

Investigation report into an allegation of abuse by Jimmy Savile at Great Ormond Street Hospital for Children NHS Foundation Trust.

A report for
Great Ormond Street Hospital for Children NHS Foundation Trust

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1. Introduction

Operation Yewtree is a police investigation into alleged sexual abuse, by Jimmy Savile (who died in 2011) and others. The investigation led by the Metropolitan Police Service (MPS) started in October 2012. After a period of assessment it became a full criminal investigation.

On 19 October 2012 the MPS reported that more than 400 lines of enquiry had been assessed and over 200 potential victims had been identified. Great Ormond Street Hospital for Children NHS Foundation Trust (the Trust) was informed in November 2012 by NHS London that an allegation had been recorded, by the National Society for Prevention of Cruelty to Children (NSPCC) helpline, of a sexual assault against an inpatient by Jimmy Savile, in 1971. The Trust was informed that an ex-patient had witnessed an assault on another patient.

Further information was requested from the MPS on the 30th November 2012 and information including the nature of the alleged offence was shared with the Trust in December 2012. The information received suggested that a patient witnessed Jimmy Savile molesting another patient whilst they were inpatients at the Trust. In January 2013 the joint report into sexual allegations made against Jimmy Savile, *Giving Victims a Voice*, was published and the Trust was listed in Appendix G of the report as a Trust in which it was reported that Jimmy Savile had offended.

The Secretary of State for Health asked Kate Lampard to assure him of the quality of the reports generated by the relevant NHS organisations. NHS organisations were asked, so far as possible, to ascertain the truth behind the allegations and the circumstances that allowed any abuse to have occurred. This required efforts by the Investigating Team to speak with alleged victims or witnesses, gather relevant information from local police forces and the examination of records polices and other relevant documents.

An investigation team was created at the Trust and an Executive Lead appointed. The Investigation Team consisted of:

- Salina Parkyn, Head of Clinical Governance & Safety
- Janice Baker, Head of Safeguarding & Named Nurse for Child Protection
- Cymbeline Moore, Head of Communications
- Sophie Pownall, Trust Solicitor
- Liz Morgan, Chief Nurse and Families' Champion (Executive Lead)

Terms of Reference

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has commissioned this investigation into the one allegation that Jimmy Savile abused an inpatient in 1971 reported in the *Giving Victims a Voice* report.

The aim of the investigation is to establish the facts of what happened; in order to try to identify what lessons can be learned. This will include what happened to whom, when and where. The Investigation Team will:

- Investigate the allegation that during the early 1970's an inpatient was sexually abused during a visit by Jimmy Savile to the Trust.
- Consider any access arrangements that may have been 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 between 1970 and 1980.
- In the light of findings of fact in respect of the above, consider whether the Trust's current safeguarding, complaints, whistle blowing and other policies and processes, relating to the matters mentioned above, are fit for purpose.
- Identify recommendations for any further action.

The final investigation report will be shared with the Department of Health and with Kate Lampard, who is conducting the independent oversight of the Jimmy Savile inquiries on behalf of the Secretary of State for Health.

3. Executive Summary and Recommendations

This Trust was listed as one of the sites where an allegation has been made that Jimmy Savile sexually abused an inpatient, as reported by an ex-patient. A complete and thorough

investigation has taken place to try to ascertain the facts of the allegation with a view to understanding if possible, what occurred and how visits were supervised at the time, and to ensure that there are robust processes in place to reduce any risk to patients who are treated at GOSH.

The investigation has been greatly hampered by the 42 years that have passed between the alleged incident and the investigation starting, and by the fact that both the alleged perpetrator and alleged Victim are deceased. Despite these difficulties, facts have been obtained from the medical records and archived files, the details of which can be found in section 5 (below).

From the information obtained via both the MPS and the NSPCC, and from the Informant, the Trust managed to identify one patient who could potentially have been the alleged Victim. However, upon reviewing the death certificate and the medical records of this patient, gaps started to materialise; these have been documented under section 16 using the gap analysis process. The information obtained from archived records of a visit to the Trust by Jimmy Savile has also indicated discrepancies in dates.

The Investigating Team have concluded that due to the lack of confidence that the alleged Victim has been correctly identified, the difference between the dates of the documented visit to the Trust by Jimmy Savile, and the dates of admission and discharge for both the Informant and the alleged victim, it is not possible to say for certain if the alleged incident on the premises of Great Ormond Street Hospital took place. The summary of evidence that led to this conclusion is found in section 16 (below).

The Trust accepts that its records (e.g. admission registers and medical records) may be inaccurate or incomplete. However, the Trust nevertheless believes it is important to document any discrepancies. The Trust is confident it has conducted a full and thorough investigation into the allegation received despite the extensive elapse of time. The Trust can confirm that throughout the investigation the team have not been able to evidence that any privileges were ever afforded to Jimmy Savile at this Trust. The Trust would be very sorry if such an event had occurred at GOSH therefore we were determined to do all we could to establish what had occurred. However, despite the best efforts of the Investigating Team, it has not been possible to reach a definite conclusion as to what occurred.

The Investigating Team have reviewed current practice on the supervision of visitors to GOSH and have not identified any recommendations for improvement or change of practice

throughout the investigation. We believe that the current processes, procedures and training in place, which are designed to maintain the safety and security of the children and young people at the Trust, are robust.

The Trust has made several attempts, formal and informal, to discuss the findings of the investigation with the Informant, without success. To prevent distress to the Informant the Trust has taken the decision that despite best efforts, to discuss the report with the Informant they have chosen not to respond and that therefore the Trust should not continue to try to do so. An open line of communication with the Informant is in place so should they decide they want to communicate with the Trust at any time in the future they are able to do so.

There is no documentary evidence to suggest that Jimmy Savile was at the Trust in the 1970's (when the alleged incident was said to have taken place).

4. Approach to the Investigation

Please see appendices B and C.

The Investigating Team aimed to ensure that the investigation was thorough, open and transparent. In order to identify staff that were present at the time of the alleged incident the Investigating Team approached the Human Resources department who scrutinised any records held however the Trust HR archive does not go back that far. We also contacted any long serving staff known to the Investigating Team. The Trust's archivist was contacted and the Investigating Team reviewed archived memoranda with a view to identify relevant information. The Trust explored all of the avenues open to them to ascertain if there was any access arrangements accorded to Jimmy Savile and to see what, if anything, the Trust could learn to reduce the risk of anything similar happening in the future.

To aid the investigation the following was carried out:

- Medical Records of the Informant were located and reviewed
- Admission Register from 1970-1974 reviewed
- Liaison and meeting with Camden Council's Births, Deaths and Marriages Registrar
- Medical Records of the possible alleged Victim were located and reviewed
- NSPCC records (between Informant and the NSPCC in 2012) requested and reviewed
- Meeting with the Informant by the Trust (2013)
- Meetings with the Trust Archivist
- Review of archived documents from 1970-1974
- Review of archived visitor books and pictures
- Factual accuracy checks

The approach of the investigating team when, meeting the informant, was to provide them with an opportunity to share their recollections of the event with staff from the Trust. The Informant was aware that information they had given to the NSPCC had been shared with the Trust staff but it was important to hear the informant's experience first-hand.

5. Great Ormond Street Hospital for Children NHS Foundation Trust Background Information

Great Ormond Street Hospital (GOSH) opened in 1852. Founded by Dr Charles West, it had just ten beds and was the first institution in the UK to offer inpatient care to children only.

Today Great Ormond Street Hospital is a specialist tertiary hospital with 50 different clinical specialities. Many of the patients treated at the Trust have rare, complex or life-limiting conditions and are referred here by other hospitals that do not have the specialist expertise to treat them. The top priority of the hospital is to provide high quality and safe care.

Since its formation in 1852, the hospital has been dedicated to children's healthcare and to finding new and better ways to treat childhood illnesses. Each year, there are over 200,000 patient visits to the hospital.

GOSH is also at the forefront of paediatric training in the UK. The Trust trains more children's nurses than any other hospital. Furthermore, GOSH plays a leading role in training paediatric doctors. The mission of the Trust is to provide world-class clinical care and training, pioneering new research and treatments, in partnership with others, for the benefit of children in the UK and worldwide.

Together with their research partner, the UCL Institute of Child Health (ICH) GOSH is the UK's only academic biomedical research centre specialising in paediatrics. Finding new and better treatments and cures for childhood illnesses has always been central to the work carried out at the Trust.

6. Chronology of Jimmy Savile's association with Great Ormond Street Hospital for Children NHS Foundation Trust

There was no association between the Trust and Jimmy Savile. The Trust can confirm that Jimmy Savile was never given office space or accommodation at the Trust, or any of its premises. Jimmy Savile was not given "open access" to the Trust at any point. There was no formal association and no informal association between the Trust and Jimmy Savile. The evidence for this can be found in section 16 (below).

The Trust has documented evidence that Jimmy Savile visited the Trust on one occasion, as he signed the visitor's book and there are photographs of this visit. This was on 19th

December 1985 when he attended the Board Room to present H.M.S. Ark Royal with a cake. In 1985 one of the wards (5D) was sponsored by H.M.S Ark Royal and the ward sister at that time recalls the attendance of Jimmy Savile at the ceremony in the Board Room but has confirmed she has no knowledge of Jimmy Savile attending the ward.

The Trust has no reason to believe that Jimmy Savile was unaccompanied at any time during this visit. There is also no suggestion that he visited any clinical area.

On the 18th November 2013 the Department of Health informed the Trust that they had received a call from an ex-employee of the Trust. The Trust contacted the ex-employee who reported a visit to the Trust by Jimmy Savile in December 1985. This correlated with the information retrieved from the Trust archive as part of the investigation, prior to this contact.

When the investigating team contacted this ex-employee she stated that she could recollect the month and year due to memorable personal events. The ex-employee reported that Jimmy Savile had, on that occasion, made an inappropriate comment to her. This was not reported at the time to the Trust or to the Police. The former staff member told the Trust that her reason for contact in November 2013 had been to ensure that, in light of recent press reports, the Trust were aware that Jimmy Savile had visited the Trust in December 1985. The ex-employee confirmed, when asked, that she did not want the information she had shared to be investigated.

Other than the one visit in December 1985, there is no other known visit to the Trust by Jimmy Savile. In particular, there is no documentary evidence to suggest that Jimmy Savile was at the Trust in the 1970's (when the alleged incident was said to have taken place).

7. Themes from Chronology

As there was no formal or informal association between the Trust and Jimmy Savile, a chronology of events has not been created and no themes have been identified.

8. The Cultural Context at the Time

Great Ormond Street Hospital for Children NHS Foundation Trust was a very different Hospital in the early 1970's (the date of the sole allegation relating to GOSH). The Hospital was known then as the 'Hospital for Sick Children'.

In the 1970's the concept of Chief Executive was not a defined role in hospital management. The Hospital Manager was the 'House Governor', with the Chief Nursing Officer (Matron until 1969) having independent and equal power over the nursing staff, and the senior medical staff, the latter probably having more power than today relative to the administration management. The House Governor in 1970 was Peter Dixon; the chair of the Board of Management was Audrey Callaghan.

As at 30th September 1970 the Hospital Service Staff Statistics for England and Wales published by the Department of Health and Social Security (DHSS) showed a total of 1,905 members of staff were employed, and for the same period there were a total of 5,943 inpatients, with 69,400 inpatient days. The average length of stay was 11 days. The hospital comprised fourteen wards over seven floors.

From 1968, the Hospital was jointly managed with the Queen Elizabeth Hospital for Children in Hackney, as The Hospitals for Sick Children Special Health Authority. This provided a clinical and nurse training link with a busy local children's hospital to complement the more specialised work that was increasingly performed at Great Ormond Street Hospital.

The Trust also had an affiliated country branch at Tadworth Children's Hospital in Surrey, (now Tadworth Court) which is still operational today, although the formal links with the Trust are no longer in place. That hospital was used mainly for long stay orthopaedic and tuberculosis patients.

Regular family visiting had only begun to be accepted from the 1960's, and the first on-site family accommodation was opened in 1969. Today, the Trust works in partnership with patients and their families, and actively encourages families to visit and participate in their child's care to ensure that the patient's experience is as effective as it can be. Indeed the Trust currently provides extensive accommodation for parents to ensure as many of them can stay as near to their child as possible.

At the time of the alleged incident, the hospital consisted of only one building, the Southwood Building. When the Variety Club Building (VCB) was opened in 1994 the Trust used the American practice of applying 'levels' instead of 'floors', which meant that the ground floor was Level 2 and the first floor was level 3. The Trust's other buildings were realigned with this practice at the same time. As a result the Southwood building, which had previously had 7 floors (G-7), now had 9 levels (2-9). (The Investigating Team considered this in order to ensure that historical naming of floors within the hospital did not lead to an apparent discrepancy, where there might not be one.)

9. Jimmy Savile's Association with Great Ormond Street Hospital for Children NHS Foundation Trust

There has never been a formal or informal association between Jimmy Savile and Great Ormond Street Hospital for Children NHS Foundation Trust.

The Investigating Team have found no evidence of Jimmy Savile fundraising on behalf of Great Ormond Street Hospital.

Fundraising for the hospital's Wishing Well Appeal – which took place in the 1980s – was well documented including in a book written by the director of the Wishing Well Appeal, Marion Allford. In this comprehensive account of the fundraising effort and its celebrity supporters, the only mention of Jimmy Savile is in the context of his role as fundraiser for Stoke Mandeville Hospital.

The only other known reference to Jimmy Savile in a GOSH publication or publication about GOSH is as a visitor to the hospital, referencing the same visit as cited in section 6 (page 8). This occurs in a book named 'The Commemorative Book' published about the hospital for its supporters in 1991.

10. Access Arrangements and Privileges Accorded to Jimmy Savile at Great Ormond Street Hospital for Children NHS Trust

There were no, and never have been, access arrangements or privileges accorded to Jimmy Savile at Great Ormond Street Hospital for Children NHS Foundation Trust.

In order to reach this conclusion the Investigating Team reviewed the evidence as listed in section 4 (above).

11. Policy, Practice and Procedures at the time of the alleged incident

In the 1970's the promotion and protection of the welfare of children was not as recognised as they are today. The Children Act 1989 – which was created to promote co-ordination between multiple official entities to improve the overall well-being of children – ensured that relevant national guidance and procedures were created and followed in order to implement the aims of the Act.

The Trust's archived historical information has shown that family visiting had only started to be accepted in hospitals in the 1960's following research about the damaging effect on children of separation from their parents; previously visits from parents and others were extremely limited. The Hospital opened its first 'Mothers only' accommodation in 1969. Therefore it is most likely that access to clinical environments by visitors to the Trust (outside of family members or known friends) would have been limited at the time of the alleged incident.

12. Jimmy Savile's Fundraising Activities

From a review of the Trust and the Charity archives, there is no documented evidence that Jimmy Savile ever carried out fundraising activities for or on behalf of Great Ormond Street Hospital for Children NHS Foundation Trust.

13. How Complaints were dealt with at the time of the Incident

On 9th December 1966 the Department of Health and Social Security (DHSS) wrote to all Hospitals asking them to keep records of all written complaints on or after 1st January 1967. They were asked to send annual 'returns' to the DHSS of the complaints that had been received, distinguishing them according to the type of procedure, either concerned wholly or partly with clinical matters.

The Trust, known then as the Hospitals for Sick Children, kept complaint data from 1967. The Investigation Team has secured the 'Complaint Procedure relating to treatment of patients' which was in use in the early-mid 1970's. This document confirms that the House

Governor had responsibility for dealing with complaints, it also outlines that verbal complaints should be investigated at ward level by the senior nursing or medical staff but should be treated with the same degree of attention as written complaints. The document states that the House Governor will bring to the Board's attention any complaints that appear to indicate gross failings by the organisation or any individual.

Complaints from 1972 are available from archive; these were reviewed by the Investigating Team. No reference was made to Jimmy Savile in any of the complaints and there were no complaints received from either the Informant or the alleged Victim. The Trust recognises, of course, that child victims of abuse rarely made complaints, possibly due to the fact that child abuse was not well recognised in society at that time; nevertheless, we believed it important to review the documents.

14. Investigation of the Allegation

There is one allegation of abuse (a single historic incident as reported by an ex-patient), which was made to the NSPCC helpline on the 23 October 2012, by an ex-patient who reported that they had witnessed Jimmy Savile sexually assault a patient whilst they were both inpatients at this Trust. (In this report this ex-patient is referred to as the Informant.) The Trust was given limited information towards the end of December 2012 and, after the publication of *Giving Victims a Voice* in January 2013. Later in January 2013 the Department of Health contacted the Trust and an Investigation Team was created.

The Investigation Team agreed that 'best efforts' should be used to investigate the allegation, with a view to learn from the incident and reduce the risk of this type of incident occurring at Great Ormond Street Hospital for Children NHS Foundation Trust.

Although the investigation was hampered by the 42 years that had elapsed between the incident and the receipt of information about the incident, the Investigation Team believe that best efforts have been used to try and understand whether the incident took place and, if it did, how it was allowed to happen.

Section 6 (above) sets out the steps the Investigation Team took to obtain information from Trust staff. This included contact with a ward sister who recalled Jimmy Savile's sole recorded visit to the Trust in 1985. However, due to the timeframe, the ward sister could not recollect specific details of the event. Their only recollection was that there was a visit, the

location of the visit (the Trust Board Room) and purpose of the visit (to present H.M.S. Ark Royal with a cake). As a result of the ward sister's limited recollection, and the fact that the ward sister's information was corroborated by photographic information from the Trust Archive, the Investigation Team have not produced a formal interview record.

During the investigation the Informant was offered, but declined to receive, a copy of this report. Towards the end of February 2014 the Investigation Team contacted the Informant to tell them that the report was nearly complete and offer them another opportunity to receive a copy. The Informant confirmed they would like to receive a copy. The report was shared with the Informant in March 2014, and the Trust has proof of receipt. Thereafter the Trust made several unsuccessful attempts to contact the informant to discuss the report. In correspondence with the informant (see Appendix E) the Trust pointed out that the investigation had not been able to align some of the information received with information held by the Trust, and sought an opportunity to discuss the findings of the report. No further comment has been received from the Informant at time of submission of the report. The Informant is aware that the report will be published, and that the Trust remains open to further contact from the Informant.

Although the investigation was hampered by the 42 years that had elapsed between the incident and the investigation starting, the Investigation Team believe that best efforts have been used to try and understand whether the alleged incident in 1972 took place and, if it did, how it was allowed to happen. The Trust liaised with a nurse manager who was employed as a ward sister at the Trust in the 1980's and who recalled the visit in 1985, however she could not recollect specific details of the event.

15. Current Policies, Practice and Procedures

The Trust currently has a number of policies, procedures and guidance to help staff ensure that Children and Young People are safeguarded at all times. These policies are compiled on the basis of national and local guidance.

The Trust has a Policy for Policies guidance which outlines the governance for the renewal and updating of trust policies and a Policy Approval Group to ensure that all policies are reviewed for robustness and are kept in date.

The Trust also has processes to manage feedback, complaints and concerns to assure the board that investigations are robust and transparent.

The following are a number of key policies that have been reviewed during this investigation:

- Recruitment of volunteers (including CRB checks, due for review in June 2014)
- Recruitment and selection (due for review in July 2014)
- Resolving Conflict between Families and Staff (due for review in September 2014)
- Information Governance Policy (due for review in January 2015)
- Security policy (due for review in May 2014)
- Policy for Policies (currently being reviewed as of March 2014)
- Incident Reporting and Management (due for review in July 2014)
- Complaints (due for review in July 2014)
- Safeguarding Children and Young People (due for review February 2016)
- Adult Safeguarding Adult's (currently being reviewed as of March 2014)
- Whistle blowing / Raising Concerns in the Workplace (due for review in June 2014)
- Visitors Policy for Very Important People (VIP) and Celebrities (under review at time of submission of the report)

16. Overall Analysis and Conclusions

In relation to the sole allegation connected with GOSH, the Investigating Team has conflicting information from the Metropolitan Police Service and NSPCC, the Informant and the records that were available at the Trust. These have been explained in the table below for ease of reference.

Information Provided by NSPCC/Met Police	Information obtained from Informant during meeting on 29.04.13	Information obtained through Investigation at the Trust
Information about the Informant's time at the Trust		
Whilst the Informant was an inpatient in 1972 they witnessed the sexual assault of another inpatient by Jimmy Savile.	The Informant confirmed that the incident happened when they were 10 so (they said) it must have occurred in 1972. The Informant clearly recalls that it was Xmas time due to the decorations and that they had celebrated their 10 th birthday whilst in hospital.	There are no records of JS visiting the Trust in 1970, 1971 or in 1972. The Informant's medical records have them as an inpatient in April 1970 when they were 8 years old. The Trust has no medical records for the Informant while they were 9 years old or 10 years old.
No evidence available.	The Informant stated that they believed that the alleged Victim was a Private Patient but that they (the Informant) were an NHS patient.	The Informant's medical records state that they were a private patient whose care was being paid for by a firm of solicitors.
The Informant had been in Hospital since December 1971.	The Informant confirmed that they had been in the hospital for a long time and had celebrated both Christmas and their 10 th birthday during the admission. They confirmed this was 1972.	The medical records of the Informant state that they were admitted on 9th April 1970 and were discharged after surgery on 24 th April 1970.
Informant informed the NSPCC that they had 'not got the faintest idea' what ward they were on but thinks it was on the 3 rd floor.	Informant stated that they could not remember the name of the ward, and when asked, stated they were on the top wing on the left hand side.	The Informant's medical records confirm that during their admission in April 1970 they were on ward 7AB which was the top floor of the Hospital and was the designated Private Patient Wing.
No evidence available.	Informant stated that they had been an inpatient at the Trust twice but had not attended any outpatient appointments and this incident had happened during their first admission to the Hospital.	Medical records indicate one admission only, in April 1970.

Information Provided by NSPCC/Met Police	Information obtained from Informant during meeting on 29.04.13	Information obtained through Investigation at the Trust
Information about the alleged Victim		
<p>Met Police confirmed the alleged Victim was a child:</p> <ul style="list-style-type: none"> • From Country A; • Of a different ethnic background from the Informant; • Aged approx. 11-12 years old; • Of the same sex as the Informant; • With a first name the same as that of the Informant; • Had the same urological surgery as the Informant; • Had died 3 days after being sexually assaulted by Jimmy Savile. 	<p>The Informant confirmed that the alleged Victim was a child:</p> <ul style="list-style-type: none"> • From Country B (in the same continent as Country A); • Of a different ethnic background from the Informant; • Aged 9 years old; • Of the same sex as the Informant; • With the same first name as the Informant; • Had died 4 weeks after being sexually assaulted. 	<p>The Death Registry at Camden Council records that only one patient with that first name died at the Trust between 1970-1972. This patient was:</p> <ul style="list-style-type: none"> • From Country C (not a country in the same continent as Countries A and B); • Of a similar ethnic background to the Informant (but not the alleged Victim); • Aged 6 years old; • Of the same sex as the Informant; • With the same first name as the Informant; • Had been treated for cancer.
<p>The Informant states that they were on the same ward as the alleged Victim who had also had the same urological surgery.</p>	<p>The Informant was admitted to a ward on the top floor in 1970.</p>	<p>The alleged Victim had a diagnosis of cancer and was being treated on ward 3AB. The Informant was being treated on the private wing on ward 7AB.</p>
<p>During the Christmas period in 1971 or 1972 Jimmy Savile visited the Hospital; the Children thought that it was wonderful as he was a celebrity.</p>	<p>Informant confirmed they recalled Christmas decorations being around the ward but was not sure if it was before or after Christmas.</p>	<p>There is no record to suggest that the Informant was admitted to this Trust again in 1971 or 1972. The alleged Victim was discharged from 3AB shortly before Christmas 1971.</p>
<p>Informant reported that the alleged Victim died 3 days after the sexual assault.</p>	<p>Informant stated that the alleged Victim died about 4 weeks after the sexual assault.</p>	<p>Medical records for the alleged Victim indicate that they were not an inpatient over Christmas but had been discharged shortly before Christmas 1971. The alleged Victim's date of death was in mid-February 1972.</p>

Information Provided by NSPCC/Met Police	Information obtained from Informant during meeting on 29.04.13	Information obtained through Investigation at the Trust
Information about the alleged incident		
Informant reported that Jimmy Savile 'quite happily' ushered staff from the ward, stating that he wanted to have a word with the children and wanted to make them 'very happy'.	The Informant stated that there were no staff around as it was lunch time. They explained this was usual and happened every day at lunch time.	It is believed that in the 1970's it was a routine part of the patient's day for there to be 'quiet time' after lunch to sleep, this is believed to have been for 2 hours.
Informant reported that there were two patients on the ward, themself and the alleged Victim. They stated there were also two younger children in a segregated room near the ward.	The Informant confirmed that it was only them and the alleged Victim who was on the ward at the time of the visit.	No evidence available.
Informant reported that Jimmy Savile lifted the bed sheet of the Informant and looked at the scar which was from their navel to their private parts.	The Informant confirmed that Jimmy Savile pulled back their bed sheet but as they were 'swathed' in bandages 'he couldn't get to it'.	No evidence available.
Informant stated that Jimmy Savile did the same to the patient opposite them (the alleged Victim) and that the Informant witnessed Jimmy Savile masturbating the alleged Victim.	The Informant stated that they did not know what was happening at the time and did not realise what had happened until they turned 18 years old.	No evidence available.
Informant reported that they didn't realise what was going on at the time and didn't realise what Jimmy Savile had been doing to the alleged Victim until they turned 18 years old.	Informant stated that they weren't sexually aware and described themself as 'naïve' but later (in the meeting) described the incident as a 'hard hitting event'.	No evidence available.

Information Provided by NSPCC/Met Police	Information obtained from Informant during meeting on 29.04.13	Information obtained through Investigation at the Trust
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Information Provided by NSPCC/Met Police	Information obtained from Informant during meeting on 29.04.13	Information obtained through Investigation at the Trust
Information regarding the two other children on the ward		
Jimmy Savile then visited another segregated room where two other, younger children were staying.	The Informant stated that there were no other patients on the ward apart from them and the alleged Victim.	No evidence available.
The Informant states they then heard one of the other children crying whilst Jimmy Savile was in the room and didn't feel that the crying sounded 'right'.	When asked if they had heard anything that could have suggested that Jimmy Savile had interfered with another patient they said no and that they had been 'stuck in one room'.	No evidence available.
The Informant recognised the different cries as they had all had surgery.	The Informant did not make any reference to two other patients and therefore no reference was made to them crying or the recognition of the cry.	No evidence available.
One of the other children (not believed to be the one who was crying) also died.	The Informant made no reference to another patient being on the ward at the time of the incident.	Camden Registrar for Births Deaths and Marriages confirmed that other patients had died in the Trust between 1970 - 1972 but could not release any further information due to their obligations under the Data Protection Act.
Neither the Informant nor the Victim informed any of the staff of the incident with Jimmy Savile.	The Informant confirmed that they didn't even think about telling anyone about what happened because they weren't sexually aware and therefore did not know.	No evidence available.
The Informant states that they have never told anyone about the events, not even their spouse.	The Informant confirmed in the meeting that their spouse knows about the incident and knew that the meeting was taking place.	No evidence available.

Information Provided by NSPCC/Met Police	Information obtained from Informant during meeting on 29.04.13	Information obtained through Investigation at the Trust
Information regarding the bodyguard/driver		
The Informant reported that Jimmy Savile had had a male with him, either his bodyguard or his driver.	The Informant stated during the meeting that the bodyguard / driver had stayed outside the ward with the door shut.	Liaised with Metropolitan Police Service who confirmed no further investigation could be undertaken in respect of a bodyguard or driver.

The Investigating Team have concluded that due to the lack of confidence that the alleged Victim has been correctly identified, the difference between the dates of the documented visit to the Trust by Jimmy Savile, and the dates of admission and discharge for both the Informant and the alleged victim, it is not possible to say for certain if the alleged incident on the premises of Great Ormond Street Hospital took place.

17. Recommendations

Although no formal recommendations have been identified through this investigation, the Trust had previously carried out an assessment based on the letter from Sir David Nicholson in November 2012 which has been added as an appendix (appendix F) to this report.

Appendix A

Investigation Team Biographies

Liz Morgan, Chief Nurse and Families' Champion

Liz trained as a Registered General Nurse at St Bartholomew's Hospital and then as a registered Children's Nurse at GOSH undertaking further training in Neonatal Intensive Care. After working in a variety of clinical, educational, and managerial posts in London, the Midlands, and Lincolnshire, Liz returned to nurse education and set up the MSc Advanced Practice in Neonatal Nursing at the University of Birmingham

Liz returned to the NHS in 1997 as Head of Nursing, becoming Assistant Director and then Director of Nursing and Family Centred Care at Birmingham Children's Hospital in 2002.

After five years as Director of Nursing, Liz moved to the Department of Health Children, Families and Maternity Policy team as Professional Advisor, where she worked on the Better Care: Better Lives guidance for palliative care, the Neonatal Toolkit following publication of caring for Vulnerable Babies, and undertook a review of community children's nursing.

During her career Liz has also gained a Professional Diploma in Nursing; a Diploma in Nursing Education; a post graduate Diploma in Health Service Management and an MSc in Public Sector Management.

Liz commenced at GOSH as Chief Nurse in June 2010, where her portfolio of responsibility includes the development of professional nursing quality, standards and education, nursing advice to the Trust Board; improving the patient experience; executive lead for infection prevention and control and safeguarding children and young people.

Salina Parkyn, Head of Clinical Governance & Safety

Started her NHS career in Operational Service Management in a number of London Hospitals before joining Great Ormond Street Hospital for Children NHS Foundation Trust in 2004 where she joined the Patient and Staff Safety team. Over the next 9 years Salina has carried out a number of roles within the team including Patient Safety and Complaints Manager and her current role of Head of Clinical Governance & Safety.

Salina has a degree in Health Service Management, a diploma in Clinical Risk and Claims Management, a Professional diploma in Managing Finance in the NHS and is currently studying for her MSc in Quality and Safety in Healthcare.

Jan Baker, Head of Safeguarding & Named Nurse for Child Protection

Jan Baker has worked for the NHS since 1975. Her general Nurse Training was completed at King's College Hospital followed by a period spent in Cardiothoracic surgery. Jan then went on to complete her Midwifery Training at King's before embarking on a Health Visiting Course and long term career in Primary Care.

Jan has worked extensively in the Health Visiting Service in numerous settings before moving into management of multi-disciplinary nursing teams which have included joint managing of adult and children's services. Jan has worked as a Community Named Nurse for Safeguarding Children since 2004, spending six years in a community setting before moving to her current role at Great Ormond Street Hospital.

At the beginning of 2013 she took up the post of Head of Safeguarding Children & Young People Service at GOSH, expanding the Named Nurse role within the organisation and developing the team to meet the needs of the workforce in the new era of Foundation Trust status.

Sophie Pownall, Trust Solicitor

Sophie Pownall is the Trust Solicitor at Great Ormond Street Hospital, a post she has held since June 2010.

Following university, Sophie completed a Postgraduate Diploma in Law and the Legal Practice Course, with a view to practicing health law. Sophie then trained as a solicitor at a firm specialising in health and social care law. Following qualification as a solicitor, she practised at the same firm for a number of years, during which time she undertook secondments with a number of Trusts, before moving to Great Ormond Street Hospital to take up the post of Trust Solicitor nearly four years ago.

Sophie's role as Trust Solicitor is a broad one, focusing in particular on the legal aspects of clinical matters (including paediatric consent, child protection issues, criminal cases, inquests and information governance).

Cymbeline Moore, Head of Communications

Cymbeline is a trained journalist that has worked in communications for the NHS for the last seven years.

After working for the Trinity Mirror group of newspapers as a news editor she moved into NHS communications at Hammersmith Hospitals. During her time there she became head of public relations and then director of communications for the newly formed Imperial College Healthcare NHS Trust. She has been head of communications for Great Ormond Street Hospital and Charity since September 2012. In this joint role she oversees all hospital and charity press and PR activity and is responsible for family stewardship, celebrity liaison and VIP visits.

Appendix B

List of Documents Reviewed

As documented in the timeline of investigation, the medical records of the Informant and the alleged potential Victim have been reviewed; so were the admissions registers for 1970, 1971 and 1972.

Information kept in the Hospital Museum and Archive store has been reviewed, this includes:

- The complaints policy and complaints received in 1972.
- Hospital magazines and newsletters from the 1970's, to see if there was any indication of celebrity visits and to also understand the context of the Hospital at that time.
- Staff returns required (then) by the DHSS.
- Various papers than had been sent to the Hospital board.
- Hospital diagrams / floor plans to ascertain the names of the wards in the 1970s, the specialities they treated and to understand what difference, if any, in where private patients were treated.

Transcripts and notes taken by the Metropolitan Police Service, NSPCC and the Investigating Team were reviewed and analysed to ensure that a robust investigation had taken place and that there were no gaps in lines of enquiry.

The current policies and procedure were also reviewed.

Appendix C

List of Those Interviewed

Formal interviews were not carried out with staff due to the 42 year gap between the allegation and the investigation.

However, a staff member who was then the Ward Sister of another ward (5D) is still employed by the Trust and was spoken to by the Investigating Team to provide the background to the 1985 visit to the Trust by Jimmy Savile.

The Informant agreed to be interviewed by the Head of Clinical Governance & Safety and the Head of Safeguarding & Named Nurse. This information has been used to complete the timeline and the investigation analysis.

Appendix D

Timeline of Investigation

Date & Time	Event	Outcome/comment	Comments
12.11.12	Trust received a letter from Sir David Nicholson.	All NHS Trusts were asked to review with their Boards, their own arrangements and practices relating to vulnerable people, particularly in relation to; Safeguarding, Access to patients (including that afforded to volunteers or celebrities) and Listening and acting on patient concerns.	An action plan was created and shared with the Trust Board and North Central London (NCL) Commissioners.
20.11.12	Archivist and Charity staff contacted to check if Jimmy Savile had any known visits or access to the Trust.	Archivist confirms that the only record of Savile visiting the Trust was in 1985 when the aircraft carrier Ark Royal presented a cake to the Hospital. Charity communications staff review Visitors' Book and only signature is of that same visit in 1985.	
30.11.12	Trust contacts Detective Superintendent of Child Abuse Investigation and Command, Met Police (DS Gray) to request information regarding the allegation.	DS Gray confirms there is 1 historic allegation that is on the police system, it is currently restricted and will arrange for the information to be obtained and shared with the Trust as soon as possible.	This is the first time that anyone at the Trust has been notified that an allegation had been made that an assault took place on the Trust premises.
03.12.12	Trust received an email from the Chief Nurse at NHS London (Jill Brockman) further to Sir David Nicholson's letter (dated 12.11.12)		

Date & Time	Event	Outcome/comment	Comments
	asking for assurance that systems have been checked and action plans created to address any gaps.		
14.12.12	Chief Nurse at the Trust responds to email from Jill Brockman confirming that a review of relevant policies and processes has taken place and an action plan has been created.		
21.12.12	Trust contacts DS Gray to confirm that the information required to aid the Trust's investigations is: date of the alleged assault; the names and ages of the Informant and Victim; and the names/descriptions of the ward.	DS Gray confirmed that the Victim was allegedly a child from Country A, of approx. 11-12 years old, with the same first name as the Informant. The offence is reported to have occurred around Christmas 1971. The alleged Victim is reported to have died 3 days after being assaulted.	Confirmation that the original call from the Informant was made to the NSPCC on 23 rd October 2012.
10.01.13	CEO at the Trust informed by NHS London that the police report into Jimmy Savile will be published early January 2013 and the Trust will be named as having 1 reported offence in 1971.		
11.01.13	<i>Giving Victims a Voice</i> published; the Trust is named as one of the sites in which an allegation had been received by Operation Yewtree.	An all user email was sent to the Trust staff informing them that the report had been published.	
15.01.13	Trust was still not aware of the circumstances of the allegation or the full names of the Informant or alleged Victim so further checks of archives and charity information were to be		

Date & Time	Event	Outcome/comment	Comments
	reviewed to see if/when Jimmy Savile visited the Trust.		
17.01.13	Contact made with the DS Gray requesting information on the allegation.	DS Gray confirmed he will let the Trust know 'over the next few weeks' information regarding the Informant/Victim.	
01.02.13	Trust receives letter from Kate Lampard asking for the allegation made about the Trust to be investigated.	Letter shared with relevant staff and Investigation Team created.	
04.02.13	Trust contacted DS Gray to see if any information had been ascertained to help the Trust investigate the allegations.	DS Gray confirmed the Informant is happy to be contacted by the Trust and supplied their name, current address and telephone number.	
04.02.13	Trust contacts North Central London Cluster (NCL) to discuss reporting the allegation as a Serious Incident (SI).	Confirmation from the Patient Safety Manager at NCL that the allegation should be reported as an SI.	
06.02.13	Contact made with the Health Records Manager to understand if records from the 1970's were still available.	Informed that name and date of birth of the patient is needed to review micro-film and/or admissions register.	
08.02.13	Informant's full name supplied to Health Records Team to review micro-film.		
12.02.13	Trust contacts DS Gray requesting further information regarding the allegation, such as date of birth or the address of the Informant at the time of the incident.		

Date & Time	Event	Outcome/comment	Comments
12.02.13	Health Records Team locate Informant's medical records within the microfilmed notes.	Informant was a private patient and is the only patient with both a first name and surname that matches that given by the police.	
14.02.13	Head of Clinical Governance & Safety and the Head of Safeguarding review the Informant's medical records.	One admission documented in the medical records for April 1970 - admitted on 9th April 1970 and discharged on 24 th April 1970.	This does not match – for month or year – with the information supplied by the Met Police regarding the alleged date of the incident (Christmas 1971).
19.02.13	Letter drafted and sent to Informant requesting communication between the Trust and themself.		
21.02.13	Contact made with the Trust Archivist to gather information regarding the wards in the 1970's, the environment and the specialities of the wards.	Head of Clinical Governance & Safety and the Head of Safeguarding meet with the Archivist and review relevant information.	
21.02.13	Health Records Team contacted again to review the admissions register of 1970, 1971 and 1972 in light of the discrepancy with dates.	Confirmed that the Informant was not listed in any of the admissions registers.	Discrepancy between medical records and admissions register but medical records staff suggest that a separate register may have been kept for private patients.
21.02.13	Trust contacted DS Gray to ask for clarification on the details of the allegation including: That the Informant and the alleged Victim had the same first name; and the dates of the allegation.		The Investigation Team were unclear if the information provided was stating that the alleged Victim and the Informant had the same first name.
28.03.13	A second letter was sent to the Informant		

Date & Time	Event	Outcome/comment	Comments
	asking for a discussion or meeting.		
09.04.13	Meeting held by the Department of Health with the NHS organisations investigating allegations made.	Instructed that the terms of reference for the investigation should be approved by the Local Safeguarding Board, the MPS and the Trust Board and a report template to be shared with Trusts.	Attended by the Executive lead for the investigation and the Trust Solicitor. Evidence shared by the police, via the DoH, was issued to the Trust Solicitor.
11.04.13	Investigating Team meeting to feedback the discussions and decisions of the meeting at the DoH.	Evidence shared with the Trust Solicitor was shared with the Investigating Team.	New information is contained in the evidence, which suggest two younger children were also on the ward at the time of the alleged incident and that Jimmy Savile had visited them. Also suggestion of a driver/bodyguard being on the ward.
12.04.13	Contact made with Camden Registrar for Births, Deaths and Marriages requesting that records be checked for: <ul style="list-style-type: none"> • A child (sex given) approximately 10-11 years old • First name given • Died at GOSH between 1970 and 1972 	Camden Registrar confirms a review will take place and will contact the Trust w/b 15 th April 2013.	
12.04.13	Contact made with Human Resources to check records of staff who may still be employed by the Trust from the 1970's.	HR confirmed they do not keep records as far back as the 1970's.	
16.04.13	Terms of Reference sent by email to Richard Tucker, Metropolitan Police.	Mr Tucker confirms the ToR is fine.	

Date & Time	Event	Outcome/comment	Comments
16.04.13	Trust contacts Deputy Director, Department of Health, William Vineall confirming that the ToR will be presented at Trust Board and providing an update on the investigation.		
19.04.13	Trust contacted by Camden Registrar who confirmed that 35 deaths occurred between 1970-1972 with the first name of the alleged Victim, but only one had a place of death listed as the Trust. The age of the deceased did not match the approximate age supplied.	Trust applied for the death certificate to identify the patient's name and date of birth. Death certificate issued and collected.	The date of death for this deceased patient is mid-February 1972 which does not correspond with the medical records for the Informant or with the detail that the alleged Victim died within days of the assault which would have been around Christmas 1971.
19.04.13	Telephone contact made with DS Gray regarding the reference to a bodyguard/driver.	Trust was unsure if this information was or would be investigated as part of the criminal investigation.	No further knowledge or investigation of this issue.
19.04.13	Health Records Team contacted and asked to retrieve the notes of the patient named on the death certificate.		
19.04.13	Camden Registrar contacted again to see if any information could be obtained regarding the other patients that were allegedly on the ward at the time of the incident.	Camden Registrar confirmed that there were a small number of other possible patients who died at the Trust in 1972. As there was no further information available and due to the Data Protection Act this line of enquiry ended.	Only information was available was that there were two younger children, who were long term patients, who had had surgery. One of these children apparently also died shortly after the visit.
22.04.13	Head of Safeguarding and the Head of Clinical Governance & Safety telephoned the	Discussions took place to plan for meeting, devise questions and obtain	

Date & Time	Event	Outcome/comment	Comments
	Informant. It was agreed that a meeting would take place at their home address on Monday 29 th April 2013.	recording equipment to record the meeting.	
22.04.13	Timeline created of Informant's interactions with the Trust created alongside the alleged Victim's interactions with the Trust.	Provided the Investigating Team with structured questions and issues to explore during the meeting.	
23.04.13	Medical records for the patient named on the death certificate is retrieved and reviewed.	Information within the medical records does not match the age or description of the patient (the alleged Victim) as described by the Informant.	Information suggests that the patient would have been on a different ward to the Informant and at a different time.
24.04.13	Terms of Reference for the investigation discussed and approved at Trust Board.		
29.04.13	Head of Safeguarding and the Head of Clinical Governance & Safety met with the Informant at their home address.	Some discrepancies were noted between the information received (via the meeting) and already held by the Trust.	
24.05.13	Contact made with the NSPCC with a view of reviewing the original transcript of the conversation between the Informant and the NSPCC.	NSPCC would consult with their Information Governance lead and get back to GOSH.	
28.05.13 – 10.06.13	Various email and telephone communication with the NSPCC regarding the information held by them. Agreed that the Trust could listen to the original conversation.	Information Governance and Data Protection Act compliance.	
29.05.13	Transcript of meeting with Informant received and reviewed.		
12.06.13	CD of the recording of the discussion	Email communication between the	

Date & Time	Event	Outcome/comment	Comments
	between the Informant and the NSPCC received by the Trust but cannot be accessed on hardware.	Trust and the NSPCC regarding the hardware required. GOSH Charity contacted and confirmed that their hardware is compatible with the CD.	
24.06.13	Head of Clinical Governance & Safety listens to the recording of the conversation between the Informant and the NSPCC when they first reported their allegations.		
25.06.13	Meeting held by the Department of Health with the NHS Organisations investigating allegations.	Attended by the Executive Lead and the Trust Solicitor.	
01.07.13	Investigating Team meeting to update the rest of the team on the discussions at the Department of Health.		
July– August	Completion of the Investigation report.		

Appendix E
Correspondence with the Informant

Great Ormond Street 
Hospital for Children
NHS Foundation Trust

Great Ormond Street
London WC1N 3JH

Tel: 020 7405 9200

14th March 2014

XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX

Dear XXXXXXXXXXXXX

I write further to our telephone call yesterday when we agreed that I would send you a copy of report for you to review.

As you know, our investigation not been able to align some of the information we have received with the information that is held by the Trust. We are sorry for these gaps but are grateful that you appreciate the difficulties with investigating something that happened 42 years ago.

If you would like to feedback any comments of the report, please feel free to do so. I am way from the Trust next week but my colleague, whom you met at your house, Jan Baker will be available next week on the following contact details: Tel: XXXXXXXXXXXX bleep XXXX
XXXXXXXXXXXXXXXXXXXXX.

If we do not hear anything from you by Friday 21st March we will submit the final report to the Department of Health as requested.

Once again, thank you for all of your help with our investigations.

Yours sincerely

Salina Parkyn
Assistant Head of Quality and Safety

Great Ormond Street 
Hospital for Children
NHS Foundation Trust

Great Ormond Street
London WC1N 3JH

Tel: 020 7405 9200

31st March 2014

XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX

Dear XXXXXXXXXXXXXXX

I write further to our telephone call today in which you explained that you had been unable to collect the copy of the report that was sent to you on the 14th March 2014 as you had been unwell. I am sorry you have been poorly and do hope you feel better soon.

As you know, our investigation has not been able to align some of the information we have received with the information that is held by the Trust. We are sorry for these gaps but are grateful that you appreciate the difficulties with investigating something that happened 42 years ago.

If you would like to feedback any comments of the report, please feel free to do so. My contact details are email; XXXXXXXXXXXXXXXXXXXX and my direct number is XXXXXXXXXXXXXXX.

Once again, thank you for all of your help with our investigations.

Yours sincerely

Salina Parkyn
Head of Clinical Governance and Safety

Great Ormond Street 
Hospital for Children
NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
Tel: 020 7405 9200

10th April 2014

XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX

Dear XXXXXXXXXXXXX

Thank you for accepting delivery of our report into the concerns you raised about a visit to the hospital by JS that you recall when you were an in-patient in 1972.

I hope you feel able to read our report, and to ask us any questions about the investigation we have undertaken and our findings.

You will see, after so many years we have been unable to confirm the points you raised with us, despite extensive enquiries and review of Trust documentation. The only proof we have found of JS's presence in the trust was in 1986 when he presented a cheque to the hospital, when there is no evidence that he went anywhere other than the Trust Board room.

However as a result of your allegations and our subsequent work we have reviewed all of our existing policies/practice for allowing celebrity personalities to visit the hospital. This is to ensure they are always accompanied by a member of staff. This has helped us be confident that no-one could gain access to a ward or child inappropriately.

We have tried to make contact with you to discuss the findings of the report but have been unsuccessful. We are mindful that you may not want to be contacted, which is of course your right and we would wish to respect that, and so we have made a decision not to continue with our attempts to talk to you.

If however you would like to discuss any part of the report further please feel free to contact me on XXXXXXXXXXXXXXXX.

Thank you for raising your concerns and please accept our apologies for any distress the investigation or our report may have caused. Can we remind you that there is support available if you wish to discuss with your GP or the NSPCC Helpline on 0808 800 5000.

Yours sincerely

Salina Parkyn
Head of Clinical Governance and Safety

Appendix F

Timeline of Patient Activity

Date & Time	Event	Outcome/comment	Comments
1962	Informant born.	Mother was prescribed thalidomide during pregnancy.	
1965	Alleged Victim born.	Nothing abnormal detected during pregnancy or at birth.	
26.02.70	Letter from Consultant's Private Secretary to parents of Informant telling them that the admission has been arranged and their child was due to attend the private wing of the Trust on Thursday 9 th April 1970.	The surgery was scheduled for the following day.	
26.02.70	Dr Innes-Williams (Consultant) writes to Miss Campbell, (secretary) thanking her for arranging the admission of Informant. The letter explains the medical history of Informant.	Letter refers to attempts to make urological repairs in 1966, 1968, 1969	Medical records refer to previous treatment at Hospital A.
06.04.70	Informant admitted from waiting list for urological surgery.	Ward was noted as 7AB.	Discrepancy between this date and the admission date on the referral letter.
10.04.70	Informant had surgery.		
24.04.70	Informant discharged from the Trust.	Last entry for this patient is on the 24.04.1970	
05.08.71	Alleged Victim admitted to the Trust for		

	surgical treatment for cancer.		
03.09.71	Alleged Victim discharged from the Trust.		
07.12.71	Alleged Victim re-admitted to the Trust as Mother had noticed their memory had 'not been so good' as it had been.	Alleged Victim was on ward 3AB.	Alleged Victim was transferred to Hospital B on 12 December 1971 and returned to GOSH on the 14 th December 1971.
23.12.71	Alleged Victim discharged from the Trust.	Discharged home.	
29.12.71	Alleged Victim reviewed in outpatients.	Entry in medical records confirms that they will be seen again in two weeks.	
05.01.71	Alleged Victim re-admitted to 3AB.	Alleged Victim transferred to Hospital C for treatment.	Medical records not clear on when alleged Victim left Hospital C.
14.02.71	Alleged Victim readmitted to the Trust	Readmitted for further therapy.	
16.02.71	Alleged Victim sadly died at the Trust aged approximately 6 years.		

Appendix G

Action Plan in response to Nicholson letter dated 12.11.12

No	Recommendation	Action	Lead	Timescale	Review & Outcome
1.	Access to patients	<p>Develop a policy for managing external visitors to the Trust who will have contact with Children & Young People in collaboration GOSH Charity & Volunteer service.</p> <p>Review pre-employment check procedures for substantive staff, Honoraries and visitors/observers.</p>	<p>Jan Baker / Mark Engledow / Jamie Wilcox / Cymbeline Moore</p> <p>Ray Conley</p>	<p>March 2013</p> <p>March 2013 for substantive staff July 2013 for other staff</p>	<p>Ensure that there is coordination of policy/guidance being developed across charities/volunteer services security services and Safeguarding Children & Young People. Completed.</p> <p>To be audited through internal (HR led) and external audit. An external audit was completed in October 2012 for substantive staff. In addition, HR run their own department pre-employment check audits for both substantive and bank staff on a quarterly basis. An external audit was completed in December 2012 for honorary staff.</p>
2.	Listening to and acting on patient concerns.	Raise awareness for all staff on what to do if a child or young person discloses?	Jan Baker / Julie Rooke / Geoff Speed	March 2013	<p>Included in level 2 Safeguarding Children training. Completed</p> <p>Incorporate into Level 2/3 newsletter To be published post Working Together publication.</p>

3.	Volunteers	Training	Jan Baker / Jamie Wilcox	January 2013	11/12 Meeting with Jamie Wilcox Volunteer Manager. Modified training at Level 2 designed for volunteers to commenced Jan 2013. On-going
4.	Charities	Training	Jan Baker / Cymbeline Moore	March 2013	Level 2 Safeguarding Children training delivered to key staff 16/01/13. Completed Level 1 Update to be delivered to remaining staff. Ongoing
5.	Establish if JS had ever visited Trust	Undertake a 'look back' exercise to establish if JS had visited organisation	Jan Baker / Salina Parkyn		Trust received Operation Yewtree report. Identified that JS did visit Trust in 1985 – allegation outlined in report. Currently completing investigation for the Department of Health . JB and SP met with Informant on 29/04/2013.
6.	Review of key policies	Ensure Trust has up to date policies to address:- <ul style="list-style-type: none"> - Recruitment of volunteers (including CRB checks) - Management of Serious Incident and Incident Reporting - Management of complaints/PALS - Child Safeguarding - Adult Safeguarding - Whistle blowing/ Raising 	Jan Baker		Policies check Completed Current review dates of policies as follow:- <ul style="list-style-type: none"> - Recruitment of volunteers (including CRB checks) under review - Incident Reporting and Management Due for review 2014 - Complaints

		<p>Concerns in the Workplace</p> <ul style="list-style-type: none"> - Visitors/Chaperone (including VIP visitors) 			<p>Due for review 2014</p> <ul style="list-style-type: none"> - Child Safeguarding To be reviewed post publication of Working Together 2013. - Adult Safeguarding Due for review - Whistle blowing / Raising Concerns in the Workplace Due for review 2014. - Visitors/Chaperone (including VIP visitors) Policy completed and ratified by PAG. Review 2014.
7.	Reporting to Trust Board	Provide Board with formal assurance that there are robust systems and processes in place to be able to identify and manage allegations relating to staff, volunteers and visitors.	Liz Morgan		<p>Once investigation completed all learning to be shared with Trust Board and assurance of existing processes.</p> <p>Completed 28.01.2014</p>