Central Manchester University Hospitals NHS
NHS Foundation Trust

Investigation into allegations that Jimmy Savile abused two Patients on the Booth Hall Hospital Site circa 1959 – 1975

A report for Central Manchester University Hospitals NHS Foundation Trust

June 2014

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Contents

1. Introduction

1.1. The Board of Central Manchester University Hospitals NHS Foundation Trust (hereafter known as CMFT) has commissioned this investigation in response to information provided by the Department of Health that Jimmy Savile (who died in 2011) allegedly abused a former patient at Booth Hall Hospital.

1.2. In October 2012, the Metropolitan Police commenced an investigation into the behaviour of the television personality Jimmy Savile and allegations of the sexual abuse of children going back several decades. The investigation was well publicised and a number of television programmes and news reports were screened relating to the allegations and the investigation, *Operation Yewtree*.

1.3. The Operation Yewtree investigation team had a dedicated phone line to receive information from members of the public about alleged abuse of patients in NHS Hospitals.

1.4. Three investigations were commissioned in 2012, followed by a further eleven investigations in early 2013. These included a number of hospitals and one hospice. In late 2013, the Department of Health then reported to Parliament that 19 further hospitals would be tasked with undertaking investigations into allegations of abuse by Jimmy Savile in their organisations.

1.5. On 28 November 2013, the Chief Executive of CMFT received a letter from the Department of Health informing him that an allegation had been received by Operation Yewtree relating to the now closed and demolished Booth Hall Hospital. The allegation made by one individual, an ex-patient, also named another local hospital, Prestwich, at which abuse took place.

1.6. The Boards in each of the two organisations commissioned their separate investigations. However, in order to minimise distress to the person making the allegation the two Trusts decided to have a single point of contact and conduct one interview.

1.7. The responsibility for Booth Hall Hospital lies now with CMFT as detailed in section 5.

1.8. The details of the allegation are as follows. Circa 1959, the alleged victim A/N249*, then aged 7-8 years old was admitted to Booth Hall Hospital to have an appendectomy. She was in a ward with other patients, there were no staff present. Savile came in to visit accompanied by the patient's father, the patient's full statement details the fact that her father not only abused her but allowed Savile to do so. She alleges that this happened numerous times over a period of years.

During the visit to Booth Hall Hospital Savile put his hands under the bed clothes and sexually assaulted her. She was not sure how long this took and does not remember it happening again at Booth Hall Hospital. She told no one.

1.9. A team was set up to undertake the investigation. Two Directors were identified to oversee the process. The Directors are Mrs Jill Alexander, Director of Clinical Effectiveness and operational manager for the Safeguarding Team and Mrs Sue Ward, Director of Nursing (Children) and professional lead for Safeguarding.

The investigation team was as follows:

Name and Designation	**Team Role**
Mrs Sarah Corcoran, Associate Director of Clinical Effectiveness	Investigation lead and report author
Dr Sarah Dixon Named Doctor – Safeguarding	Designated professional to advise on the allegations in the context of previous and current safeguarding procedures and any implication that any learning points have on safeguarding procedures
Mrs Bernie Ryan Lead Nurse, St Mary's Sexual Assault Referral Centre (SARC)	Specialist support in interviewing and supporting victims of sexual assault
Ms Anne Kubiak Lead Nurse, Safeguarding	Investigation of current position in relation to associated safeguards in place and recommendations required
Ms Vanessa King, Trust Solicitor	Legal advice

Information and further support was provided from teams in Informatics, Human Resources, and the Royal Manchester Children's Hospital.

1.10. On 17th January 2014, CMFT was formally notified, following a discussion at the meeting facilitated by the Department of Heath on 9th December 2013, that there was another allegation which might relate to Booth Hall Hospital. At this time it was not clear which hospital the allegations related to as the person making the allegation (Alleged victim *B/4055) did not remember which hospital it was and could only describe the building.

1.11. The details of the allegation are as follows. In 1974, when the alleged victim was 9 or 10 years old he was a patient in hospital. He named the hospital as 'Middleton Hospital'. He alleges that the nurses told the patients Jimmy Savile was coming to visit and that they were to hide under the covers and pretend to be asleep. Savile then came over to the bed put his hands under the sheets and onto the victim's genitals. The victim alleges he then chased Savile from the ward. He reported that he had told his parents when they visited and that they had reported this to Middleton Police Station. On interview he reported that it had been an Aunt

and Uncle who had visited in hospital, when asked if they could be interviewed stated “no, you won’t get anything out of them”.

1.12. The team was tasked with delivering this report to Verita Consultancy who have been asked by DH to assist Kate Lampard in providing assurance about the quality of the reports.

*N249 / 4055– Operation Yewtree Reference Numbers.

2. Terms of Reference

1. The Board of Central Manchester University Hospitals NHS Foundation Trust (CMFT) has commissioned this investigation under its responsibility for oversight of the organisation in response to information provided by the Department of Health that Jimmy Savile allegedly abused two former patients at Booth Hall Hospital.
2. The investigation will be overseen by the Director of Nursing (Children) and the Director of Clinical Effectiveness.
3. If the report contains any express or implied criticism of any individual or organisation, they will be afforded the opportunity to respond to that section of the document prior to finalisation of the report (the 'Scott Process').
4. The investigation will comply with the requirements of the Data Protection Act (1998).
5. The investigation does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability.
6. The investigation will be conducted and a written report will be produced that will seek to;

- Explore an allegation that an inpatient was abused in Booth Hall Hospital on a single occasion in the 1960s
- Establish the credibility of the allegation, the dates that the alleged abuse took place and whether Jimmy Savile visited the hospital on any other occasions
- Identify a chronology of events leading up to the incident
- Establish a chronology of any other dates that Jimmy Savile visited Booth Hall Hospital
- Review past and current complaints and incidents concerning Jimmy Savile's behaviour at any hospitals managed by CMFT and its predecessor bodies
- Where complaints or incidents were not previously reported or investigated, or where no appropriate action was taken, consider the reasons for this
- Establish whether Jimmy Savile had any formal relationship with the Hospital and if so what access he was afforded and what governance was in place regarding this

* Later extended to a number of other organisations.

- Establish the extent to which anyone in the organisation at the time knew about the allegations
- Identify and interview relevant individuals, including the alleged victim (with consent) to inform the investigation. The victim's identity will be anonymised unless they state they wish to be named

- Adopt the PEACE (Preparation & Planning, Engage and Explain, Account clarification and Challenge, Closure, Evaluation) method of interviewing
- Devise a protocol to offer and arrange appropriate support for the alleged victim during and after the investigation
- Explore policies, practice and procedures in place at the time of the allegation with particular regard to volunteers, staff vetting, safeguarding procedures, whistle blowing and complaints handling and identify any relevant learning
- Establish current policies, practice and procedures with particular reference to volunteers, staff vetting, safeguarding procedures, whistle blowing and complaints handling and identify any current risks that a similar incident could happen now
- Maintain a full log of individuals, information and documentation sought and recovered including the source of the information
- Analyse evidence against benchmarks of good practice and identify any learning

7. A draft report will be produced and submitted to the Medical Director by 31st January 2014 and discussed at the Safeguarding Effectiveness Committee.

8. The final report will be provided to the Board of Directors.

9. The draft written report, agreed by the Trust Legal Advisors, will be submitted to Verita on behalf of the Department of Health by 21st February 2014.

10. Any decision to publish the findings will be agreed by both the Board of Directors and the Department of Health.

3. Executive Summary and Recommendations

3.1. Running throughout this investigation has been the challenge of finding any supporting evidence for the allegations made by the alleged victims.

3.2. It has not been possible therefore to produce conclusive evidence that the events described by both alleged victims took place.

3.3. However, despite this, what is clear is that both alleged victims raise issues which were well worthy of investigation and that the Trust has a responsibility to review current practices and procedures in relation to the protection of both children and vulnerable adults both on the hospital sites and in the community.

3.4. The team discussed in some depth the detail relating to both cases. The primary concern was that the events described by alleged victim A/N249 would be the most difficult to detect and prevent today and in the future. These events detailed a parent as both an abuser and as a person facilitating access to another abuser.

3.5. The emergence of Safeguarding as a nursing and medical specialty in its own right over the last few decades and changes to safeguarding processes have increased both recognition of abuse and support to its victims. The only way to address the type of abuse described by alleged victim A/N249 would be early recognition by the healthcare profession and immediate action taken.

3.6. There is clear evidence that immediate action is now taken with issues escalated to the Safeguarding Team by the community and hospital staff on a regular basis. Policies and education are in place to support this and these are monitored both internally and by external bodies.

3.7. Both internal and external monitoring indicates that safeguarding policies are well embedded in the organisation and that current practice is of a high standard.

Recommendations

3.8. The Trust Access to Vulnerable People Group should continue working towards a suite of policies and guidance to manage visiting celebrities to all areas of the Trust.

3.9. The Safeguarding Team, on behalf of the Trust, should continue to regularly review and audit safeguarding practice to ensure the high standard of safeguarding practice continues.

3.10. It has been proposed that a system will be developed to provide a daily account of resident parents/carers and to provide visitors with name badges/bands. This should be progressed. The Head of Nursing for the Children's Hospital has

been allocated to this programme of work and it is anticipated it will be complete by December 2014.

4. Approach to the Investigation

4.1. The location of documents has been a challenge for the investigation team. Booth Hall Hospital has not physically been in existence for three years having been demolished in 2011. As an organisation, it became part of the Central Manchester University and Manchester Children's Hospitals from April 2001 and, in accordance with information governance requirements, many records have been destroyed during organisational changes and geographical moves. NHS Information Governance states: Effective records management requires that an organisation is able to identify and retrieve information when and where it is needed. The organisation must have records management procedures in place that cover the creation, filing, location, retrieval, appraisal, archive and destruction of records in accordance with the Records Management: NHS Code of Practice, and other relevant guidance and legislation.

4.2. Efforts were made to trace medical records for both the alleged victims. No records were found for alleged victim A/N249* (in patient circa 1959/60) and adult records only were located for alleged victim B/4055 (paediatric in patient circa 1974). Both the alleged victims have passed the age of 25 years where the records, if they existed, would have been destroyed.

4.3. Efforts were made to locate admission records for the time period but these could not be identified and were reported as having been destroyed in line with information governance requirements.

4.4. A search of the Booth Hall archive record (documents now located in a storage facility managed by CINTAS a document management company contracted to store archive documents on behalf of the Trust), indicated that no admission records or similar documents had been kept. An online search indicated that some records may now be stored in the Greater Manchester County Archive Office which is closed for refurbishment until Spring 2014. However, the online index indicates that admission records were only kept up to the early 1950s.

4.5. Efforts were made to trace staff records via the Human Resources Department for the period under investigation. Again, very little was found as many of these records have been destroyed in line with information governance requirements. Some 40

years have passed since the latest of the time periods under review and therefore, it is likely all staff working at the hospital at that time have now retired.

4.6. Identification of which staff members would need to be located is also problematic. Neither alleged victim can be clear about the date of admission or location of care. Alleged victim A/N249 reports being a patient in 1959 but does not know which ward or department. It would be very difficult to identify which staff were working on the ward at the time and the likelihood of them remembering a visit to a patient of a father and an 'uncle' at a point in time some 50 years ago is extremely low. Alleged victim B/4055 is not clear or consistent as to what hospital he was in or when. The Trust has considered this issue and is of the view that even if those staff working on the ward at the time of the alleged incident were located there is little they could add to the investigation.

4.7. The Trust considered pursuing further the possibility of accessing the news archives to establish any further evidence of Savile visiting Booth Hall Hospital. These are also held in the Greater Manchester County Archive which is closed until Spring 2014.

4.8. The investigator concludes that as, enquiries with the Charities Team in relation to records of donation have not provided any evidence to link Savile formally with the Hospital and the Operation Yewtree team have indicated that no further allegations have been received to date, on balance, the likelihood of finding anything was low. The process would also be extremely labour intensive, requiring a microfiche search of newspaper articles over a 15 year period. An intensive online search yielded nothing in respect of official visits made to Booth Hall Hospital by Jimmy Savile.

5. Booth Hall Hospital Background Information

5.1. Booth Hall Hospital first opened as a hospital in 1908, becoming Booth Hall Children's Hospital in 1949. At the inception of the NHS in 1948, Booth Hall, Monsall Hospital for Infectious Diseases and the Duchess of York Children's Hospital were grouped under Manchester Babies' and Children's Hospital Management Committee, and the Hospital was incorporated into the NHS.

5.2. Following the introduction of the NHS, Booth Hall continued until 1991 when Manchester Children's Hospitals Trust was established. In April 2001, the Children's Hospital Trust merged with Central Manchester Hospitals to become Central Manchester and Manchester Children's Hospitals NHS Trust. The Management Boards are detailed below.

Regional Hospital Board (1948-74)	Manchester
Regional Health Authority (1974-82)	North Western
Regional Health Authority (1982-)	North Western
District Health Authority (1974-82)	North
District Health Authority (1982-)	North Manchester

5.3. Central Manchester and Manchester Children's Hospitals NHS Trust became Central Manchester University Hospitals NHS Foundation Trust on January 1st 2009.

5.4. The services and a proportion of staff of Booth Hall Children's Hospital moved into the new Royal Manchester Children's Hospital in the summer of 2009 and the Booth Hall Hospital buildings were demolished in 2011.

6. Jimmy Savile's association with Manchester and Booth Hall Hospital

6.1. An online search indicated that Savile was living in the Salford area from the mid-1950s to the mid-1960s. He is reported to have managed a number of music / dance related establishments across the period including the Plaza Ballroom on Oxford Road.

6.2. Whilst known reasonably well locally, at the time of the allegation made by alleged victim A/N249, Savile was as yet not a national celebrity, he was known initially as a wrestler.

6.3. Savile regularly worked in the Manchester area throughout the 1960s and 1970s hosting music television and managing a number of dance halls.

6.4. The Trust has not been able to find any evidence of a formal relationship with Savile either as a fundraiser or volunteer

6.5. Discussion with a previous Director of the Hospital yielded no information supporting any formal fundraising or charitable link. This Director worked at the Hospital from 1994 so did not cover the period during which the alleged events took place.

6.6. Enquiries were made of the Charities team for any historical records relating to fundraising activity. The Manager of the team reported that governance standards dictate that financial records are destroyed after six years and therefore these would not be in existence.

7. Changes in Safeguarding Policy

7.1. The literature described below suggests that response to concerns of abuse of children and the treatment of children in the 1960s and 1970s differed substantially from the current time, safeguarding resources, knowledge and understanding were also very different.

7.2. The detail below, a summary produced by the online publication Community Care, sets out some of the changes to safeguarding legislation over the period against a timeline.

7.3. **Children Act 1989**

While the protection of children from harm has always existed in legislation in some form throughout the 20th Century, the Children Act 1989 is seen as the first significant law which put in place most of the child protection structures and principles we use today. These included ensuring the needs and safety of a child is always put first, that professionals should initially attempt to work with parents to keep the child safe and that children should always be placed with their own family rather than in care unless it would put them at risk of significant harm to do so.

However, numerous child abuse cases over the recent decades have prompted a series of overhauls to child protection procedures.

7.4. **Victoria Climbie, Every Child Matters and The Children Act 2004**

One of the most high profile case was the death of Victoria Climbie in February 2000. She died with 128 separate injuries on her body after months of abuse at the hands of her great aunt Marie Therese Kouao and her boyfriend Carl Manning. Despite coming into contact with health, police and social services on several occasions and twice taken to hospital the abuse was not discovered until her death.

In the aftermath of her death and the court case convicting Kouao and Manning of murder, Lord Laming was instructed to undertake an inquiry into the circumstances leading up to Climbie's death and make recommendations on how the system should change.

As a result of this report the government published a green paper entitled "Every Child Matters" and consequently passed the Children Act 2004. The changes it put in place included scrapping child protection registers in favour of child protection plans and creating an integrated children's computer system (ICS) to ensure information was more routinely and robustly collected.

7.5. Structural changes included creating the post of a director of children's services in each council who would ultimately be accountable for the safety of all children in

their area. A common assessment framework was created so practitioners within health, education and the police could instigate better support for families not deemed to reach child protection thresholds. Local safeguarding children boards were also set up taking on the responsibility for multi-agency child protection training and investigating the causes of deaths and incidents of serious harm which may have been preventable in their area.

7.6. **Jessica Chapman, Holly Wells and Vetting and Barring**

In August 2002 two 10-year old girls, Jessica Chapman and Holly Wells, went missing from their home in Soham, Cambridgeshire. Less than two weeks later their bodies were found in a ditch at Lakenheath, Suffolk. In December 2003 Ian Huntley, a school caretaker in the village, was found guilty of the murders. After Huntley was convicted, it was revealed that he had been investigated in the past for sexual offences and burglary, but had still been allowed to work in a school as none of these investigations had resulted in a conviction.

An independent inquiry into the events was conducted by Sir Michael Bichard which questioned the way employers recruited people to work with vulnerable groups and in particularly the way in which background checks were carried out. One of his recommendations was for a single agency to vet all individuals who want to work or volunteer to work with children or vulnerable adults. The Vetting and Barring Scheme, run by the Independent Safeguarding Authority was set up and began rolling out voluntary registration in all UK countries except Scotland in 2009.

In May 2010, following the change in government, coalition ministers put the scheme on hold pending a review which resulted in some changes to the scheme and a ‘more common sense’ approach.

7.7. **Baby P, the Second Laming Report and Working Together to Safeguard Children**

In 2008 Peter Connelly (originally and still often referred to as Baby P or Baby Peter), a 17 month old toddler, died after suffering extensive internal and external injuries over a nine month period. Despite having been seen by a range of professionals on numerous occasions and having been the subject of a child protection plan, social services were never aware the mother had a new boyfriend who, along with a friend, were largely responsible for the injuries and the child’s death. Because Connelly died in Haringey, the same borough where Victoria

Climbie had also died it prompted a media frenzy, which resulted in major scrutiny of child protection procedures in England.

Lord Laming was instructed to conduct a review of child protection procedures. As a result of his recommendations the government's official child protection guidance Working Together to Safeguard Children was strengthened and the ICS system guidance was relaxed. However, many of the issues identified lay in failures of practice rather than policy. As part of his review, Laming recommended the recruitment, training and supervision of social workers as a key issue to be tackled. The government set up the Social Work Taskforce and later the Social Work Reform Board to overhaul the profession and make it fit for purpose.

7.8. **The Munro Review**

Following the election in May 2010 the incoming Conservative/Liberal Democrat coalition government asked Professor Eileen Munro, of the London School of Economics, to review all child protection procedures in England on the basis that previous changes had now made the system too bureaucratic and stifled social worker initiative in making difficult decisions. Professor Munro published her first report analysing the problems in October 2010. These included issues around poor IT systems, high caseloads, limited supervision and not enough emphasis on reflective practice and decision making. She also highlighted that she wished to take a "systems approach" that would allow feedback on any unintended consequences of recommendations. "

http://www.communitycare.co.uk/2005/03/15/child-protection-3/

7.9. It is clear that the knowledge and expertise available to support children in the period covered by both alleged victims is entirely different from that available today. It is much more likely today that the alleged abuse by the primary carers (Parents and Aunt and Uncle) in both cases would have been recognised and acted upon.

8. How complaints were dealt with at the time of the Incidents

8.1. In respect of policies and procedures circa 1959/60 and 1974 it has not been possible to locate documents relating to these. These documents were destroyed under the requirements of the destruction policy and Booth Hall Hospital has undergone a number of organisational changes in that time period.

8.2. Neither of the alleged victims recalls making a formal complaint to the hospital at the time.

9. Investigation of Current Allegations

The Trust was notified of two allegations. Allegation 1 (Alleged victim A/N249) related to an in-patient admission to Booth Hall Hospital, circa 1959. Allegation 2 (Alleged victim B/4055) related to an in-patient admission in a Manchester hospital which has not been identified.
The summary findings of this report will be shared with the alleged victims on completion and prior to publication.

9.1. **Allegation 1 (alleged victim A/N249) –** A/N249 provided a witness statement to the Metropolitan Police Service on 17th October 2012 and a telephone contact pro-forma documenting a telephone conversation with them on 8th November 2013. These documented statements formed the basis for the start of this investigation.

9.2. The first presenting problem for the team was that this allegation described an episode during which Savile, whom the alleged victim knew as 'Uncle Jimmy' visited the patient in hospital in the company of her father. This was not an organised visit involving a celebrity; indeed at that time, Savile was known locally but little known outside of wrestling circles.

9.3. A/N249 was seven or eight years old and an in-patient for a routine surgical procedure at the time and she reports that Savile sexually assaulted her after her surgery in a bed on the ward. This assault is described as Savile putting his hands under the bed clothes and sexually assaulting her, touching her. A/N249 reports that she did not tell anyone. According to the age at which she alleges the incident happened the timeframe would have been 1959/60'

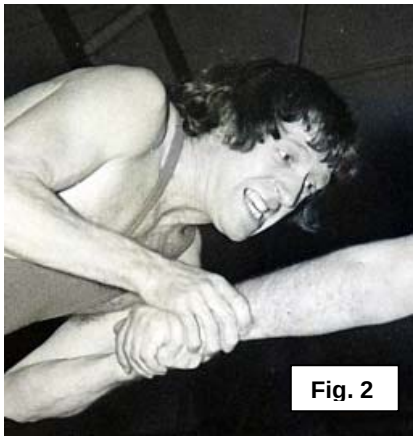
Fig. 2

9.4. A/N249 describes him as looking quite different at that time, having short dark hair and she did not make the connection between 'Uncle Jimmy' and Jimmy Savile the celebrity until some years later. This description fits with images of Savile in his early wrestling career. See fig. 2 opposite.

9.5. It was decided that although separate investigations would take place an approach would be made jointly to A/N249 by CMFT and Greater Manchester West NHS Foundation Trust (GMWFT). This was due to the fact that the allegations related to both Booth Hall Hospital and Prestwich Hospital and both organisations wished to avoid unnecessary duplication or distress for the alleged victim.

9.6. A letter was prepared and sent on 17th January 2014 (see appendix A), inviting A/N249 to meet with both organisations to discuss the allegations. No reply was

received within one week of sending by Royal Mail, so this was followed up by e mail on 29th January 2014 to which no reply was received. Following further discussion between Richard Backhouse (GMWFT) and Sarah Corcoran (CMFT), it was decided that a telephone approach would be made by CMFT.

9.7. Sarah Corcoran made two attempts to telephone A/N249 and made contact on the morning of 07th February 2014. A message was left at 09.02hrs and the call returned at 09.04hrs on the same day. A/N249 reported that she had been unsure of who had called and therefore not returned the initial call.

9.8. On instigating the conversation, Sarah Corcoran first introduced herself explaining why the contact had been made and then enquired as to whether the posted letter and e-mail communications had been received. A/N249 reported that she had received an e-mail but thought that it was something "dodgy" and therefore did not reply.

9.9. Sarah Corcoran explained her role and that of CMFT as the organisation responsible for the now demolished Booth Hall. A/N249 expressed some surprise that the hospital had been demolished.

9.10. During the early part of the phone call, the duration of which was only 6 minutes, Sarah Corcoran explained that she was coordinating an investigation into the allegations made. She was clear immediately that it was entirely up to A/N249 as to whether she contributed any more to the investigation than the original detailed statement given to Operation Yewtree. She further explained some of the challenges with the timescales involved.

9.11. A/N249 immediately stated that she did not feel that there was anything she could add in relation to Booth Hall Hospital. She reported that Savile had visited with her father (now deceased) and that the ward was dark with a Nurse stationed at one end of it. She did not feel there would be any benefit in discussing anything further with the investigation team. Sarah Corcoran expressed sympathy for the situation that A/N249 had found herself in having to raise these concerns in the first place and stated that if she required any further support to deal with the issues then the Trust would be happy to assist in that provision. This was declined, A/N249 stating that it was a long time ago and "things were different then".

9.12. On closing the conversation, Sarah Corcoran confirmed the position in relation to Booth Hall and asked if A/N249 was happy with the same approach in relation to Prestwich Hospital (GMWFT). The response was, "Oh no, that was a very different situation. I was taken there a few times. I could show them places in that hospital I bet they don't know exist." Sarah Corcoran asked if A/N249 thought it

would be helpful to discuss this further with the investigation team at Prestwich Hospital and she replied that she thought it would be helpful.

9.13. In respect of how this meeting would be arranged, A/N249 had already explained that driving was difficult and getting over to Manchester from her home would not be possible. It was explained that that was not a problem and that the meeting could take place at a place of her choosing. A/N249 requested that the Prestwich investigation team get in touch first by e-mail to make the arrangements and it was agreed that Sarah Corcoran would pass this information to the team.

9.14. This information was handed over to the investigation team at Prestwich Hospital by telephone immediately and followed up with an e mail on the same day.

9.15. Based on the information contained in the statement made by A/N249 it is possible that she was a patient in Booth Hall for the surgical procedure detailed in 1959/60. Her home location at the time, Whitefield, suggests that would have been the hospital of choice for such a procedure. Unfortunately, due to the length of time passed, it has not been possible to locate medical records or admission records to corroborate this.

9.16. It is also reasonable to conclude that the events as described could have taken place without the knowledge of medical or nursing staff. This was a visit by a family member and was not reported to staff. The statement notes that A/N249's father facilitated access to his child by Jimmy Savile on a number of occasions at other locations of which this was one. The description of events in relation to Booth Hall and more broadly in respect of timescales fits with the period that Savile was reported as living in the Salford area (mid-1950s to mid-1960s).

9.17. The draft report was shared with alleged victim A/N249 and consent was given for publication.

9.18. **Allegation 2: Alleged victim B/4055*** provided a statement to the Metropolitan Police Service by telephone on 01st February 2013. A summary of this statement formed the basis for the start of this investigation.

9.19. This complaint was at first allocated by the Department of Health to Pennine Acute Hospitals NHS Trust (PAHNT). However, due to the fact that the allegations pertained to children and Central Manchester University Hospitals NHS FT now has responsibility for a large proportion of the tertiary children's services in Manchester and the possibility that it was Booth Hall, the Trust agreed to take on lead responsibility for the investigation.

9.20. CMFT took receipt of the statement and investigation to date from PAHNT in mid-January 2014. Below is a summary of information that had already been obtained during initial investigations at PAHNT;

- A telephone call between the Head of Safeguarding and the Associate Director of Nursing Manchester Mental Health FT confirmed that there are no records of any psychiatric history and no reason to suspect that a telephone call to discuss the JS allegation would cause unnecessary distress or anxiety and nothing to suggest the alleged victim is a high suicide risk. On the basis of this information PAHNT decided to go ahead and make contact with alleged victim B/4055.
- A telephone conversation with Claire Smith, Named Nurse: Safeguarding Children at CMFT. Claire confirmed that the alleged victim has had only a couple of appointments, unrelated to the allegation, at CMFT and no attendances at A&E after 2004.
- The alleged victim B/4055 stated in a telephone call and his police statement that a report was made by his mother to Middleton Police Station at the time of the allegation. An email and telephone call to Trish Owen, the Single Point of Contact Officer for the JS investigation at Greater Manchester Police. Request made for a copy of the original report to Middleton Police Station made by the victim's mother between 1969 and 1974 in the hope there would be specific reference to the hospital. A telephone call was received from Trish Owen stating that if a report had been made it would no longer exist, records dating from that period would have been destroyed.

It was decided to make contact with B/4055 by telephone to ascertain whether he would like to meet with the investigation team at CMFT to discuss the complaint. A telephone call was made on 29th January 2014. Sarah Corcoran asked if he was aware that Suzanne Smith, Head of Safeguarding PAHNT, had passed his details onto her and why.

9.21. Sarah Corcoran explained why the Trust was doing an investigation and that the Trust needed to ascertain first whether his experience had occurred at Booth Hall Hospital. Sarah Corcoran asked whether he was happy to speak to the Team about his experience at the time. He explained that he was unwell. He would like to talk to us when those problems were sorted out. Sarah Corcoran explained gently that it would be helpful to speak to him/her before mid-February when the Trust was hoping to conclude its initial investigations. He then offered to see someone from the team on 6th or 7th Feb. Sarah Corcoran did explain that it was completely up to him

and that the Trust would not wish to press him into any interview but he stated he would be happy with one of those days. B/4055 also explained that it would be helpful to have the interview early as he had another appointment at 14.00hrs the same day.

9.22. It was then explained that it might be difficult to obtain records from the period of time in question and he stated that he understood that this was difficult.

9.23. A meeting took place on Thursday 6th February 2014. The meeting took place in the St Mary's Sexual Assault Referral Centre (SARC). SARC has facilities designed for interviewing and counselling and it was felt that this would be the most suitable environment. The interview commenced at 09.30hrs and completed at 10.30hrs. The interviewers were Sarah Corcoran and Mrs Bernie Ryan, Directorate Manager, SARC. Bernie Ryan led the interview, notes were taken.

9.24. It transpired on arrival that the 14.00hrs hospital appointment was in fact at the Manchester Royal Infirmary, on the same site as SARC. Sarah Corcoran made arrangements for this appointment to be brought forward in order that B/4055 did not have to wait for a prolonged period of time in the hospital.

9.25. Detailed notes were made of the interview. Due to the personal nature of much of the information contained therein, which has little or no relevance to the investigation itself, these notes have not been included in this report. A summary is provided below. The alleged victim B/4055 did not wish to receive a copy of the notes from the meeting but the report has been shared with him in advance of publication and consent given to publish.

9.26. B/4055 was not able to give further information to help in the identification of the hospital. The events were discussed in detail and any information sought which was felt might help identify the hospital, the period of time or the events themselves. Unfortunately, the information provided was very sketchy with B/4055 stating that often things were 'blocked out' and that he was sorry he could not be more helpful. He described arriving at a hospital, coming up a drive and the hospital being on the "left hand side". Some of the information discussed changed during the course of the interview and indeed conflicted with information given earlier to the team at PAHNT. Examples of this relate to the description of the hospital, key individuals being currently living or dead and the medical history evidenced in current medical notes not detailing the previous significant medical history.

9.27. The team concluded the interview by ensuring that the alleged victim had access to information about support and offering support if it was required in the future.

9.28. The view of the investigation team members who conducted the interview and who authored the report is based solely on these discussions and a review of the medical notes and no other documentary evidence. The view formed is that it is not possible at the current time to locate any evidence to corroborate the statement made by the alleged victim and that this statement has lacked detail and consistency throughout.

10. Current Policies, Practice and Procedures

10.1. Following receipt of Sir David Nicholson's letter in December about the wider lessons from the Savile Inquiry the Trust established a programme of work to review access to vulnerable people, and this includes safeguarding, access to patients afforded by the Trust to volunteers and celebrities, and listening and responding to patients concerns. This work is being delivered by a multi-professional working group with representation from the following:

- Clinical staff from Hospital and Community Adult and Children's services
- Security Service
- Safeguarding Service
- Human Resources
- Charities
- Voluntary Service
- Risk Management

10.1. The work programme was commissioned by the Trust Safeguarding Effectiveness Committee chaired by the Medical Director which reports to the Board of Directors. The programme is led by a Director of Nursing. The work has included a mapping exercise to establish the key issues with regard to access to vulnerable patients, followed by an assessment of the current position and an exploration of the associated risks and mitigations. This exercise has identified that the Trust has appropriate policies and processes in place to manage the access to patients afforded to celebrities and volunteers and further work will be undertaken to explore whether any additional safeguards are required and to provide assurance that policies are consistently applied.

10.2. The Trust's work programme also includes the following areas, which have been identified through discussion with representatives of a range of services:

- work on HR processes relating to contractors and work placements,

- a review of the environment,
- a review of the processes to record the presence of resident family members,
- a review of information provided to patients and visitors regarding staying safe
- assessment of operational security processes

10.3. The approved Safeguarding Children Policy is in place and all staff have access to this on the Trust intranet. A programme of training is in place to support the implementation of the policy.

10.4. The current arrangements for Safeguarding Children take into account the risk presented by individuals who may have access to public and patient areas. Any celebrity visit is organised via the CMFT Charities Department. Any celebrity visiting the inpatient/outpatient areas is always accompanied by at least one member of Trust staff and they are never left alone with a child or young person. There is currently work in progress to adapt the Royal Manchester Children's Hospital guideline for visiting celebrities to ensure appropriate guidance is available Trust wide.

10.5. All ward areas are secured with video intercoms (swipe access for Trafford Hospital areas). It is impressed on staff at Trust Induction the necessity of wearing identification badges at all times and challenging anyone without the appropriate identification. The Security team has recently undertaken a programme of awareness raising in relation to access and, in particular, 'tailgating' through protected doors.

10.6. Family visiting is encouraged throughout the hospital. At present, this is not formally recorded. However, staff are expected to keep abreast of those patients with family members resident and when patients are left alone without visitors. It has been proposed that a system will be developed to provide a daily account of resident parents/carers and to provide visitors with name badges/bands.

10.7. It is acknowledged that family members may pose a risk to children whilst in the hospital setting. The Trust has robust Safeguarding policies and procedures in place to enable staff to identify and assess risk and act on any concerns. All staff who regularly work with children and families access Level 3 Safeguarding Children and Young People Training. It is not possible to completely mitigate risk to a child from a parent/ carer. However, the training equips staff with the appropriate awareness and understanding of the potential risks and what to do if they have a concern. The Safeguarding Team work across the Trust to support and advise staff with any safeguarding concerns.

10.8. There are a number of other policies in place which provide assurance to the Trust Board that concerns of this nature are acted on in the appropriate manner.

The Managing Allegations of Abuse Against Staff Members Policy is well embedded in practice. This supports senior staff to effectively manage such situations with the support of Human Resources and the Safeguarding Team. There is a clear Raising Concerns (Whistle-Blowing Policy) in place which supports staff to be open and honest where poor practice is seen or suspected. The Chaperone Policy provides additional assurances and is designed to protect staff against spurious allegations if followed correctly.

10.9. Finally, there is an incident reporting policy and procedure which all staff are encouraged to utilise. Safeguarding incidents are reported onto this system and reported in real time to the Safeguarding Team.

10.10. The risks and mitigation were set out in a letter to Kate Lampard in tabular format on 15th July 2013 and these are detailed in table 1 below.

Table 1.

Issue	Mitigation
Safeguarding	• Safeguarding policies and procedures in place and have been recently updated to reflect acquisition of community services and Trafford Hospital. • Safeguarding governance structure in place, led by Medical Director as Board safeguarding lead. • Extensive safeguarding training programme provided to all Trust staff. • Large Trust-wide safeguarding team who provide support and expertise to staff. • Safer Recruitment Policy in place • Security Policy recently updated and publicised in Trust newsletter. • Trust and divisional annual safeguarding work programmes in place, which are monitored by the Trust Adult and Children's Safeguarding groups
Access to patients afforded to volunteers and celebrities	• Processes in place for authorisation and management of celebrity visits. • Identified that no celebrities are visiting regularly. • Visitors that come via the CMFT charities office are by appointment and accompanied by a charities officer. • Recruitment process for volunteers requires completion of a Trust Application Form, formal interview, two reference checks, DBS disclosure, medical questionnaire/assessment, attendance at Trust Induction and local training.
Listening and responding to patients' concerns	• Patient Advice and Liaison Service well established. • Critical Friend process in place, which allocates a senior officer (Director or deputy level) to provide support to the patient/family following complex adverse events. • Complaints Policy in place. • Being open Policy in place. • Local and national patient surveys, which lead to action to implement change in response to results. • A programme of Leadership walk rounds by Board

	members and senior staff. • Ward accreditation programme led by senior nursing team includes listening to patients. • Monthly Quality of Care Rounds conducted by ward managers and matrons; results feed into the Trust's on-going Improving Quality Programme. • Values and behaviours programme has identified Trust values and expected behaviours (including listening and responding). • Use of patient stories to inform learning and improvement • Whistle blowing policy in place

11. Overall Analysis and Conclusions

11.3. Running throughout this investigation has been the challenge of finding supporting evidence for the allegations made.

11.4. Alleged victim A/N249 has provided an exceedingly detailed statement, many aspects of which fit with the limited amount of information available to the investigation team. This includes the location of Savile during the time period, his association with wrestling in Manchester at the time and his physical description. The view of the investigation team is that due to the passage of time and resulting paucity of documentation, it has not been possible to locate evidence to corroborate the detailed statement made. It is therefore not possible to reach a conclusion on whether or not the incident took place.

11.5. Alleged victim B/4055 was less able to provide clarity and for that reason it has been even more difficult to reach any definite conclusion. The view of the investigation team members who conducted the interview is based solely on these discussions and a review of the medical notes. The view formed is that it has not been possible to locate any evidence to corroborate the statement made. It is therefore not possible to reach a conclusion on whether or not the incident took place.

11.6. However, despite this, what is clear is that both alleged victims raise issues which were well worthy of investigation and that the Trust has a responsibility to review current practices and procedures in relation to the protection of both children and vulnerable adults both on the hospital sites and in the community. The work on this has been detailed in section 10.

11.7. The team discussed in some depth the detail relating to both cases. The primary concern was that the events described by alleged victim A/N249 would be the most difficult to detect and prevent in the future. These events detailed a parent as both an abuser and as a person facilitating access to another abuser.

11.8. The emergence of Safeguarding as a nursing and medical specialty in its own right over the last few decades and changes to safeguarding processes have increased both support and recognition of abuse. The only way to address the type of abuse described in the events described by alleged victim A/N249 is early recognition by the healthcare profession and immediate action taken. Evidence suggests that immediate action is now taken with issues escalated to the Safeguarding Team by the community and hospital staff on a regular basis. Policies and education are in place to support this and these are monitored both internally and by external bodies.

12. Recommendations

12.3. The Trust Access to Vulnerable People Group should continue working towards a suite of policies and guidance to manage visiting celebrities to all areas of the Trust.

12.4. The Safeguarding Team, on behalf of the Trust should continue to regularly review and audit safeguarding practice to ensure the high standard of safeguarding practice continues.

12.5. It has been proposed that a system will be developed to provide a daily account of resident parents/carers and to provide visitors with name badges/bands. This should be progressed. The Head of Nursing for the Children's Hospital has been allocated to this programme of work and it is anticipated it will be complete by December 2014.

Appendix A

Greater Manchester West Mental Health NHS Foundation Trust | Central Manchester University Hospitals NHS Foundation Trust

Room 214
Medical Directors Office
Trust Headquarters
Manchester Royal Infirmary
Oxford Road
Manchester, M13 9WL

Tel: 0161 276 8764
Fax: 0161 276 8033

17 January 2014

Private and Confidential

Dear **********

We have been provided with your contact details by the Department of Health and we understand that you have given your permission for our respective organisations to make contact with you. We have read with sadness of your previous experience of events involving Jimmy Savile that occurred at the hospitals that we now have responsibility for and we have been asked by the Department of Health to investigate these events. We hope that by working together we can conduct our separate investigations, but support you jointly in that process.

We would very much value your contribution to the investigation and would appreciate the opportunity to meet with you in person, if you felt able to. We appreciate how upsetting it may be for you to recall and talk about these experiences. If you do feel able to meet with us we can arrange for this to take place at one of our hospital sites, at another venue or at your home if you would prefer. We would like to propose that we try and coordinate the meeting so that you can meet separately with representatives from both Prestwich Hospital (Greater Manchester West) and Booth Hall Hospitals (Central Manchester) on the same day, thus, it is hoped, only needing to meet on one occasion.

We understand that you may have been in receipt of support via the Metropolitan Police Service and that you may want us to provide you with additional support throughout this investigation. This is something we are more than happy to agree with you. Central Manchester University Hospitals NHS Foundation Trust has a sexual assault referral centre who can offer support to people who have experienced sexual violence recently or in the past and if this is something you would like to discuss we can arrange contact directly with the team.

We hope that you will feel able to give consideration to this request. If you are willing to meet, or if you would like to discuss anything about our investigation, you can either contact in relation to Prestwich Hospital, Richard Backhouse, Deputy Director of Governance either by e-mail at Richard.Backhouse@gmw.nhs.uk or by telephone on 0161 772 3519. Or for Central Manchester (Booth Hall), Sarah Corcoran, Associate Director of Clinical Effectiveness either by e mail at sarah.corcoran@cmft.nhs.uk or by telephone on 0161 276 8764. We are more than happy to tak to each other if need be so only need to call one person if you prefer.

Yours sincerely

Andrew Maloney
Director of HR and Governance
Greater Manchester West NHS FT

Sarah Corcoran
Associate Director of Clinical Effectiveness
Central Manchester NHS FT

End Report