists and other specialists. It was a monitoring body rather than an inspectorate or regulator. Its concern was primarily the legality of detention and the protection of individuals' human rights. In addition to a visiting programme, the Commission provided important safeguards to patients who lack capacity or refuse to consent to treatment.
7. These responsibilities have now been taken over by the Care Quality Commission who monitor the use of the Mental Health Act (MHA) and check that it is being used properly. Commissioners perform this work by visiting all places where patients are detained under the act, and meet with them in private.
8. In 2011 a statement of Government policy on Adult Safeguarding was published. This statement set out clearly the six principles that underpin all adult safeguarding work.
<https://www.gov.uk/government/publications/adult-safeguarding-statement-of-government-policy>
9. 'No Secrets' published in 2000 sets out a code of practice for the protection of vulnerable adults. This guidance is being refreshed as part of the package of statutory guidance that will support the implementation of the Care Act (2014) where Safeguarding Adults Boards are placed on a statutory footing for the first time.
<https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care>
<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

Whistleblowing

- The Public Interest Disclosure Act (PIDA) 1998
10. PIDA is part of the wider employment rights legislation and provides the full protection of the law to all staff who act in the public interest, providing they follow the procedures it sets out.
 11. To support the introduction of PIDA, the Department of Health issued a Health Service Circular 'HSC1999/198' on 27 Aug 1999 which advised NHS Trusts that they should have PIDA-compliant whistleblowing policies in place.
 12. Then Department of Health issued a guidance pack, *So Long Silence – Whistleblowing: The Policy Pack*, to the NHS in July 2003, and introduced a whistleblowing helpline for NHS staff and employers. The helpline was provided by the charity Public Concern at Work (PcaW).
 13. In March 2013, following the Mid Staffordshire Inquiry, the Secretary of State for Health announced an end to "gagging clauses" which prevent NHS staff from speaking out about patient safety or care. The government has extending to all healthcare professionals the protections of the Public Interest Disclosure Act 1998 (which inserted Part 4A into the Employment Rights Act 1996) by the Enterprise and Regulatory Reform Act, which received

Royal Assent in April 2013. The government has also acted on compromise agreements, updating guidance in March 2013 to make clear that where a compromise agreement is used it must include an explicit clause making clear that nothing within the agreement prevents an individual from making a protected disclosure under the Public Interest Disclosure Act. The Government has recently consulted on the proposal to introduce a statutory duty of candour as a CQC registration requirement in secondary legislation.

Complaints handling and investigation

- Hospital Complaints Procedure Act, 1985
- Guidance on implementing the NHS complaints procedure, 1996
- The NHS (Complaints) Regulations 2004

Early NHS complaints procedures

14. In 1975 the Department for Health and Social security published a special hospitals grievance and dispute procedure. However, there was no legislative basis for a hospital complaints procedure until the Hospital Complaints Procedure Act 1985, although authorities managing hospitals may well have had their own local processes for handling complaints.
15. A new NHS complaints procedures came into force in April 1996. For the first time, the Department of Health issued detailed guidance on how the NHS bodies and primary care practitioners should handle complaints. This expanded on the mandatory requirements set out in the Directions and Regulations.
16. The complaints procedure had two local stages. If these were not sufficient the complaint then went to the Health Service Ombudsman.
17. The Ombudsman's remit was extended from April 1996 to include clinical issues and complaints about primary care practitioners. NHS staff and primary care practitioners (and their staff) were also enabled to complain to the Ombudsman if they felt that they had suffered hardship or injustice through the operation of the NHS complaints procedure.
18. In April 2009 the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 came into effect.

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx>

19. The NHS Constitution sets out the rights of an NHS patient. These include a right to complain if things go wrong.

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

Charity Commission, charity funds & fundraising in the NHS

20. The Department of Health is responsible for the policy that allows any NHS body to set up a charity for the benefit of the healthcare services, but it does not regulate the activity of the Charity. The charity must be registered with the Charity Commission who are responsible for regulating their activity.

21. Records for NHS charities from the 1970s and 1980s for individual charities are very sparse. Full electronic filing of casework only began in the early 2000s, and most of the hard copy earlier correspondence was destroyed 5 years after each “case” was closed.

22. A couple of the charities bearing the Savile name elected to wind up immediately as they had no viable future with that connection. Despite the high level publicity, and the alleged ubiquity of Savile’s activities, the Charity Commission has had no reports of serious incidents for any charities (NHS or otherwise) referring to abuse by Savile whilst acting for a particular charity in any capacity.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213104/full-report-review-of-NHS-charities.pdf

Charities Act 2011 <http://www.legislation.gov.uk/ukpga/2011/25/contents/enacted>

Vetting arrangements

- Safeguarding Vulnerable Groups Act, 2003

23. The Bichard inquiry reported in 2004, following the Soham murders. Its main impact has been the introduction of Criminal Records Bureau (CRB) checks for those wishing to work with children or vulnerable adults.

24. The Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) merged into the Disclosure and Barring Service (DBS) in 2012. CRB checks are now called DBS checks.

<https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance>

In addition to the duty to check the barred list the Department of Health and the Department for Education have a number of regulations that relate to checking. For the Department of Health these are the CQC registration regulations. These place a legal duty on registered providers to operate safe and effective recruitment procedures, including considering taking up checks where staff and volunteers are eligible. This requirement regarding safe recruitment does not cover visitors.

<http://www.cqc.org.uk/organisations-we-regulate/registered-services/legislation>

High secure hospitals security

25. Security has been reviewed regularly in the special hospitals. Notable developments have been:

- 1992 The Committee of Inquiry into Complaints about Ashworth, chaired by Louis Blom-Cooper.. The goal was to investigate the death of a patient named Sean Walton, who died whilst in solitary confinement in March 1988.
- 1994 Government Review of High Security Services, chaired by John Reed
- 1999 The Fallon report, into paedophile activity and security at Ashworth <http://www.archive.official-documents.co.uk/document/cm41/4194/ash-01a.htm>
- 1999 Safety and Security Directions originally given to the Ashworth, Broadmoor and Rampton Hospital Authorities under cover of HSC 1999/150
- 2000 The Tilt report into security at the high secure hospitals

- 2000 Safety and Security Directions – substantial revision
- further substantial revision coming into force on 1 August 2011 (The High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011). Minor amendment in 2012 to change a reference to an appeal period.

Security Directions and guidance were reviewed in 2013.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268547/Safety_and_Security_Guidance.pdf

