A Special Review about:

What ABMU Health Board did when it employed Mr W

And what it did about the complaints people made against him

This is an easy read report.

Date: 29 January 2019

You can read the full report on our website www.hiw.org.uk

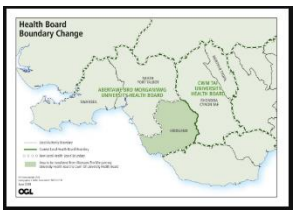
You can ask for a copy of the report

email: hiw@gov.wales

post: Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Phone: 0300 062 8163
Fax: 0300 062 8387

What happened?



Abertawe Bro Morgannwg University Health Board looks after health services in Swansea, Bridgend, Neath and areas close by.

In this report we call them the health board.

Mr W was a student studying computers.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

He worked for the health board looking at their computers.

His father was a Director at the health board.

In 2001 Mr W started a full time IT job at the health board.

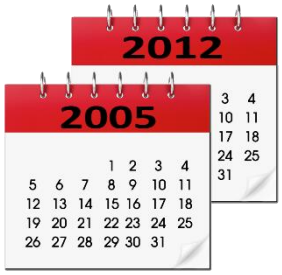
In 2004 he went off sick.

He did not go back to his IT job.

He felt the computer screens were making him ill.

He was given a different job in another part of the health board.

The new job was to care for people with a learning disability.



He started in 2005

He worked in that job until 2012

3 patients made allegations against him.

An allegation is when someone says someone did something wrong.

All the patients had a learning disability.

They made their allegations between 2011 and 2013.

They said Mr W did sexual things to them that they did not want.

1 Allegation 1

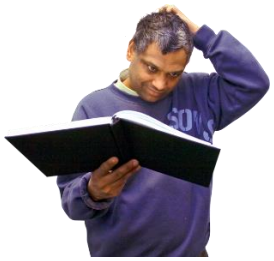
The allegation was made in December 2011.

Mr W was a support worker for people with a learning disability.

A woman said Mr W did sexual things to her that she did not want.

The staff wrote what she said in her notes.

Nothing else happened.



In January 2012 a manager read her notes.

They read about what the woman said happened.

They held a POVA meeting.

POVA means:

Protection of Vulnerable Adults.
It is about keeping people safe.

Mr W was put on special leave.

This means he was paid but stayed at home when the health board looked at what the woman said.

There was another POVA meeting.

Police did an investigation.

They did not find enough to say Mr W should be taken to court.

The health board looked to see what else they could find out.

They did not find anything.

They held a 3rd POVA meeting.

There was not enough information for the health board to do more investigation.

In April 2012 Mr W came back to work.

Mr W did not work with the same people.

He was a support worker in a different service.

2 Allegation 2

In October 2012 another person made an allegation against Mr W.

It was about things that happened 2 years before.

The health board held a new POVA meeting.

The police started to investigate.

Mr W was on special leave again.

In December the police said there was not enough information to go to court.

There was another POVA meeting.

The health board thought about doing an investigation.

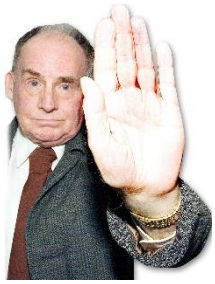
In February 2013 the health board decided an investigation would not help.

Allegation 3

In February 2013 another woman made an allegation about Mr W.

The new allegations were about things that happened in 2011.

There was a new POVA meeting.



In March 2013 the health board suspended Mr W.

This means he was away from work but still paid.

In April 2013 there was another POVA meeting about the new allegation.

The police said their investigations were ending.

The police said they were sending all 3 allegations to the CPS.

The CPS is the Crown Prosecution Service.

The CPS decides if someone must go to trial about a crime.

The police also said that the health board could investigate.

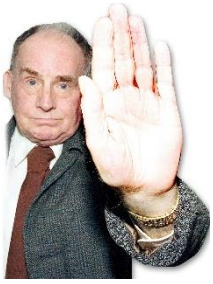
The health board did not hold another POVA meeting at this point.

They wanted to wait to hear what the CPS decided first.

In January 2014 the CPS decided not to take Mr W to court.

The health board held a POVA meeting about the allegation.

The police said they were very worried that Mr W was a risk to patients.



The health board kept him suspended.

The health board did their own investigation.

The police said they would give all their records of the case to help.

The investigation report was finished in March 2015.

In December 2015 there was a hearing about how Mr W behaved at work.

The health board were trying to plan the next part of the hearing.

Mr W was arrested for the murder of a woman.

The murder was separate from

what happened at the health board.

It happened in March 2016.

Mr W was still employed by the health board.

He was found guilty and sent to prison for murder.

What the health board did next

In 2017 the health board did a review about how they handled the 3 allegations.

They did this by looking at all their paperwork.

They found they could have done things better.

They made a plan to improve how to:

1. Keep people safe

2. Report things that go wrong

3. Hire staff in the right way

4. Manage and run a healthy workplace

They also felt there was no way they could have known what Mr W was going to do.

They said there was no way they could have stopped him.

What HIW found

HIW found that the health board did not learn enough from what happened.

This is because they only looked at their paperwork.

That means some important things got missed.

None of Mr W's work records say he was not safe to work in care

But the health board should not have said there was no way to have stopped him.

This is because the health board could not have known this from what they looked at

The review looked at how the allegations against Mr W were handled.

The first allegation was not reported in the right way.

This shows it is very important for staff to listen to patients.

There was also a time that Mr W was allowed to carry on working with patients before he was sent on leave.

That should not have happened.

Allegations 2 and 3 were treated more seriously.

But social services were not involved as much as they should be.

Police investigated all 3 allegations.

The CPS said there was not enough evidence for Mr W to go to court.

The health board investigation took a long time.

This was because the staff doing the investigation did not have enough time and support to help them.

HIW did not think the health board were good at how they planned to keep people safe.

Other reports have found the same thing.

The health board has made some things better.

But not enough has changed.

How the health board plans to keep people safe is still not clear.

HIW thinks this stops the health board seeing the whole picture.

The health board did not follow their own rules when they gave Mr W the support worker job.

Mr W did not have a DBS check when he was employed.

A DBS check looks to see if a person going for a job is a risk to vulnerable people.

It looks at criminal records

It also sees if police are looking into you you for any reason

Other workers at the health board do not have the check either.

This is not ok.

This puts people in danger.

The rules about how people are kept safe in Wales are being looked at again.

HIW says Wales needs this work soon.

It will tell all professionals in Wales to do the same things to keep adults safe.

There were things the health board did badly in this case.

Staff did not see how serious the allegations were at the time.

HIW says the health board now do some things better.

But much more needs to be done.

HIW Recommendations

This is what HIW says should happen now.

You can read the full recommendations on our website.

HIW has made 24 recommendations to make sure things like this do not happen again.

Recommendation 1

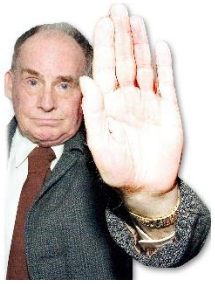
The health board must always follow the rules when it gives a worker a different job.

Recommendation 2

This is about occupational health.

Occupational health is the department that supports people with health problems to keep working.

The health board must think how occupational health can share advice with managers.



Recommendation 3

The health board must always follow the rules about suspending a worker or putting them on special leave.

All staff must understand how to use these rules when they have employees under investigation.

Recommendations 4-5

The health board must find and spend enough time and money on investigations to make sure they happen quickly.

The health board must make sure the right professionals are there to understand what a person with a learning disability says about a member of staff that hurt or upset them.

Recommendations 6-7

All Wales rules and processes on keeping people safe should help professionals work in the same way.

The health board should look again at its plan to keep adults safe (Safeguarding strategy).

It needs to make sure it is up to date.

Recommendations 8-9

Welsh Government should look at how to update DBS (police checks) for NHS staff.

The health board must make sure all staff get a DBS check if their job means they need it.

Urgent DBS checks must be done for staff who have not had one.

The way the health board does the checks must be looked at to make sure they are kept up to date.

When an employee moves from another part of the health board it must be clear who will do the DBS check.

Recommendations 10-12

The health board must look at their training on keeping adults safe.

They should think about

- face to face training
- training based on stories

The health board must find a better way to share what they learn from each safeguarding case.

The health board needs to look at how they measure how good their training and supervision for managers is.

The health board must follow the Welsh guide called All Wales Safeguarding Best Practice.

Recommendations 13-14

The health board must look at how they make sure all the right professionals can take part in meetings about keeping adults safe.

They should also use a good way to check what was done when a safeguarding case is closed.

There should be a good way to make sure all the recommendations of an investigation are done.

Recommendations 15-18

The health board must tell people where to find advocacy and support if they are hurt or upset by something that happened.

While an investigation is happening, the health board must communicate well with them (if that follows the rules)

The health board must make staff understand that anyone raising a safeguarding allegation must always be treated seriously.

The health board should think about how to support staff who are affected by abuse and staff who are accused of abuse.

The health board should think about ways staff can suggest how to do things better.

Recommendation 19

The health board must tell HIW what it did after the NHS Delivery Unit report.

Recommendations 20-23

The health board must quickly improve how it reports on safety and how good its services are.

It must be better at sharing learning from things that go wrong.

Llywodraeth Cymru
Welsh Government

Welsh Government should think of how to share safeguarding lessons across Wales.

Recommendation 24

The health board agreed new rules to plan and to check their leaning disability services.

They must follow these rules.