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Healthcare Inspectorate Wales

Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality care.

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Collaborative**
- **Authoritative**
- **Caring**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. Foreword

Between 2011 and 2013 three female patients within the learning disability directorate of Abertawe Bro Morgannwg University Health Board ("the health board") made allegations of sexual abuse against the same member of staff ("Mr W"). Mr W was subsequently arrested and convicted of murder in 2016. At the time of his arrest, he was still an employee of the health board but not working with patients due to his suspension. He had been suspended from work since 2012 pending the outcome of the health board's disciplinary investigation following the abuse allegations. The health board carried out an internal review of the events to look at how it had handled the allegations made by its patients and the subsequent disciplinary process. The health board's review found some shortcomings in its processes and established an action plan for improvement.

HIW was asked by Welsh Government to carry out an independent review of the health board's actions.

HIW's review focused on the following areas in relation to the events in this case:

- Staff recruitment and employment
- Incident reporting
- Adult safeguarding
- Governance and culture.

Specifically, HIW's review considered whether:

- The health board's internal review was sufficiently thorough
- The health board's conclusions were appropriate on the basis of the evidence considered
- The actions taken by the health board in light of those conclusions were adequate to ensure patient safety
- Additional or different conclusions should be reached on the basis of additional evidence considered during this review
- There was any wider additional learning for the NHS in Wales.

The review did not look at the actions of the police or the Crown Prosecution Service (CPS) as this is outside HIW's statutory remit.

We are grateful to former and current members of the health board staff, to the police for their co-operation, and to all the interested parties who took time to contribute to this review. We are particularly thankful to the three patients and their families/representatives who were able to give information to this review.

2. Summary

Between 2011 and 2013 three patients within the Learning Disability (LD) directorate of Abertawe Bro Morgannwg University Health Board made allegations of sexual abuse against the same member of staff (Mr W). In 2016, towards the end of the disciplinary process addressing the allegations of abuse Mr W was arrested and convicted of murder. At the time of his arrest, he was still an employee of the health board. He had been suspended from work since 2012 pending the outcome of the health board's disciplinary investigation following the abuse allegations. The health board decided to carry out an internal review of documentary evidence (desktop review), which concluded in July 2017, to look at how it had handled the allegations made by its patients and the subsequent disciplinary process. The health board's review found shortcomings in its processes and established an action plan for improvement. The areas of concern identified were safeguarding processes, incident reporting, recruitment practices and governance and culture. It also concluded that Mr W's actions could not have been 'predicted or prevented'.

HIW's independent review of the health board's actions found that the decision to undertake a review that only considered documentary evidence meant that the effectiveness of the review was limited. Documentary reviews tend to focus on the actions of a few frontline staff and often miss the wider context of events. Whilst the health board's conclusions were not unreasonable, based on the limited evidence considered, the conclusion that Mr W's actions outside of his employment could not have been predicted or prevented is not based on evidence to either support or refute it. What we can say, having considered a wider range of evidence, is that there was nothing in Mr W's training, supervision or occupational health records that would have indicated that he was unsuitable to work in a care setting.

The review considered how the allegations against Mr W were handled. The fact that the first allegation was not initially recognised as a safeguarding incident despite being repeated to staff highlights the importance of listening to patients. There was also a delay in removing Mr W from clinical duties. The other allegations were recognised and reported as such. Whilst the safeguarding procedures were followed, multi-agency involvement is vital if the safeguarding process is to be robust. In the latter part of the safeguarding process in Mr W's case, there was often no social services presence at strategy meetings. All the agencies involved in safeguarding have a responsibility to facilitate multi-agency involvement in meetings, either in person or remotely.

A criminal investigation was undertaken into all three allegations but the CPS took the decision that there was insufficient evidence to secure a conviction. The health board therefore investigated the allegations under its disciplinary process. However, the process took an excessively long time because the health board did not provide any additional resources to support the disciplinary investigation.

HIW identified weaknesses in the quality and safety governance arrangements at the health board. These have been highlighted previously in other national reports (including Trusted to Care in 2014). The health board has made changes to improve its governance and reporting structure, both in terms of the escalation of concerns to Board level and the sharing of

learning at an operational level throughout the health board. However, it is of concern that progress has been slow in this area and the governance structures within the health board relating to quality and safety are still not clear. HIW is concerned this does not give assurance about the quality of current processes within the health board for scrutinising safeguarding concerns and that the Board may not be sufficiently sighted on what is happening at operational level.

HIW also noted that Mr W did not have a Disclosure and Barring Service (DBS) check when he was employed. We also found that there were a number of employees within the mental health and learning disability directorate who do not have a DBS check because their employment had predated the requirement for those checks. DBS checks are also not updated on a regular basis. This is an unacceptable safeguarding risk.

The Wales Safeguarding Procedures are currently under review and this is an important piece of work. However, this work needs to progress quickly to ensure that Wales has an effective and consistent approach to adult safeguarding.

The weaknesses identified in the health boards handling of this case strongly suggest that senior health board staff did not appreciate the seriousness or complexity of the allegations at the time. Whilst we found the health board has made improvements to its governance arrangements following the Trusted to Care and desktop reviews, we are disappointed to find that significant work is still needed in this area to ensure there are robust systems to effectively identify areas of concern, manage risk and share learning across the health board.

3. What we did

Scoping and initial information gathering

We spoke with interested parties and looked at the documentary evidence considered by the health board's review in order to determine the scope of the review. The terms of reference for the review were published in February 2018. These are set out in Appendix B.

Review team

The review was led by a Review Manager from HIW. We established a small team of peer reviewers to provide the range of skills and knowledge required. The peer review team consisted of:

- Consultant Learning Disabilities Forensic Psychiatrist (NHS Trust in England)
- Former Head of Nursing (Health Board in Wales)
- Learning Disability Advocate (third sector organisation)
- Chief Nurse (NHS Trust in England).

Document review

We considered a range of documentary evidence to inform this review. These included:

- The documents considered by the health board's desktop review team, including:
  - Mr W's HR records
  - Disciplinary investigation documents for the allegations against Mr W
  - Electronic safeguarding records for the three allegations
  - Police statements taken during the investigation of all three allegations.
- Additional records requested by HIW, including:
  - Mr W's supervision and training records
  - Mr W's occupational health records
  - Relevant payroll records for Mr W
  - Email correspondence and additional records supplied by individuals who were interviewed
  - The health board's policies and procedures relevant to this review
  - Records of action taken by the health board following its desktop review
  - Electronic Police records in relation to the three allegations.

We did not consider:

- Mr W's medical records (other than those which formed part of his occupational health records held by the health board)
- CPS documentation (this was not made available to us)
- Paper Protection of Vulnerable Adults (POVA) files (these were not located by the health board and we accessed the electronic records only).

Interviews

We spoke with a number of interested parties to inform this review.

Where possible, we spoke with the women who made the allegations. Where this was not possible, we contacted their representatives or members of their family.

We contacted key current and former members of health board staff. All were willing to speak with the review team. Members of the review team interviewed over 40 current and former members of staff. These included:

- Former senior management staff within the LD Directorate
- Former senior clinicians within the LD Directorate
- Current senior management staff within Mental Health and Learning Disability (MHLD) service delivery unit
- Former executive Board members
- A selection of current staff at learning disability Unit A, including longstanding staff members who had worked with Mr W and those who had been employed since his dismissal in 2016.

We also visited Unit A and spoke with representatives of Cardiff and Vale University Health Board and Cwm Taf University Health Board.

Report

HIW's conclusions, and the evidence on which these are based, are set out in this report.

It is not the intention that this report should include every detail that has been considered during the course of this review. The report covers the relevant significant events and evidence.

HIW is mindful of its responsibility to maintain confidentiality for those involved and the wording of the report reflects this. The report has been anonymised throughout using letters as opposed to names. Details which may cause certain individuals to be identifiable have been omitted as far as possible. Staff are referred to by their titles only.

Throughout the report reference is made to relevant legislation, policies and national standards.

4. Brief summary of the background events

The health board's learning disability directorate

At the time, the health board's LD directorate provided specialist health services for people with learning disabilities covering three health board areas in South Wales (Abertawe Bro Morgannwg, Cwm Taf and Cardiff and Vale) and includes seven separate local authority areas.

In 2015, as part of restructuring at the health board, the LD directorate was merged with the health board's mental health directorate to form a new mental health and learning disability service delivery unit. The service delivery unit continues to provide specialist learning disability health services to the three health board areas.

The events that led to this review

Mr W is the son of the former Clinical Director of the health board's LD directorate.

Mr W was first employed by the health board in its IT department. At that point he was studying for an IT degree and completed a six month paid student placement at the health board between March and September 2001 as a trainee systems developer. He continued to complete a piece of IT work on an unpaid basis as part of his final year degree project. On completing his degree, he was reemployed by the health board's IT department on a permanent basis.

In July 2004, Mr W went on sick leave. In October 2004, he remained absent from work on sickness grounds and his sick pay entitlement had been exhausted. A meeting was arranged with the IT service manager to discuss the situation. Options discussed included termination of his employment or redeployment as it had been suggested that working with screens may be contributing to his ill health. He was referred to the health board's occupational health department in November 2004 for advice on his suitability for redeployment. Occupational health supported Mr W's move to the LD directorate. Mr W started work as a nursing assistant at one of the health board's Acute Assessment and Treatment Units (Unit A) on 17 December 2004.

In December 2011, one of the residents of Unit A (Ms X) made several allegations to staff that Mr W had inappropriately touched and sexually assaulted her. These allegations were recorded in the care records. In January 2012, the care manager was reviewing Ms X's case records and noted these entries. The allegations were then reported as a safeguarding concern. Mr W was placed on special leave. A police investigation and then subsequently an initial review under the health board's disciplinary policy concluded that there should be no further action. Mr W returned to work on 4 April 2012 in a different residential setting (Unit B).

In October 2012, a former resident of Unit A (Ms Y) made an allegation that Mr W had sexually assaulted her whilst she had been an inpatient at Unit A in 2010. Mr W was again placed on special leave while the allegation was investigated by the police. A third allegation of sexual assault was made in February 2013 by another resident of Unit A (Ms Z). Her allegation related to events in 2011. This allegation was also investigated by the police. In 2014, the police confirmed that whilst they had put the case to CPS, the CPS had determined that it did not meet the evidential test to proceed to prosecution. The health board therefore started its own disciplinary process under its disciplinary policy. An investigating officer was appointed and the investigation report was completed in early 2015. It concluded that there was a case to answer and the matter proceeded to disciplinary hearing. The disciplinary hearing took place in December 2015. It was determined that additional supporting evidence should be sought. Mr W remained suspended from work throughout this period. A dismissal letter was sent to Mr W on 21 April 2016 stating that the health board was terminating his employment for gross misconduct. The letter noted the three allegations made against him, the nature of these allegations and suggested that, on the balance of probability, inappropriate behaviour had taken place. It concluded that it would be too great a risk to allow him back to the health to return to his role or any other healthcare post.

However, by this point, Mr W was being held on remand, having been arrested on 7 March 2016 on suspicion of the murder of Ms J, one of his neighbours. He was convicted of her murder in September 2016.

The health board undertook an internal review of the circumstances around the handling of the allegations against Mr W to ascertain whether additional action could have been taken. The review entailed consideration of documentary evidence in relation to Mr W's employment and the allegations made against him (known as the desktop review). The lead investigator was the then head of the health board's serious incident review team. The desktop review process concluded in July 2017. Its report[1] identified a number of process issues relating to governance, recruitment and safeguarding. The main conclusions of the desktop review were that:

- There was a delay in recognising the first allegation as a safeguarding incident and reporting it as such
- No DBS check was done on Mr W's redeployment to the LD directorate
- The disciplinary process took too long to reach the final dismissal decision
- There was a suggestion that the individuals making the allegations may not have been believed, referring to the delay in reporting the first allegation and the wording of the disciplinary report.

[1] Health Board Lessons Learned Desk Top Review (ABMUHB) August 2017
www.wales.nhs.uk/sitesplus/documents/863/4.3%20desktop%20review%20and%20lessons%20learned%20report.pdf

However, the desktop review report noted that all three allegations had been escalated to the Police and social services under safeguarding processes and investigated by the Police and referred to the CPS for a prosecution decision. It concluded that Mr W's future conduct and behaviour outside of his employment could not have been predicted or prevented.

A health board action plan was compiled, based on the issues identified in the report. This included:

- Relationship policy for health board employees
- Designated Lead Manager (DLM)[2] numbers had been reduced to ensure level of training was up to date. The health board also introduced a system for peer supervision for DLMs
- Creation of a centralised team to assist with disciplinary investigations to ensure investigations are adequately resourced and completed in a timely way.

The action plan also noted actions that had already been taken since the events in question in 2012:

- Recruitment was now completed through a centralised process (managed by the NHS Shared Services Partnership) rather than within each directorate
- Work on organisational culture. This included work on the health board's values; the 'See it, Say it' initiative; the 'Family and Friends test', the 15 Step challenge and 'In your shoes'
- Datix recording (of incidents and safeguarding) was now a web based system
- Reorganisation of the directorates into six service delivery units.

General context

It is important to set out the general context in relation to learning disability services and safeguarding at the time that the allegations in this report were made and investigated (2011 onwards).

The high profile case of institutional abuse of residents in a private learning disability setting at Winterbourne View was highlighted in the media in 2011. The case resulted in staff being convicted for the abuse and started considerable debate about how to ensure that vulnerable patients were effectively safeguarded. A report looking into the circumstances of the actions of staff and the abuse of patients was produced in 2012[3] with recommended actions pertinent to all learning disability settings. Similarly a report into how Jimmy Savile was able to abuse children and patients in a variety of settings (including hospitals) caused widespread concern[4].

[2] Designated Lead Managers are senior workers (usually team managers or senior practitioners) who are responsible for the delivery of safeguarding work within their organisation.

[3] Winterbourne View Hospital, A serious case review (South Gloucestershire Adult Safeguarding Board); Margaret Flynn 2012. http://sites.southglos.gov.uk/safeguarding/adults/i-am-a-carerrelative/winterbourne-view/

[4] Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile; Department of Health 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480059/lessons-response.pdf

A Police investigation started in 2012. The extent of the allegations made prompted a review of safeguarding processes in many public sector care settings, including hospitals.

In 2013, a teenage patient with autism drowned at a care setting in England having had an epileptic seizure whilst in the bath unsupervised. This focussed attention on the culture of care environments and the standard of care and treatment available to people with learning disabilities.[5]

The Social Services and Well-being (Wales) Act 2014 received royal assent on 1 May 2014 and came into force on 6 April 2016. Before this, there was no specific legal provision for safeguarding adults in Wales. There were non-statutory procedures in place for reporting and investigating safeguarding incidents involving adults at risk. The introduction of the Act put the safeguarding of adults on a statutory footing to bring it into line with the safeguarding of children. The Welsh Government has published statutory guidance for adults to accompany the provisions of the Act[6]. Work to update the Wales Safeguarding Procedures is being undertaken by Cardiff and Vale Safeguarding Board on behalf of all Safeguarding Boards in Wales. This work is intended to be completed in July 2019. Therefore, agencies are still using the previous safeguarding adults (POVA) procedures in the interim.

Context - Abertawe Bro Morgannwg University Health Board

It should be noted that the events of this case span a 15 year period encompassing the existence of the former Bro Morgannwg NHS Trust and Swansea NHS Trust, prior to their merger in 2008 to become Abertawe Bro Morgannwg University NHS Trust. In 2009, Abertawe Bro Morgannwg University NHS Trust formally merged with the local health boards of Swansea, Neath Port Talbot and Bridgend to become Abertawe Bro Morgannwg University Health Board.

It may also be helpful to set out two important and high profile events that were happening at a similar time to the events described in this report.

A review of care concerns at Princess of Wales Hospital and Neath Port Talbot Hospitals took place in 2013. It was commissioned in response to complaints about an unacceptable standard of care being provided to elderly and vulnerable patients. The resulting report 'Trusted to Care'[7] was published in May 2014. It highlighted issues about the culture and values within healthcare settings. As a result of Trusted to Care, the health board implemented a behaviours and values framework and a number of 'values-based' initiatives to promote a more positive patient-centred care culture within the health board's hospitals.

[5] Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk; Verita, October 2015 https://www.england.nhs.uk/wp-content/uploads/2015/10/indpndnt-rev-connor-sparrowhawk.pdf

[6] Welsh Government codes of practice and statutory guidance in relation to the Social Services and Well-being (Wales) Act 2014 https://gov.wales/topics/health/socialcare/act/code-of-practice/?lang=en

[7] Trusted to Care, An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board; May 2014 Professor June Andrews and Mark Butler. https://gov.wales/topics/health/publications/health/reports/care/?lang=en

All health boards in Wales were also required to consider and respond to the findings outlined in the report. A follow-up report to look at the improvements made was written in 2015.

In 2013, discrepancies in some blood glucose readings taken by nursing staff at Princess of Wales Hospital were discovered. As a result, a significant number of nursing staff were suspended and some were eventually convicted of falsifying blood glucose measurement records. The criminal process took some time to complete, but after its conclusion, the health board commissioned a report to identify any learning and improvement to prevent any recurrence. The report was completed and considered by the health board in 2016.[8]

[8] Commissioned Review, June to September 2016. Review of the Blood Glucometry Investigations in Abertawe Bro Morgannwg University Health Board. Establishing lessons learned. Professor Angela Hopkins. http://www.wales.nhs.uk/sitesplus/documents/863/4.5%20Blood%20Glucometry.pdf

5. What we found

Recruitment and employment

Mr W's redeployment did not follow the health board's redeployment policy.

The redeployment policy is not clear about who is responsible for DBS checks when a member of staff is redeployed.

Mr W's supervision and training records did not indicate any concerns with his performance.

Mr W's occupational health records did not indicate he was unsuitable to work in a healthcare setting.

Mr W should have been formally suspended from work at a much earlier stage, as opposed to remaining on special leave.

As a result of lack of resources being provided by the heath board, the disciplinary process took far too long.

Occupational health involvement was offered to Mr W throughout his employment.

Mr W's redeployment to the learning disability directorate

The redeployment policy was not followed. There was no evidence that a specific permanent vacancy existed at learning disability Unit A prior to Mr W starting work in December 2004. Mr W had previous experience of working in a care setting and positive references on his HR file about this employment.

The former Bro Morgannwg NHS Trust's redeployment policy[9] sets out the process for redeploying staff who are not able to continue in their current roles to other vacancies within the health board. It gives current staff on the redeployment register preference in applying for vacancies that have arisen within the health board. Relevant extracts from the policy are set out in Appendix D. The process entails comparing the health board's vacancy list each week against the list of staff on the redeployment register to identify any suitable vacancies. Staff on the redeployment register who meet all the minimum criteria for the vacancy will be offered it[10].

[9] Redeployment Policy 2003 (the former Bro Morgannwg NHS Trust) which was in use at the time of Mr W's redeployment. The current version of the redeployment Policy dates from 2016

[10] Section 5.2 and Appendix 2 of the Redeployment Policy 2003

A meeting with Mr W's managers in the IT department in October 2004 indicated that Mr W had, at that point, been absent on sickness grounds since July 2004 and it was noted that he had exhausted his sick pay entitlement on 13 October 2004. The health board said that it was not able to support the continued employment of an employee once their sick pay had been exhausted, though it agreed to Mr W continuing to be on unpaid leave pending an upcoming occupational health appointment.

At that appointment (30 November 2004), as well as assessing Mr W's general fitness for work, the occupational health consultant noted that he would 'fully support' Mr W's redeployment to a nursing assistant post within the LD directorate, although recommended that he avoid night shifts for the first three months. The consultant recorded that he was 'optimistic' that Mr W would be generally fit to provide regular and effective service in this area of work in the long term. A letter from the occupational health consultant confirming this is dated 9 December 2004.

Mr W started work at learning disability Unit A on 17 December 2004[11]. The Vacancy Requisition Form (VF1) was completed and signed by three members of management staff on 10 January 2005. All three signatures have the same date. The VF1 form referred to a new, permanent, full-time nursing assistant vacancy at Unit A 'because additional funds had been made available by Cardiff and Vale University Health Board'. The form also indicated that the post was 'to be filled from redeployment register'.

An undated redeployment counselling form completed by Mr W stated that the change would give him a break from computer screen work which was felt to be exacerbating his sleep problems.

Evidence from staff interviews suggested that there was no vacancy at Unit A at the time of Mr W's redeployment. A contrary view was that additional funds had been made available by Cardiff and Vale University Health Board (as stated on the VF1 form). This was due to a specific resident who required a higher level of support being admitted for a period of assessment to Unit A, prior to moving on to a permanent residential placement. There was no documentary evidence in relation to this but the availability of additional funds for the duration of the placement was corroborated by a Cardiff and Vale University Health Board staff member. This resident's placement at Unit A had started in April 2004 and was a temporary assessment placement which lasted for around a year. It is difficult to see why this placement resulted in a permanent full-time vacancy arising at Unit A in December 2004 when Mr W required redeployment.

Mr W had already started working at Unit A three weeks before the VF1 was completed and signed. The process did not follow the one set out in the health board's redeployment policy. This may in part explain why no DBS check was completed for Mr W. The subject of DBS checks is dealt with in the 'Safeguarding' section of this report.

[11] Payroll records and absence records

However, Mr W did have previous experience working in a learning disability care setting (for an independent care provider). There were two positive references on his HR file in relation to this employment[12]. There was no documentary evidence to indicate that, at this point, he would have been unable to secure a position within a care environment.

The redeployment policy[13] did not state where the responsibility for carrying out DBS checks lies for redeployed staff. The current version of the policy (2016) does not clarify this either. HIW's recommendations regarding DBS checks are included within the 'Safeguarding' section of this report.

Recommendation 1

The health board must ensure the redeployment policy is consistently followed.

Training and supervision

Mr W completed training relevant to the role. There were no concerns about his performance from his supervision records (other than sickness absence). Staff who worked with Mr W did not notice anything of concern about his interaction with patients.

Mr W's training records indicated that he completed all required mandatory training, including training in positive behavioural management techniques and safeguarding. He had also started a National Vocational Qualification Level 3 in Health and Social Care.

Supervision records from February 2005 stated that Mr W had settled in well to his new role and there were no concerns about his performance. The supervision records HIW reviewed cover a number of years of Mr W's employment, but not the entire employment period. The records did not suggest any concerns about Mr W's performance other than his level of sickness absence and the fact that working predominantly night shifts impacted on the experience he gained of working with patients. Staff who worked with Mr W at Unit A, and those who managed him, told us they had no concerns about his interaction with patients at the time.

Sickness absence and occupational health

Occupational health support was available to Mr W throughout his employment. Mr W was working late afternoon and night shifts as a result of occupational health advice. However, managers felt that the

[12] These were the references provided when Mr W was first employed by the health board in 2001 within the IT department

[13] Redeployment Policy 2003 (for the former Bro Morgannwg NHS Trust)

occupational health advice given to them about Mr W was unclear. There was nothing in Mr W's occupational health records to suggest he was unsuitable to work in a healthcare setting or with adults at risk.

In the first year following his redeployment to the nursing assistant post, Mr W took three days of sick leave. In subsequent years his sickness absence increased, but was not sufficient to trigger the health board's sickness absence policy until May 2011. At that point, a letter was sent to Mr W informing him that his sickness absence was being dealt with formally under the health board's sickness policy.

The role of the occupational health department is to support employees to ensure they are able to fulfil their employment role and to assist management in facilitating this. HIW looked at Mr W's occupational health records as part of this review. However, it should be stressed that this is not a review of Mr W's clinical status or care. The occupational health records formed part of HIW's review because they are pertinent to the health board's management of Mr W's employment and indicate any concerns that the health board may have been aware of at the time.

Mr W attended a total of 14 appointments with the occupational health department during his employment with the LD directorate. These were either at Mr W's request (self-referral) or via referral by Mr W's managers for occupational health review when there were concerns about his level of sickness absence. Based on occupational health advice, there was an agreement that Mr W should work a mixture of late afternoon and night shifts. This was a compromise following the occupational health advice for night shift working. Management staff indicated that no staff worked night shifts only as the operational needs of the unit required staff to work different shifts for training, cover and to ensure they are aware of patient needs.

Mr W's occupational health records did not note any health condition to indicate Mr W was unsuitable to work in a healthcare setting or with adults at risk.

The evidence from staff interviews indicates that there was a lack of clarity for managers about the occupational health reasons for the request for night shift working only. Staff acknowledgement there would always be tension between the needs of an individual employee and the needs of the service as a whole. However, management staff felt unsupported by the nature of the occupational health advice given in this case. Clear advice is important to identify and agree the best way to accommodate both the needs of the employee and the operational requirements of the service.

Recommendation 2

The health board needs to consider how occupational health advice can be more clearly communicated to management staff, in order to accommodate the needs of the employee concerned.

Disciplinary process

Suspension vs. special leave

Mr W was inappropriately left on special leave as opposed to being suspended or working in a non-clinical role. Whilst this had the same result, in that Mr W was removed from any contact with patients and remained on full pay, it created a suspicion amongst staff that he was being treated differently and meant that his suspension was not reported as such as part of the health board's figures.

The health board's policies[14] on suspension and special leave are clear. Where allegations are made against staff, authorised absence is to be used as a short term measure only to remove someone from the clinical environment while facts are being initially established to determine how to proceed. Once a decision is made to proceed with an investigation either under the disciplinary policy or safeguarding procedures, suspension on full pay or temporary reassignment to a non-clinical role should be considered. The policy states that suspension is a 'no fault' option and is to protect both the member of staff and the patient. Suspending a member of nursing staff requires permission from a senior HR staff member and the executive director of nursing. The option to place someone on long-term special leave for disciplinary reasons was outside of the health board's procedures. The special leave policy outlines the specific instances where special leave is granted. These include bereavement, public duties and emergency leave. The policy states that any absence due to illness or disciplinary reasons should be dealt with under the sickness absence or disciplinary policies.

Although staff told us Mr W was placed on special leave due to concerns for his health, this was not in line with the health board's policies and no formal justification was given for why Mr W was placed on special leave as opposed to suspension. Evidence from interviews indicated there was inconsistency in the use of special leave and suspension amongst managers. A view expressed by staff was that the result of both special leave and suspension was the same (that is, removal from work on full pay), though they felt that suspension seemed a harsher way of dealing with this, and staff felt more comfortable using the term 'special leave'. However, differences in practice create suspicion that staff are being treated differently. The disciplinary policy is clear that suspension is a 'no blame' measure, and should be viewed by all staff as such. Incorrectly, or inconsistently using 'authorised absence' or 'special leave' on a longer term basis, as opposed to suspension, also means that absences for disciplinary reasons are not adequately recorded or monitored in the health board's performance figures.

Mr W was offered a temporary move to a non-clinical role but he declined this because it would mean working day shifts as opposed to the late afternoon and night shift pattern in his nursing assistant role.

[14] Disciplinary policy 2011 and 2017; Special Leave policy 2014

Recommendation 3

The health board must ensure the suspension and special leave policies are applied consistently and all staff are clear about their correct use in relation to staff members under investigation.

Disciplinary investigation and hearing

The disciplinary process took far too long. This was a complex and sensitive case, which was evidentially difficult as there was no independent witness evidence. No additional resources were offered or provided to the investigating officer. This was a shortcoming and was in contravention of the health board's own disciplinary policy. This also strongly suggests that senior health board staff did not appreciate the seriousness or complexity of the allegations.

Following the CPS decision not to proceed with prosecution, a POVA strategy meeting was held on 22 January 2014.

The decision of this meeting was to proceed with the disciplinary process against Mr W. The health board's disciplinary policy[15] outlines the disciplinary process. This involves investigation by an investigating officer. On the basis of that investigation, a recommendation is made to the disciplining officer as to whether there is a case to answer, the case is proven or that there should be a disciplinary hearing. The case is then passed to the disciplining officer to make the decision as to how to proceed.

Mr W was informed about the disciplinary investigation at a meeting on 6 February 2014. An investigating officer was appointed from outside the LD directorate. As the former Clinical Director of the LD directorate was also the father of Mr W, we explored their involvement in respect of the disciplinary investigation due to the potential conflict of interest. The investigating officer confirmed to HIW that she did not know the former Clinical Director or have any contact from him during the disciplinary process. Evidence from interviews also indicated there was no contact between investigating officer or disciplining officer and the former Clinical Director throughout the disciplinary process. The former Clinical Director did attend on the day of the disciplinary hearing, but this was after he had left the health board's employment. From staff interviews, there was no indication of any direct influence on the disciplinary process by the Clinical Director.

The investigating officer completed her report in February 2015 and was forwarded to the HR department. The report stated that there was evidence to support a disciplinary hearing so that a panel could hear the evidence. No additional resources (either administrative support or time) were made available to the investigating officer to support the investigation. As a

[15] Disciplinary Policy and Procedure 2011, (this was revised in 2014 and in 2017 – the current version)

result, the investigating officer completed the investigation on top of her normal duties. A disciplinary hearing scheduled for 30 July 2015 was postponed at the request of Mr W's representatives. The hearing finally took place on 2 December 2015. Mr W was dismissed on 21 April 2016.

The investigating officer and the disciplinary panel had access to all the police statements for the three allegations so were aware of the evidence provided by the three women involved. It would have been helpful to have input from clinicians with knowledge of the abilities of the individual patients in the disciplinary process. This would have assisted the investigating and disciplinary panel to fully understand the evidence and any limitations within that evidence which may have arisen due to their learning disabilities. The disciplining officer stated that he had approached the three clinicians involved following representations made at the disciplinary hearing by Mr W's representative. One clinician raised concerns about the need for up-to-date consent from the patient concerned before sharing information as part of the disciplinary process. The clinicians were therefore not contacted again for information about their specific clients and this avenue was not pursued further. It should have been, and at an earlier stage. This would have led to a better understanding of the evidence given by the women when it was considered by the investigating officer and subsequently presented to the disciplinary panel. General evidence was provided to the disciplining officer by one of the clinicians, but evidence specific to the abilities of the three women individually to explain their evidence would have been much more helpful in the process.

It is HIW's view that the disciplinary investigation was hampered by limited resources and clinical input. HIW notes that one of the outcome actions following the health board's desktop review was to fund a specific team to support disciplinary investigations, but this action is yet to be completed.

Recommendations 4-5

The health board must identify and provide sufficient resources for disciplinary investigations to ensure their timely completion.

The health board must ensure there is relevant and timely clinical input to support the understanding of evidence from vulnerable patients within disciplinary proceedings.

Safeguarding

There are staff whose employment started prior to the requirement for Criminal Records Bureau (CRB)/DBS checks who have never had a CRB or DBS check.

DBS checks are now completed centrally as part of the recruitment process, but the health board's policies are unclear about the responsibility for checks for staff who are redeployed or for volunteers.

There was an unacceptable delay in recognising and reporting the first allegation as a safeguarding issue.

All allegations were dealt with via multi-disciplinary strategy meetings in line with the safeguarding process (involving the police and social services).

The safeguarding process was managed by a Designated Lead Manager (DLM) outside of the LD directorate from 2013 onwards. All allegations should have been overseen by a DLM from outside the directorate from the outset because of the family relationship between Mr W and the LD Clinical Director.

The outcome actions at the conclusion of the safeguarding process were not completed. The health board does not have a mechanism to properly check this.

Safeguarding encompasses a number of measures which together help to provide reporting, information sharing and learning to ensure that children and adults at risk are protected and to minimise any risk of harm. Safeguarding has been recently described as an 'imperfect art'[16]. Effective safeguarding requires constant vigilance, learning and adherence to safeguarding processes for any system to be able to minimise the risk of harm to adults at risk.

The Welsh Government has published statutory guidance[17] for adults to accompany the provisions of the Social Services and Wellbeing (Wales) Act[18]. Work to update the Wales Safeguarding Procedures following the introduction of the Act is being undertaken by Cardiff and Vale Safeguarding Boards on behalf of all safeguarding boards in Wales. The result of this is expected in July 2019. In the interim, the health board, along with many other agencies in Wales, is still using the previous 'POVA'[19] procedures. A recent report by the Older Peoples Commissioner for Wales highlighted the lack of consistency of safeguarding practice across

[16] Presentation by Margaret Flynn, Chair of the National Independent Safeguarding Board. https://bromley.mylifeportal.co.uk/media/19694/02_margaret.pdf

[17] Welsh Government codes of practice and statutory guidance in relation to the Social Services and Well-being (Wales) Act 2014 https://gov.wales/topics/health/socialcare/act/code-of-practice/?lang=en

[18] Social Services and Well-being (Wales) Act 2014 www.legislation.gov.uk/anaw/2014/4/contents

[19] Interim Procedures for the Protection of Vulnerable Adults Procedures 2010 (amended 2013)

the different health boards[20]. This results in inconsistency of reporting thresholds, investigation processes, information collection and sharing, and patient involvement throughout Wales. Whilst its findings relate to the needs of older people in hospital, some of its conclusions in respect of safeguarding practice are equally applicable to other adult patients.

An audit[21] of its POVA processes, completed by the health board in 2015, highlighted that there were policies which were out of date. The health board noted that the safeguarding adult processes were being reviewed nationally, but renewed its POVA policy by referring it to the safeguarding committee. The health board's previous safeguarding adults strategy dated from 2009. The health board have confirmed this has now been replaced by a strategic work plan for safeguarding. The health board said that it measures its safeguarding performance by benchmarking to national standards and priorities.

Recommendations 6-7

Welsh Government, through its work with the safeguarding boards, needs to ensure that national safeguarding processes enable consistency of reporting to facilitate benchmarking, and information sharing across Wales.

The health board should ensure that there is consistency between the safeguarding strategic plan and safeguarding policies to ensure aims are clearly reflected in all documents.

DBS checks

Mr W did not have a CRB/DBS check in place. In addition, a number of longstanding members of MHLD directorate staff have never had CRB/DBS checks as there has never been a national requirement to carry out these checks retrospectively. DBS checks are now conducted centrally at the health board as part of recruitment and staff are not allowed patient contact prior to completion of these checks. However, it is unclear whether this centralised system covers redeployed staff or volunteers.

The Disclosure and Barring Service was formed in 2012. Checks under the DBS scheme replaced the previous CRB checks. DBS checks can either be standard or enhanced depending on the requirements of the post. Clinical roles, where there is contact with patients, will generally require enhanced checks.

[20] Safeguarding in Hospitals in Wales: Review of the Actions which Health Boards are taking to ensure that older people who are hospital in-patients are safeguarded from harm in line with the requirements of the Social Services and Wellbeing (Wales) Act 2014 Sections 7 and 10. March 2018; Older Peoples Commissioner for Wales.

[21] ABM Protection of Vulnerable Adults Audit 2015 – ABM-1516-038 (NHS Wales Shared Services Partnership Audit and Assurance Service)

A staff view expressed during interviews was that the DBS check is "only as good as the day it is done". This is a common view amongst many employers and staff within caring sectors, and is to some extent true. However, this is not a reason to conclude that it is not important. It is one of a number of measures that exist to promote patient safety and if any one of these measures is not robustly followed, it compromises the safeguarding system as a whole.

In Mr W's case, as previously stated, no CRB, or latterly DBS, check was ever completed when he was first employed or during his employment. Although later evidence from the police showed that no concerns would have been identified had Mr W received a DBS on his redeployment, The health board does not appear to have been recognised or reviewed Mr W's DBS status after the allegations were made against him.

The health board has a DBS policy[22] which states that all required DBS checks must be completed before an employee starts work. The health board has stated that this process is now managed centrally (alongside its central recruitment process), and therefore such an omission could not recur. Interview evidence also confirmed that newly recruited staff would not be allowed to start work in a clinical environment until the DBS checks had been completed. One member of staff also described the induction process in place for all new health care support workers which must be completed before they are allowed onto the ward. This is in line with national guidance[23].

However, it is not clear to HIW that the centralised recruitment process is used by the health board for those who are redeployed under its redeployment policy. Interview evidence suggested that the responsibility for this remains with each delivery unit, rather than centrally. However, as previously stated, the redeployment policy does not specify where the responsibility for undertaking DBS checks for redeployed staff lies. The DBS policy is also unclear about the responsibility for DBS checks for volunteers.

An additional concern is that there are staff in post who were employed prior to the requirement to undertake either CRB or DBS checks. Learning disabilities has a relatively static workforce and a number of long standing staff members, whose employment predated this requirement, have never had a DBS check. There was no requirement in Wales to perform these checks retrospectively and it was never done by the health board. This is reflected in the evidence HIW obtained from staff at interview including confirmation of a recent audit within the MHLD service delivery unit which identified 142 members of staff who did not have a CRB/DBS check in place. Staff interviewed told us that the health board was relying on the contractual obligation for employees to notify them (as the employer) of any changes which may affect their employment. This is inadequate for safeguarding purposes and represents an unacceptable risk.

The health board does not currently renew DBS checks for staff who work with adults at risk. Whilst there is no national requirement to do so, it is a matter of good practice to update

[22] ABMUHB Disclosure and Barring (DBS) Policy 2018

[23] Code of Conduct for Healthcare Support Workers in Wales; 2015, Welsh Government.

these checks regularly. In a previous response to HIW on this issue in 2014[24], the health board noted it was committed to following NHS Wales policy regarding the three year renewal of DBS checks, but that this commitment is being managed on an all Wales basis due to the scale of the exercise and burden there would be on DBS services if there was no coordinated approach across NHS Wales. However, it is unclear what progress has been made regarding this.

The facility is also available to have 'ongoing' DBS registration and this tends to be used by staff who move jobs within the NHS frequently (such as doctors on rotation).

In order to promote a culture where safeguarding is a priority, updating of DBS checks should be considered on a national basis.

Recommendations 8-9

Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.

The health board must ensure all staff, where required by their role, receive a DBS check and address the following:

- As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check
- The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role
- The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff
- The responsibility for conducting DBS checks for redeployed staff and volunteers is clarified within health board policies.

Safeguarding training and learning

Face-to-face scenario-based safeguarding training, in addition to the online statutory mandatory training, is beneficial for staff to feel confident in properly recognising and reporting safeguarding issues. We found the pathway for sharing learning on safeguarding at operational level is unclear.

There is a statutory requirement for health professionals to receive safeguarding training. The statutory mandatory training for staff (level 2) is delivered via online training. However,

[24] Action plan in response to unannounced inspection report of Cefn Coed Hospital November 17-20 2014 gov.wales/docs/hiw/inspectionreports/Mental%20Health%20Learning%20Disability%20Inspection%20-%20Cefn%20Coed%20Hospital%20-%2017-20%20November%202014.pdf

staff we spoke to felt that online training cannot replace the effectiveness of face-to-face training particularly in areas such as safeguarding which involve a number of complex factors. Interviews with staff indicated that the health board has piloted some sessions of face-to-face scenario based safeguarding training for staff. This can be helpful in all areas of practice, but particularly within mental health and learning disabilities, where there are high incident levels and potentially challenging safeguarding issues. Interview evidence indicated that the feedback from staff to this training was positive, however, it was unclear whether resources would be available to repeat or extend this training to other areas of mental health and learning disabilities, or other areas of the health board.

Documentary and interview evidence suggested that staff at operational level within the delivery units felt there is no clear pathway for sharing learning and good practice from safeguarding cases.

During interviews with current staff, we were told about how the learning from the Mr W case had been adopted at Unit A. This included adapting staff handover meetings to cover information from the last three shifts (24 hours) to ensure any emerging issues are identified. We were also told that Unit A now have combined multi-disciplinary care notes to ensure information relating to the care of individuals is kept together and easy to review. However, it is unclear from staff we spoke to whether this learning has been shared with other units across the heath board.

The health board has stated that, since the events detailed in this report, it has improved training and access to peer supervision for DLMs. This is a positive step, though there was no evidence available to HIW to assess how effective the supervision is in practice or whether it meets the standards set out in the safeguarding supervision guidance[25].

Recommendations 10-12

The health board must consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training.

The health board must ensure there are clear pathways within and across delivery units to share learning and good practice from safeguarding cases, including whether learning from Unit A has been shared with other units.

The health board needs to consider the arrangements to evaluate the effectiveness of training and supervision for DLMs. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance.

[25] All Wales Safeguarding Best Practice Supervision Guidance June 2017 http://www.wales.nhs.uk/sitesplus/888/page/91797

Safeguarding process

In relation to the allegations made against Mr W, the first allegation should have been recognised and reported as a safeguarding incident. Each allegation against Mr W was reported to social services and investigated by the police. The police considered the three allegations together and submitted them to the CPS for a prosecution decision. We found the POVA multi-agency process was followed, but there was no social services involvement after 2013. This compromised the robustness of the multi-agency process and limited external scrutiny.

HIW looked at the electronic safeguarding documentation in relation to the three cases central to this review. Interview evidence indicated that there were paper safeguarding files kept for each allegation by both the DLMs throughout the safeguarding process, until its completion in 2016. However, these paper files have not been located by the health board and so were not available to HIW. The content of these files has not been transferred to the Datix system as it should have been. These files would likely have included copies of correspondence (written and verbal), non strategy meeting notes, threshold assessments for reporting incidents, amongst other information which (in addition to statutory reporting forms and strategy meeting minutes) would have provided more detail about what happened during the process. The documents viewed by HIW were those that were available electronically on the Datix system[26], in addition to email correspondence and information provided directly by those interviewed.

The safeguarding process is a multi-agency one consisting of strategy meetings where different agencies, including the police and social services are present. The strategy meetings will determine the most appropriate course of action to promote safeguarding.

Allegation 1

There was a delay in reporting the first allegation as a safeguarding incident. It is documented in the care records that Ms X first made an allegation against Mr W on 21 December 2011. Three further occasions are documented in the care records (22, 24 December and 6 January) when she referred to this allegation against Mr W. However, it was only on 13 January 2012 when the care manager reviewed the notes that this was recognised as a safeguarding issue. Throughout this time, Mr W remained at work in Unit A. This delay is recognised in the health board's desktop review report.

When the allegation was formally reported on 13 January 2012, the standard safeguarding processes in place at the time were followed. The Head of Nursing for the LD directorate was the DLM with responsibility for overseeing the safeguarding process. The DLM alerted the police and social services (in the area of Unit A) immediately. A multi-agency strategy meeting

[26] Vulnerable Adult Case Management Records (known VA1, VA2 and VA4 forms, minutes of strategy meetings, Serious Incident reports (where completed).

was convened on 16 January 2012 with representatives from Ms X's care team, (care manager and consultant psychiatrist), the health board's HR and safeguarding teams, and social services. The outcome of the strategy meeting was that the police would investigate. A further strategy meeting took place on 23 January (no minutes of this meeting were available to HIW). The police interviewed Ms X, Mr W and members of staff as part of their enquiries. The police decided there was insufficient evidence to proceed with the criminal investigation. The allegation was therefore passed back to the health board to consider under its disciplinary procedures. The health board's initial assessment under the disciplinary policy[27] was presented to a final strategy meeting in March 2012 and the decision was that there was insufficient evidence to take the matter further.

Mr W returned to work on April 2012. He was placed at Unit B. The reason for this was documented to be because Ms X was still a resident at Unit A. In addition, evidence from interviews indicated that Unit B was a residential setting with only three full time residents and there was no requirement for staff to provide personal care to any of those residents.

Allegation 2

On 2 October 2012, Ms Y made an allegation via text message to one of her care team that a student nurse (with the same first name as Mr W) had assaulted her whilst she had been an inpatient in Unit A. The police and social services were notified the following day. The allegation was reported as a safeguarding incident. Arrangements were made to visit Ms Y on 8 October to obtain some further information.

A strategy meeting was held on 12 October. Members of the care team, Ms Y's consultant and representatives from the police, social services and the health board's safeguarding team all attended. The decision was made for the police to investigate. Mr W was not in work on the day of the strategy meeting but he was contacted and placed on special leave the following day when he was due back on shift (13 October).

Police interviewed Ms Y and Mr W, and took statements from relevant staff. The police submitted the case to the CPS on 20 November 2012. The CPS decision, on 5 December, was that the matter should not proceed to prosecution. The police notified Ms Y and the health board of this decision the following day.

A strategy meeting was held on 20 December. The outcome of this was that the matter should be considered under the health board's disciplinary policy.

The initial assessment report about Ms Y's allegations under the health board's disciplinary process was completed in February 2013. This report concluded that a full investigation under the disciplinary policy would not uncover any additional evidence to that identified during the police investigation. However, by that point, the third allegation had been made and the police were investigating all three allegations together.

[27] Para 9.2, Disciplinary Policy 2014. The Initial Assessment is a fact finding process under the Disciplinary Policy to establish how to proceed with the investigation. Possible outcomes include: no further action, proceed to disciplinary investigation or hearing, or proceeding under a different policy (e.g. capability)

Allegation 3

On 2 February 2013, an inpatient at Unit A reported to staff that she had been sexually assaulted by Mr W between May and June 2011 during a previous admission at Unit A. It was reported as a safeguarding incident (on the adult protection case management record, known as VA1 form, dated 8 February 2013) and the police and social services alerted.

During this time, Mr W was still on special leave pending the outcome of the previous disciplinary investigation.

On 6 February 2013, a second DLM was appointed from outside the LD directorate. This appears to have resulted from a complaint letter from the family of one of the women who had made a previous allegation. The complaint related to the investigation being overseen by someone within the LD directorate due to the family relationship between the clinical director and Mr W.

On 11 February 2013, the first strategy meeting to discuss the third allegation was held. The previous two allegations were noted and the decision was taken that the police should start an investigation of the third allegation (and would consider all three allegations together).

On 26 February 2013, the second DLM sought permission from the health board's Executive Director of Nursing for Mr W to be formally suspended. This was actioned on the 7 March 2013.

During March and April 2013, the police investigated the third allegation, including conducting interviews with Ms Z and Mr W, and taking statements from staff.

On 12 April 2013, a second strategy meeting was held. The police confirmed that they were nearing the end of their investigations and would be submitting a file to CPS relating to all three allegations. The police confirmed that the HB's internal investigations could commence.

The police forwarded the case file to the CPS in May 2013. The CPS response requested that further enquiries should be made.

A third strategy meeting was scheduled for 19 August 2013 but was postponed. The reasons for this delay are unclear, but may have related to further enquiries requested by the CPS.

It is recorded on 24 September 2013 that the police had passed the file back to the CPS for a charging decision. The CPS decision was not to proceed to prosecution on the basis of the evidence. The police requested a review of the CPS decision in January 2014, but the decision not to prosecute was upheld.

The third strategy meeting finally took place on 22 January 2014. At this meeting, the police fed back the decision that the CPS would not be taking matters further as the evidence did not support proceeding with the case. The minutes of that meeting state that the police still had considerable concerns about Mr W returning to that setting. In light of the CPS decision not to prosecute, the matter was left with the health board to address under its disciplinary procedures. The police agreed to provide their evidence to the health board to facilitate this.

It should be noted that the burden of proof is different for the different processes. In criminal cases, the case must be proved 'beyond reasonable doubt'. In civil cases (such as disciplinary cases) there is a lower burden of proof, 'on the balance of probability'. The matter therefore proceeded in line with the health board's disciplinary policy.

The process initially followed in each of the three cases involved decisions being made by multi-agency strategy meetings with social services, police and clinical input. This is in line with the safeguarding processes at the time. There was no social services representative at the strategy meeting in January 2014 at which the police confirmed the CPS decision not to proceed with prosecution. This was a point when external scrutiny and input in the form of a view from social services would have been helpful.

Following the strategy meeting in January 2014 there are no further documented strategy meetings until the final strategy meeting in 2016, after Mr W's dismissal. There was no social services input into that meeting. It is not clear whether social services did not attend these meetings because they were unable to attend, or were not invited, but their absence compromised the security that the multi-agency safeguarding approach provides.

It is important that attendance of external agencies is facilitated at strategy meetings, either in person, or via phone/video conferencing, to enable multi-agency input into the safeguarding process.

When safeguarding incidents have taken place within the health board, the safeguarding process and investigation is overseen by a DLM. This is usually a senior member of nursing staff. In this case, it was initially the Head of Nursing for the LD directorate. The Head of Nursing was managed professionally by the health board's Executive Director of Nursing, but was line managed by the LD directorate's Clinical Director. A view expressed during the interviews was that the safeguarding process is a multi-agency one where decisions are made collectively through multi-disciplinary meetings. All attendees have to sign up to the actions from those meetings and therefore the process is a safe and robust one. This is an entirely reasonable view and there was no suggestion that different actions would have resulted from a different DLM being in place. However, given the family relationship between the Clinical Director of the LD directorate and Mr W, HIW is concerned that not only did this put the Head of Nursing, and to some extent the Clinical Director, in a difficult position, but also had the potential to affect public confidence in the safeguarding process because of the perception of a conflict of interest.

It is HIW's view that a person outside of the LD directorate should have been appointed to lead the safeguarding process from the outset, rather than only once a complaint from an involved family was received.

Recommendations 13-14

The health board must review its processes to ensure all relevant safeguarding agencies are invited to strategy meetings and are facilitated to attend, either remotely or in person.

The health board needs to implement an effective way of checking the completion of the outcome actions when a safeguarding case is closed.

Support for people during safeguarding processes

Support was provided to the women making the allegations against Mr W through the police interview process by trained intermediaries. This is in line with guidance. However, no professional independent advocacy support was offered.

Occupational health support was available to Mr W throughout the investigation and attempts were made to keep in contact with him throughout the disciplinary process. No formal support was provided to Mr W's former colleagues by the health board.

The three women had access to clinical support from staff and to professional intermediaries (as part of the police interview process). There does not appear to have been any independent professional advocacy made available to the women, either at an early stage or on an ongoing basis.

There were some concerns raised by one family about a lack of information about the allegation and inclusion in the police interview process. There are issues of confidentiality in what can be fed back to families but they should be kept informed of events, where this is appropriate, and they should receive an explanation as to why they cannot be involved in the process if this is the case. Another family also felt that the health board had not kept them informed during the process and it was always up to them to chase responses from the health board, as opposed to the health board proactively keeping in contact with them to update them.

In two cases, concern was expressed about whether the women had been believed. In one case, this related to whether health board staff had believed her; in another case, the police process and the outcome of the police investigation resulted in the feeling of not being believed.

Those interviewed confirmed that the police decision on their case was explained to them and, whilst they may or may not have agreed with that decision, they understood why the cases were not being taken further. The fact that the health board had assisted them in following the 'PTR'[28] process was described as helpful by one family, including the visit at the end of that process from the then Chief Executive in 2017.

One of the families raised concerns about the detrimental nature of reminders of the events from ongoing media attention. It is clear from speaking with the women and their families that they continue to be affected by what happened to them.

[28] Putting Things Right (PTR) is the statutory process for managing concerns in the NHS in Wales. http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright

Whilst the focus in such cases should be on the welfare of those making the allegations, the health board as an employer also has a duty of care to its employees. This includes both the member of staff who is the alleged perpetrator of abuse and other staff members who may be affected by what has happened.

Mr W was given the option of an alternative non-clinical role (afternoons only) to keep him in a work environment whilst the allegations were investigated. However, he declined this. There is evidence that contact with Mr W whilst he was away from work was difficult. Despite this, staff did make frequent attempts to keep in touch with him via letter and text message at his request. He had access to occupational health support throughout the period of suspension and also the Wellbeing through Work Counselling Service was suggested to him.

Whilst not part of the safeguarding process, it seems reasonable to include in this section the support provided to staff who worked with Mr W. After Mr W's arrest and conviction, staff noted that there was informal support available to them from the unit managers. However, staff clearly remained affected by the events, questioning whether they had missed something at the time and concerned about the level of adverse media coverage about Unit A, which continues to have an effect on the confidence of current patients and their families, as well as the morale of staff.

Recommendations 15-18

The health board must ensure there is signposting to advocacy and support for the individuals and families affected by incidents within any of its service delivery units.

The health board must ensure there is effective and timely communication with individuals and families affected by incidents (where appropriate) throughout the safeguarding process.

The health board must ensure staff understand that anyone raising a safeguarding allegation should be treated seriously in all cases.

The health board should consider the formal support available for any members of staff who may be affected by adverse incidents, including for staff who are the alleged perpetrators of abuse. Furthermore, the health board should consider how it enables staff to feed in to improvements to practice

Incident reporting

There is evidence of a good level of awareness of the need for incident reporting at Unit A, that staff are encouraged to do so and feedback is provided regularly.

The way in which serious incidents are investigated in the health board is inconsistent.

The health board needs to improve its processes for 'joining up' data from incidents, concerns and claims to provide a robust system for identifying any areas of concern and managing risk.

Incident reporting is a means for staff to highlight areas of concern which may affect the provision of health board services. This is vital so that any concerns about health board services can be identified and addressed. There is also a requirement for health boards to report serious incidents (that is, those where harm is or may be caused) to Welsh Government.

Serious incident forms were completed for the first two allegations. All serious incident forms have to be signed by the health board's Chief Executive or an executive member of staff and this is done centrally before the form is forwarded to Welsh Government. As noted in the desktop review, the form for the second allegation, whilst it was completed, does not appear to have been submitted. This suggests a shortcoming in the central systems at the health board which resulted in a failure to forward on the relevant form after it was completed. It is unclear why a serious incident form was not received by Welsh Government in relation to the third allegation.

All the current staff at Unit A interviewed as part of this review were aware of the procedures for reporting incidents. Staff also said that they received feedback about incidents which had been reported. This indicates a positive culture of reporting incidents at Unit A.

Both DLMs interviewed stated that they worked hard to encourage incident reporting within their respective directorates at that time. This is supported by a governance review of the LD directorate in 2012[29] which recorded a high level of incident reporting within the LD directorate.

The health board has also stated it encourages reporting of incidents across the health board and this was one of the recommended actions of the desktop review. The health board now has a serious incident investigation team but this team only has capacity to investigate a proportion of serious incidents. It has provided training staff in the delivery units to assist with consistency of incident investigations.

[29] Directorate Governance Review: Learning Disabilities; Internal Audit Report 006/2012. September 2012

In February 2018, the NHS Delivery Unit carried out a review of the health board's processes for managing serious incidents[30]. The review resulted from two specific areas of concern, not related to learning disabilities, but its findings on serious incident reporting are relevant to all areas of the health board. Of relevance to this case, the NHS Delivery Unit review highlighted key areas needing improvement:

- The Board was insufficiently sighted on serious incidents and the associated risks
- There was a lack of strategic direction to deliver consistency in the health board's management of concerns, including inconsistency in the investigation methodology for serious incidents and operational risk management processes, and reporting and sharing of information from frontline services to the Board
- There are significant variations in approach across the service delivery units which adversely impacts on Board assurance, risk management and the health board's ability to learn lessons and make improvements to improve patient safety
- There was a lack of consistency of monitoring arrangements due to the limited corporate oversight and the difference in practice between delivery units in managing and learning from concerns.

Follow up work by the Delivery Unit in November 2018 demonstrated improvement in these assurance systems, but reiterated that there were still improvements to be made. Of particular relevance to this review, the recommendations included:

- There were still inconsistencies in the quality of some investigations of serious incidents. A specific area of concern was cited as the MHLD service delivery unit
- Further and ongoing action to improve the systems for sharing learning across the health board.

The NHS Delivery Unit is continuing to work with the health board to monitor the above issues.

Recommendation 19

The health board is required to provide HIW with an update on the actions it has taken in response to the NHS Delivery Unit report, including where actions are incomplete or ongoing.

[30] Intervention into systems and processes for the management of serious incidents at Abertawe Bro Morgannwg Health Board; NHS Delivery Unit, February 2018, and: Follow-up report Summarising Progress, NHS Delivery Unit, November 2018

Governance and culture

Some executive Board members were individually aware of the details of the allegations against Mr W throughout the investigation. Whist there was individual awareness by members of the Board, this case was never formally reported to the Board.

The reporting structure for quality and safety remains unclear. There is no clear mapped route for escalation and scrutiny of safeguarding events through the quality and safety structure to Board level, or for effective dissemination of learning back to delivery unit level.

The issue of the line of sight between the Board and operational services has been a recurrent theme since 2014.

It has not been the purpose of this review to specifically look at the governance of the former LD directorate. However, the review team has looked at evidence related to concerns about the governance of the directorate which were presented at interview.

Interviews with longstanding and former staff revealed governance concerns within the LD directorate at the time of the allegations. Staff used phrases such as "corridor management" to describe the management style and that meetings were often not minuted. Documentary evidence refers to the partnership working within the directorate as 'informal'[31]. The report of an internal governance audit in September 2012 (which was completed for all directorates within the health board) indicated an 'amber' assurance rating (that is, limited assurance) for governance in the LD directorate. Actions arising from that audit were improved regular recording of meetings, with agreed decisions and actions. This indicates that at the time these were not being routinely done.

Of greater concern is that interviewees, almost without exception, described a significant dispute between two very senior members of directorate staff. This became evident from around 2011 onwards, but deteriorated over subsequent years, including a grievance process which resulted in mediation. Staff expressed the view that this dispute affected the running of the directorate at a management level but it did not affect the day to day care provided to patients because of the systems and good partnerships in place between staff at operational level. It is a concern that so much energy was put into managing the effects of this one poor relationship. This included the involvement of members of the Board, specifically the Interim Medical Director and the Chief Operating Officer, and then in 2014, the then Chief Executive. The Chief Executive asked the former Board Secretary to review the governance processes within the directorate in early 2015. We saw no evidence of the outcome of this review. It should also be noted that by this point, the reorganisation of the directorate into the service delivery units had been planned.

Whilst there is no evidence to suggest that this dispute impacted on the handling of the case of Mr W, HIW has no doubt that a dispute between such senior members of staff affected the

[31] Letter from the former Clinical Director dated 28 September 2012

strategic management of the LD directorate more widely. It diverted a considerable amount of energy and time away from planning the future progress and direction of the learning disability service. This issue of a lack of a clear strategy for learning disability services within the health board was also a key finding from the reviews of learning disability services in 2015-16 conducted by HIW and Care Inspectorate Wales[32].

Interview evidence indicates that there were regular performance reviews between executive Board staff and senior directorate staff. The individual members of the Board who were aware of the concerns within the directorate had no concerns about the performance of the directorate as a whole. Due to its size and good reputation it was able to recruit and keep quality staff and had greater resources available to it (in terms of expertise, flexibility of care provision and in terms of budgets) than a smaller unit would have had. The performance indicators that were pressing at the time were much more applicable to acute health board departments (such as waiting list times, bed occupancy rates and delayed discharge). These measures did not apply to learning disability patients given the specific nature of the need of those patients. There were no operational or budgetary concerns about the directorate's performance and it was very much left to run itself with minimal intervention from the health board.

By virtue of their positions, some executive Board members were aware individually about Mr W's case. Specifically, the Executive Director of Nursing and the Chief Operating Officer were fully aware of the allegations against Mr W and the progress of the investigation. Email correspondence from the DLM in charge of the safeguarding process showed that regular updates were provided to both these executive Board members during the latter part of the police investigation and throughout the disciplinary process. Areas of concern were highlighted, including the suggestion for an external investigator to undertake the disciplinary investigation. However, Mr W's case was never formally reported to the Board until after his arrest.

Updates were given from the safeguarding committee to the health board's quality and safety committee about Mr W's suspension. However, whilst these updated indicated that the investigation was ongoing, they were inadequate in their level of detail to enable any effective scrutiny and did not mention timescales.

During interviews, staff explained that there were a number of high profile issues for the health board at that time. In particular, health board's focus had been on addressing concerns about the standard of care at Princess of Wales Hospital (which resulted in the 'Trusted to Care' report and police investigations of nursing staff). As a result, there were a significant number of nursing staff suspended because of police investigations; therefore the suspension of a healthcare support worker would not have stood out amongst the multiple suspensions (over 20 nursing staff) at that time.

It was also noted that the health board was undergoing significant reorganisation during this time with the creation of its service delivery units.

[32] HIW review of learning disability services 2015-16
hiw.org.uk/reports/natthem/2016/learningdiasbilityreview/?lang=en
National inspection of care and support for people with learning disabilities 2016
careinspectorate.wales/national-inspection-care-and-support-people-learning-disabilities

Current arrangements

It is clear that the health board has done considerable work to improve its quality and safety systems (such as the implementation of the quality and safety forum). However, the fact that this review of governance processes is still ongoing indicates that progress in this area has been very slow. There still remains a question over whether the escalating and reporting systems in place within the health board's governance framework give the Board effective oversight of areas of concern.

The health board's current Executive Director of Nursing gave a written response to HIW to clarify some of the governance processes for safeguarding. He confirmed that each service delivery unit reports suspensions as part of their performance reviews. Suspensions and allegations are also reported on a monthly basis through the senior workforce team to the Director of Workforce and Organisation Development. Suspensions are also reported to Welsh Government.

All discussions in relation to proposed nurse suspensions would initially be with the relevant Unit Nurse Director and a discussion would then take place with the Director of Nursing and Patient Experience or Interim Deputy Director of Nursing and Patient Experience. Service delivery units are required to provide updates on the progress of cases involving such situations to the health board's safeguarding committee (meeting every two months). All cases are closely monitored by the corporate safeguarding team and any concerns regarding delays escalated.

The Director of Nursing and Patient Experience is the chair of the health board's safeguarding committee. The committee receives all the service delivery unit safeguarding reports as part of the committee agenda. Case outcomes are also reported by service delivery units in their reports to the committee and these now include any lessons learned. Cases are also monitored by the corporate safeguarding team, who will provide additional updates on an individual case basis.

Operationally, each unit has its own quality and safety committee, where incidents, serious incidents, concerns, POVA (adults at risk) and never event figures are reported and reviewed. Each service delivery unit is required to submit a quality and safety report to every quality and safety committee. At a corporate level, a search is undertaken before any new entry in added to the Datix system to establish any links between incidents/ serious incidents, POVA and never events.

There is no current formal (computerised) system for identifying incidents involving specific staff members. However, service delivery units and their HR leads are aware of all concerns involving staff within their units and will highlight where previous concerns have been raised about specific staff members.

As part of the safeguarding bi-annual report, themes and trends are monitored across the service delivery units. This paper is submitted twice yearly to quality and safety committee.

All safeguarding cases are reported to the health board's safeguarding committee as part of the service delivery unit's performance reports. High risk safeguarding cases are escalated from the health board's safeguarding committee to the quality and safety committee. A high risk safeguarding case would be any adult or child concern, where there has been formal police enquires/investigations and/or referrals to professional bodies.

Board minutes from December 2016 note the intention to review what is reported to the quality and safety committee because of the volume of information presented there. A quality and safety forum was created and considers the operational aspects of quality and safety and reports into the quality and safety committee. This should allow the quality and safety committee to concentrate on more strategic aspects of the health board's quality and safety performance. Review of current health board minutes indicates that this process is still ongoing.

The Trusted to Care report in 2014 stated that current assurance processes at the time were not fit for purpose[33] and referred to the disconnect between the Board and service provision. The NHS Delivery Unit report in 2018 also refers to the Board not being sighted on serious incidents and there is concern about the lack of governance assurance.

Due to the size of the health board, it will always be a challenge to ensure that the Board is fully appraised of what is going on at operational level. However, this is more reason to have clear and robust governance structures in place. The health board's current reporting and escalating structures are not sufficiently robust to underpin assurance mechanisms throughout the organisation.

Recommendations 20-23

The health board must rapidly improve its governance and reporting/escalation structures (including ward to Board governance) around quality, safety and clinical governance.

The health board must ensure there are effective arrangements and information systems in place to triangulate:

- Workforce issues relevant to safeguarding, such as staff suspension, with its safeguarding processes.
- Information from claims, concerns and incidents to highlight areas of concern.

The health board must ensure there are clear and effective pathways for sharing learning from safeguarding and incidents throughout the health board.

Welsh Government should consider how a more robust mechanism for sharing safeguarding learning can be developed across Wales.

[33] Trusted to Care Professor June Andrews and Mark Butler, 2014 Para 3.79
https://gov.wales/topics/health/publications/health/reports/care/?lang=en

Desktop review

Senior health board staff chose a documentary review format to consider Mr W's case after consideration of a number of factors.

In the main, the conclusions of the desktop review were not unreasonable based on the information that was considered within the review.

The conclusion that Mr W's actions outside of his employment could not have been predicted or prevented is not evidence based as there is no evidence in the desktop review report to either support or refute it.

In looking at limited documentary evidence only, the desktop review focused on the actions of frontline individuals only, as opposed to considering wider issues relevant to this case, such as governance and reporting structures.

There were gaps in the documentary evidence available to the desktop review team. Records including Mr W's supervision, training and occupational health records were not made available.

Much of the desktop review action plan referred to actions already implemented as a result of the Trusted to Care report, rather than specific to the events of this case.

Following Mr W's arrest, the health board decided it needed to review the circumstances of his employment and suspension. The review took the form of a desktop review, based on available documentary evidence. No interviews with staff were conducted.

No documentary evidence has been provided by the health board about the rationale for its decision to use a document review format. The interview evidence from those involved in this decision noted this was a decision made collectively by executive health board staff after detailed consideration. There appear to have been several factors that influenced the decision to undertake a desktop review:

- The aim of the review was to establish facts and to identify any learning from the events
- Given the length of time from the events in question, a document review would be completed more quickly so that the facts, and any learning points arising from the review could be actioned sooner
- There was concern that conducting interviews would be stressful and a large number of staff involved had already left the organisation.

It was noted that not conducting interviews would limit the breadth of evidence available to the review, but weighing up the above factors, the health board decided that a document review was the most appropriate way forward.

It was also highlighted by some interviewees that the review format and scope, including that it would be conducted internally by the health board, had been shared and agreed with the Welsh Government in advance of the review.

Unfortunately, the desktop review team did not have access to all the documentary evidence held by the health board. Interviews with staff would have given some context to the documentary evidence. That said, there does not appear to be anything inherently inaccurate or wrong with the review team's factual conclusions on the basis of the available evidence. The only exception to this is the statement that Mr W's actions outside of his employment could not have been predicted or prevented [34]. This is not evidence based as there is no evidence cited in the report which either supports or refutes this statement. This statement appears to rely on the involvement and actions of the police rather than any specific evidence cited in the report about the actions the health board took.

At interview, some staff expressed concern that the report had commented on their actions without their input. Some of the key staff involved did not know that the desktop review had been undertaken until the final report and the action plan was circulated around the health board. HIW acknowledges the health board's concern about stress to staff of conducting interviews. Many of the staff we spoke with acknowledged that it was stressful to be interviewed by HIW about events but appreciated being involved in the process and being given the opportunity to contribute what they knew about events. The health board also missed an important opportunity to identify further learning and areas of practice improvement but by not involving staff within its review.

The action plan from the review is a generic, health board wide action plan. HIW understands that each directorate within the health board was required to identify actions relevant to their own directorate arising from the health board wide action plan. At interview, a number of staff were critical of the content of the action plan. The most prevalent view was that many of the actions outlined in the action plan had already been carried out and were a result of the previous 'Trusted to Care' report in 2014[35] as opposed to resulting from the specific events of this case. Looking at the actions from the report, it is clear to HIW why staff have formed this view.

The nature of a review of documentary evidence only is that it tends to concentrate on the specific actions of those front line staff that are responsible for completing documentation. It therefore often misses out details of the wider context of the processes, culture and management within a service. Interviewing staff could have provided key additional evidence to give a broader view of events and fill in evidential gaps.

[34] Executive summary and paragraph 6.3 ; Health Board Lessons Learned Desktop review, August 2016 www.wales.nhs.uk/sitesplus/documents/863/4.3%20Desktop%20Review%20and%20Lessons%20Learned%20Report.pdf

[35] Trusted to Care; Professor June Andrews and Mark Butler 2014

Commissioning arrangements

There is no formal commissioning arrangement between the health board and Cardiff and Vale and Cwm Taf University Health Boards in relation to the provision of learning disabilities services in their areas.

Despite there being longstanding agreement that the health board provides LD services for both Cardiff and Vale and Cwm Taf University Health Boards, there has never been a formal agreement about those services between the health boards and interaction between all the parties has been limited and informal. Historically, this has been due to funding arrangements where the health board received funding directly from Welsh Government and there was no financial transaction between Abertawe Bro Morgannwg University Health Board and Cardiff and Vale and Cwm Taf University Health Boards.

In this case, those health boards were not notified where the allegations may have involved patients resident within their geographic areas.

A formal service agreement would assist with:

- Effective planning of services in the respective health board areas
- Ensuring the services were meeting the needs of patients in the respective health board areas
- Engagement of all parties in the provision of those services
- Promoting information sharing between the health boards about the services in their area and their patients
- Performance monitoring.

The lack of formal agreement has previously been raised with all three health boards following HIW's review of Learning Disability Services in 2015-16[36]. It was included as part of the actions required following that review, but the response from the health boards has lacked sufficient detail around this issue.

It was noted at interview that there was now dialogue between the three health boards and discussions about the needs of each health board for learning disability service provision and how this can best be provided. Whilst, there is still no service agreement, and progress with these discussions has been slow, agreement is now being pursued through a joint commissioning group.

Recommendation 24

The health board must progress a formal commissioning arangement, across the three health board areas, regarding the provision, planning and performance monitoring of learning disability services provided

[36] Learning Disability Services Thematic Report 2015-16; Healthcare Inspectorate Wales http://hiw.org.uk/reports/natthem/2016/learningdiasbilityreview/?lang=en

6. Conclusions

The questions that the review sought to answer:

Was the health board's internal review sufficiently thorough?

The health board was aware of the limitations of conducting a review based on documents alone and gave consideration to a number of factors in reaching this decision. However, the absence of input from staff who were involved in the events in question was a missed opportunity to gather evidence not only about the specific events but also the wider context of the health board's processes.

In addition, there was documentary evidence which was not made available to the review. This compromised the robustness and clarity of its findings. Therefore, HIW cannot conclude that the internal review was sufficiently thorough.

Were the health board's conclusions appropriate on the basis of the evidence considered?

In the main, based on the documentary evidence available to the desktop review team, the conclusions reached were not inappropriate. The exception to this is the conclusions that Mr W's actions outside of his employment could not have been 'predicted or prevented'. This conclusion was not reasonable because it was not based on evidence cited within the report. This statement appears to rely on the involvement and actions of the police rather than any specific evidence cited in the report about the actions the health board took.

Were the actions that the health board took in light of its conclusions adequate to ensure patient safety?

The health board has taken some positive actions in light of the evidence in this case. It has carried out most of the actions recommended by the desktop review report. The exception to this is the central team to undertake disciplinary investigations (similar to the serious incident investigation team which already exists within the health board). The health board confirmed they have approved funding for three disciplinary officer posts but are yet to create the disciplinary investigation team; therefore the factors which contributed to the lengthy disciplinary process in this case remain unaddressed.

Furthermore, the shortcomings in the desktop review methodology meant that governance issues within the health board were not adequately considered, particularly in relation to reporting and escalating of safeguarding concerns. We found the governance structures within the health board are still unclear relating to quality and safety, in terms of the committee structure for reporting of incidents and also dissemination of learning back to operational level. HIW is concerned this does not provide assurance about current processes within the health board for effective scrutiny of safeguarding concerns and to ensure the Board is sufficiently sighted on what is happening at operational level. It is also of concern that issues about the Board being 'properly sighted' were highlighted in the Trusted to Care report in 2014 and attempts to address this are still ongoing. This has taken far too long and must be prioritised as a matter of urgency.

On the basis of additional evidence considered during this review, are there additional or different conclusions?

As stated previously, based on the evidence considered by the desktop review the conclusions reached are not unreasonable, with the exception that the actions of Mr W outside of his employment could not have been 'predicted or prevented'. However, the evidence available to the desktop review team was limited since the team did not see all the evidence and did not interview staff members involved in the events in question. This additional evidence would have provided further context to the circumstances surrounding the events in question.

Does this review highlight wider learning for the NHS in Wales?

This review highlights areas of learning which are of relevance to the NHS in Wales. We expect all health boards to consider the findings within this report and the recommendations in Appendix A. Of particular interest on a national basis is the need for:

- Up-to-date DBS checks for staff (both retrospective and renewal of checks)
- Updated Wales Safeguarding Procedures (through all safeguarding boards) to ensure consistency practice and reporting, and benchmarking, throughout the NHS in Wales
- Robust mechanism for sharing safeguarding learning across Wales
- Improved systems for triangulation of information from concerns, incidents and claims
- Robust governance and board oversight in relation to quality and safety.

This case also highlights some positive areas, including:

- The changes to the handover process in learning disability Unit A to cover shifts in the last 24 hours as a result of this case to ensure the information shared is more robust
- A general increase in awareness and reporting of incidents throughout the health board
- The pilot of some sessions of face to face scenario based safeguarding training for staff, in addition to the statutory online learning. This can be helpful in all areas of practice, but particularly within mental health and learning disabilities, where there are high incident levels and potentially challenging safeguarding issues
- The 'values-based' initiatives to promote a more positive patient-centred care culture within the health board's hospitals resulting from the 'Trusted to Care' report. This included encouraging staff to report incidents and view care from the perspectives of patients, families and carers.

7. What next?

This case highlights the importance of consistent and robust safeguarding and governance processes which are an essential part in contributing to effective safeguarding for adults at risk. The robustness of these processes are intrinsic to the confidence that patients and their families can have in the safeguarding system as a whole. This is why the review of Wales Safeguarding Procedures through safeguarding boards is so important. HIW hopes that the content and learning from this review will be helpful in informing that process, as well as highlighting the need for the new safeguarding guidance to be delivered in a timely way.

The recommendations for Abertawe Bro Morgannwg University Health Board and Welsh Government are detailed in the following section but they have relevance for all health boards in Wales.

Appendix A – Recommendations

As a result of the findings from this review, HIW has made the following overarching recommendations which should be addressed by Abertawe Bro Morgannwg University Health Board, Welsh Government and considered by all health boards in Wales.

The following recommendations relate to Health and Care Standards 2015[37].

No.	Recommendations	Related Health and Care Standard
1	The health board must ensure the redeployment policy is consistently followed.	Standard 7.1 Workforce
2	The health board needs to consider how occupational health advice can be more clearly communicated to management staff, in order to accommodate the needs of the employee concerned	Standard 7.1 Workforce
3	The health board must ensure the suspension and special leave policies are applied consistently and all staff are clear about their correct use in relation to staff members under investigation.	Standard 7.1 Workforce
4	The health board must identify and provide sufficient resources for disciplinary investigations to ensure their timely completion.	Standard 7.1 Workforce
5	The health board must ensure there is relevant and timely clinical input to support the understanding of evidence from vulnerable patients within disciplinary proceedings.	Standard 7.1 Workforce Standard 6.3 Listening and Learning from Feedback
6	Welsh Government, through its work with safeguarding boards, needs to ensure that national safeguarding processes enable consistency of reporting to facilitate benchmarking, and information sharing across Wales.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
7	The health board should ensure there is consistency between the safeguarding strategic plan and safeguarding policies to ensure aims are clearly reflected in all documents.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

[37] Health and Care Standards 2015 https://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en

No.	Recommendations	Related Health and Care Standard
8	Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
9	The health board must ensure all staff, where required by their role, receive a DBS check and address the following: • As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check • The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff • The responsibility for conducting DBS checks for redeployed staff and volunteers is clarified within health board policies.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
10	The health board must consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Standard 7.1 Workforce
11	The health board must ensure there are clear pathways within and across delivery units to share learning and good practice from safeguarding cases. This should include whether learning from Unit A has been shared with other units.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
12	The health board needs to consider the arrangements to evaluate the effectiveness of training and supervision for DLMs. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Standard 7.1 Workforce

No.	Recommendations	Related Health and Care Standard
13	The health board must review its processes to ensure all relevant safeguarding agencies are invited to strategy meetings and are facilitated to attend, either remotely or in person.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
14	The health board needs to implement an effective way of checking the completion of the outcome actions when a safeguarding case is closed.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
15	The health board must ensure there is signposting to advocacy and support for the individuals and families affected by incidents within any of its service delivery units.	Standard 6.3 Listening and Learning from Feedback
16	The health board must ensure there is effective and timely communication with individuals and families (where appropriate) affected by incidents throughout the safeguarding process.	Standard 6.3 Listening and Learning from Feedback
17	The health board must ensure staff understand that anyone a raising safeguarding allegation should be treated seriously in all cases.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
18	The health board should consider the formal support available for any members of staff who may be affected by adverse incidents, including for staff who are the alleged perpetrators of abuse. Furthermore, the health board should consider how it enables staff to feed in to improvements to practice.	Standard 7.1 Workforce Standard 6.3 Listening and Learning from Feedback
19	The health board is required to provide HIW with an update on the actions it has taken in response to the NHS Delivery Unit report, including where actions are incomplete or ongoing.	Governance, leadership and accountability
20	The health board must rapidly improve its governance and reporting/escalation structures (including ward to Board governance) around quality, safety and clinical governance.	Governance, leadership and accountability

No.	Recommendations	Related Health and Care Standard
21	The health board must ensure there are effective arrangements and information systems in place to triangulate: • Workforce issues relevant to safeguarding, such as staff suspension, with its safeguarding processes. • Information from claims, concerns and incidents to highlight areas of concern.	Governance, leadership and accountability Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Standard 3.4 Information Governance and Communications Technology
22	The health board must ensure there are clear and effective pathways for sharing learning from safeguarding and incidents throughout the health board.	Governance, leadership and accountability Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
23	Welsh Government should consider how a more robust mechanism for sharing safeguarding learning can be developed across Wales.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk
24	The health board must progress a formal commissioning arrangement, across the three health board areas, regarding the provision, planning and performance monitoring of learning disability services provided.	Governance, leadership and accountability

Appendix B – Terms of reference

Background

HIW has been asked by Welsh Government to undertake an independent review of how Abertawe Bro Morgannwg University Health Board handled the employment of and allegations made against Mr W.

In 2016, Mr W was convicted of the murder of Mrs J. At the time of the offence, Mr W was employed by the health board as a care assistant, but had already been suspended from work pending the investigation of three separate sexual assault allegations made against him by individual patients. He worked in a learning disabilities setting run by the health board.

The health board undertook an internal review looking into the management of Mr W's employment and the handling of the three separate allegations made against him. This was an internal, desktop review, undertaken by senior individuals within the health board who were independent of the learning disability directorate.

The health board's internal review identified a number of significant issues of concern and procedural weaknesses relating to governance, recruitment, adult safeguarding, incident reporting and culture within the health board. It highlighted several areas for learning and improvement. An improvement plan outlining actions taken to date has been published alongside the report. The health board's review concluded that Mr W's future conduct and behaviour outside of his employment could not have been predicted or prevented.

In order to be satisfied that appropriate actions had been identified by the health board and that its action plan for improvement is sufficiently robust, Welsh Government has asked HIW to undertake an independent assessment to determine whether the learning and actions as a result of that review were appropriate.

In requesting the review, Welsh Government suggested a number of broad parameters. HIW has taken time to consider these views and the views of others in order to develop its own terms of reference for the independent review. This consisted of initial consideration of the documentary evidence on which the health board's review was based, and inviting discussions with other interested parties.

HIW's review methodology will consist of thorough examination and analysis of the documentary evidence. We will also collect evidence from interviews. There will be discussion and engagement with other key individuals throughout the process, and independent professional input from peer reviewers.

It is anticipated that this review will be concluded by December 2018. A report will be published at the end of the review process.

Sources of information to inform the HIW review

In order to ensure a robust and independent review, HIW will consider a wide range of information and evidence. During the course of the review, we will:

- Speak with key stakeholders and other interested parties
- Interview relevant individuals
- Examine and analyse documentation held by the health board, and other key stakeholders, pertinent to the review
- Obtain input from relevant independent peer reviewers
- Produce a public report at the end of the review detailing HIW's findings.

What the review will consider

The independent review will determine whether:

- The health board's internal review was sufficiently thorough
- The health board's conclusions were appropriate on the basis of the evidence considered
- The action that the health board has taken in light of those conclusions is adequate to ensure patient safety
- Additional or different conclusions should be reached on the basis of additional evidence considered during this review
- There is any wider additional learning for the NHS in Wales.

The areas and processes within the health board that HIW will be considering in relation to this case include:

- Staff recruitment and employment
- Incident reporting
- Adult safeguarding
- Governance and culture.

What the review will not consider:

The decisions or actions of the police or Crown Prosecution Service will not form part of this review. This is not within the remit of HIW as it is only able to investigate matters in connection with the provision of healthcare services. However, we will be seeking the co-operation of and information from South Wales Police which may assist us in our consideration of the health board's actions.

Appendix C – Extracts from health board policies

Extract from Disciplinary Policy (March 2011)

8. Procedure for Dealing with Alleged Misconduct

8.1 Where the manager becomes aware that an incident or misconduct has apparently occurred, the following procedure should be followed. It is expected that the employee will be afforded due courtesy and sensitivity at all stages, and that the procedure will be followed with appropriate promptness.

8.2 Initial Assessment

The purpose of the initial assessment is for the manager to determine, on the information available at that time, what the next appropriate course of action might be. This fact finding assessment may involve discussing the alleged incident/ misconduct with the employee as well as obtaining other, preliminary pieces of information as necessary. Following the assessment, the manager may decide that:

- No further action is necessary because there is no evidence to support the allegation that an incident or misconduct occurred.
- Given the minor nature of the misconduct, counselling is a more appropriate measure than formal disciplinary action. (Paras 6.1 to 6.5 refer).
- The Fast Track Disciplinary process may be appropriate because the individual has admitted misconduct or where prima facie evidence exists. Fast tracking can only occur in incidents where it appears that the nature of the misconduct would only warrant a verbal or first written warning.
- A formal investigation will be required, with due consideration given to the need to suspend the employee without prejudice or redeploy him/her whilst the investigation is ongoing.

8.3 Fast Track Disciplinary Process

8.3.1 The Fast Track disciplinary process allows for cases to be dealt with in a timely manner, within one month of the initial assessment unless there are exceptional circumstances. There will not be any need for a formal investigation report although a thorough examination of the known facts will take place. An investigating officer will not, therefore need to be appointed.

8.3.2 Those situations where fast tracking may be suitable are as follows:-

- Incidents that are regarded as 'Misconduct' which would normally result in either a verbal or first written warning.

- The employee against whom the allegations are made has admitted to them in full.
- Where the employee does not admit to the allegation but there is factual evidence which the employee cannot refute, i.e. there is indisputable prima facie evidence, fast tracking may take place.

8.3.3 If the manager feels that the fast track approach is appropriate, they must, in the first instance, discuss this with the HR adviser. A review of the information will be undertaken in conjunction with the manager, the employee and his/her representative and a decision taken as to whether the fast track process should be adopted. This must be agreed by all parties.

8.3.4 If the decision has been made to Fast Track then the following process should be followed:

- The manager will ensure (if not done already) that there is a written statement from the individual who reported the incident and also from the employee involved, together with any supporting information gathered.
- The Disciplining Officer will write to the employee involved asking them to attend the fast track Disciplinary Hearing, and will provide a copy of all information gathered. The employee will be given the right to be accompanied if they so wish.
- The Disciplining Officer will be supported by, an HR Advisor and professional adviser where appropriate. The employee and their representative will also be present. No witnesses will be called from either side.

8.4 The procedure for the fast track Hearing is as follows:

- Introductions are made.
- The Disciplining officer outlines the nature of the allegation(s) and advises that it (they) may result in disciplinary action.
- The Disciplining Officer confirms with the individual that he/she admits to the allegations previously stated or confirms the evidence available.
- The employee or Staff Side Representative will have the right to put forward any comments or statements relating to the incident (including any mitigation).
- The Hearing Panel may wish to question the employee.
- The Hearing Panel will adjourn briefly to discuss the outcome of the Disciplinary Hearing.
- The Disciplining Officer will then communicate the decision of the Hearing to the employee and their representative. The penalty should not exceed a verbal or first written warning.
- The Disciplining Officer will send a letter confirming the decision of the Hearing to the employee, advising them of their right of appeal. The record of any warning will be kept on the employee's personal file.

9. Formal Investigation

9.1 Where the case is not suitable for a fast track hearing, an Investigating Officer should be appointed to undertake a full investigation. The Manager must ensure that the Investigating Officer is provided with sufficient support in terms of time, administrative facilities and reallocation of their work responsibilities to be able to carry out a careful and thorough investigation in a timely manner.

Regular verbal updates on progress will be provided by the Investigating Officer to the manager and the employee and his/ her representative.

9.2 The investigation is commissioned by and conducted on behalf of the employee's manager.

9.3 The Investigating Officer will produce a factual report, and draw on his/her findings to determine whether there appears to be evidence to support the allegations being made against the employee concerned. It is not the role of the Investigating Officer to make any judgement about the case.

9.4 The report will be considered by the Manager who will make a decision about the appropriate course of action.

9.5 Where a disabled employee is subject to a formal investigation, the duty to consider reasonable adjustments should be taken into account in the context of the arrangements for conducting the investigation and, where relevant, the issues under investigation. Advice from an HR Advisor may be sought if necessary.

9.6 The Investigating Officer should normally be appointed from a different department to that in which the employee works. In certain cases it may be necessary for an Investigating Officer with specialist skills and/or knowledge to be appointed or made available for advice.

9.7 The employee must be made aware of all the allegations made against them and be interviewed as part of the investigation process. They may be accompanied by their representative at this meeting, the aim of which is to establish, impartially, all the key points pertinent to the investigation that can be provided by the employee. The employee should be allowed to offer any information that they feel is relevant during this interview as it may affect the decision about whether to proceed with a disciplinary hearing. A written record of the interview should be made and signed by the employee as an accurate record. The investigation will also make enquiries of relevant witnesses and collect documentary evidence as necessary. Such evidence must be copied to the employee and their representative.

9.8 If an employee becomes unwell during the disciplinary process, the investigation may continue, albeit in a sensitive and considerate manner. Advice from the occupational health department may be sought, if appropriate.

9.9 The Investigating Officer will be given advice on the process by an HR advisor who would not then be part of a disciplinary panel. Where the Investigating Officer

requires secretarial support, then the Manager must take this into account when instigating the investigation. However, disciplinary matters require high standards of confidentiality and the number of staff involved must be the absolute minimum to deliver a comprehensive report within a reasonable timescale.

9.10 The Investigating Officer will attend the disciplinary hearing to present his/her report and to answer any points of clarification required.

9.11 Once the investigation is complete the Investigating Officer will prepare a report of their findings, providing documentary evidence of the facts, and any witness statements and concluding whether there appears to be evidence that the alleged misconduct occurred. On receiving the Investigating Officer's report, the Manager will determine, within 10 calendar days what further action should be taken. i.e:

- no case to answer
- to proceed to a disciplinary hearing
- to proceed through an alternative procedure (for example, capability)

Where a decision is made to proceed to a disciplinary hearing, this should take place as soon as possible after the decision is made.

9.12 Where the allegation is of a potentially serious nature, in the interests of minimising unnecessary delay it may be advantageous to arrange, a provisional date for a disciplinary hearing at the outset of an investigation.

This is a practical measure that does not, in any way, attempt to prejudge whether such a disciplinary hearing will be deemed necessary.

9.13 Witnesses

9.13.1 All employees of the ABMU Health Board have a duty to co-operate with management in disciplinary proceedings. Witnesses who have provided statements should be advised of the fact that a hearing may take place and of their being required to attend.

9.13.2 The employee or their representative must make the Disciplining Officer aware of those staff they wish to call as witnesses.

9.13.3 The Disciplining Officer will arrange to call all witnesses required after having discussed and agreed these with the employee and his/her representative.

9.13.4 Witnesses are obliged to attend if requested to do so by the Disciplining Officer.

9.13.5 Arrangements will be made for witnesses to be released from their duties to enable them to attend the hearing. They may bring a representative or colleague with them for personal support if desired.

9.13.6 People not directly employed by ABMU Health Board may be invited to attend the hearing as a witness but cannot be compelled to do so.

10. Suspension from the Workplace

10.1 In some circumstances it may be appropriate to suspend the employee or to transfer the employee to another post/work pattern or to another work place on a temporary basis. Where alternatives to suspension are being considered, this would only be done following consultation with the employee and their Representative and would take into account its reasonableness in all the circumstances. LCFS / CFS Wales should always be advised of any decision to suspend or transfer an employee when the employee is under investigation by the LCFS/ CFS Wales.

10.2 Suspension is not a disciplinary penalty and is without prejudice Suspension from the workplace will be with pay, in accordance with Paragraph 10.4.1 of this Policy. Suspension may be considered appropriate where keeping the employee in the workplace after the incident/ misconduct may:

- Compound the offence.
- Interfere with or prejudice the investigation.
- Jeopardise the safety or well being of patients or employees.

10.3 If the decision to suspend is taken by the manager (in consultation with a senior HR Advisor or, where not available, another manager of equivalent seniority) the employee should be told of this decision immediately. Where possible the employee should be given the opportunity to be accompanied at the meeting when they are informed of their suspension if they wish.

10.3.1 Unavailability of a preferred representative or colleague may not, however, delay the meeting from taking place.

10.3.2 The employee should be given information regarding the support available to them e.g. Occupational Health, via the ABMU Health board's Occupational Health Service and Stress Counselling Service by their manager and their representative.

10.4 During suspension the employee must not (unless as a patient or to access sources of help e.g. to meet with their Representative) enter ABMU Health Board premises or their normal place of work without the express permission of their manager. Details of the suspension will be confirmed in writing giving the reason(s) for this course of action by the manager.

10.4.1 Pay during suspension will be calculated according to the normal duty roster worked by the employee and during this period the employee will be recorded as paid leave of absence in order to maintain confidentiality.

10.4.2 Employees who are suspended must make themselves available to attend meetings and interviews as part of the disciplinary process.

10.4.3 Where alternatives to suspension are being considered, this would only be done following consultation with the employee and their Representative and would take into account its reasonableness in all the circumstances.

10.5 If an incident occurs, or is reported out of hours and an employee's manager or an appropriate member of the HR Department is not available, an appropriate senior member of staff can make a decision to send an employee home on the basis that there is a risk to themselves and/or others if they were to stay in work. The individual will be asked to report to their manager on a specified day. This decision will not constitute suspension but is required in order that the facts of the case are reviewed as soon as reasonably possible. The employee will be recorded as on special leave and paid as per their normal shift.

10.6 The manager must ensure that the period of suspension is kept to a minimum and that the investigation takes place as swiftly as possible. The manager should review fortnightly the period of suspension, and any that continue beyond four months should be reported, together with information on the expected completion of the investigation to the Board of ABMU Health Board

Regular reports should be made to every Board detailing current suspensions and their duration. Information identifying individual members of staff should not, however, be presented in the open Board meeting.

10.7 If an employee wishes to book annual leave during the period of their suspension they must apply to the manager giving due notice. Such applications will be considered sympathetically but may reasonably be refused if the leave would delay the resolution of the disciplinary matter. Annual Leave booked prior to the suspension will be honoured and will be deducted from the employees total annual leave entitlement.

11 Procedure for reporting staff to the Independent Safeguarding Authority/appropriate professional body

11.1 All organisations, with effect from 12th October 2009, will have a legal duty to refer any information about individuals who could pose a risk of harm to children and adults at risk to the ISA who will assess the information and make a barring decision. Such referrals will include when an incident comes to light, when a member of staff has been dismissed, or resigned before dismissal.

11.2 'Harm' is stated as being physical, sexual, emotional, neglect or financial. Neglect could include a failure to act or an omission.

11.3 It will be the responsibility of the HR Advisor dealing with each individual case, or an appropriate senior manager, to report staff to the ISA. Where such a referral is made, the Head of Profession should be notified.

11.4 It will be the responsibility of the Head of Profession to contact the appropriate professional regulatory body at the point at which it is decided that there is some evidence of a concern relating to fitness to practice. The decision on when this occurs should be taken in discussion with the appropriate regulatory body.

11.5 During a period of suspension, the employee is prohibited from working in another NHS organisation without the express written permission of their manager. Where the alleged offence relates to the protection of children and adults at risk, further restrictions on employment in other sectors may be imposed by the Independent

Safeguarding Authority. The employer will take advice from ISA should this be the case.

Extract from Redeployment Policy (2003)

Scope of Policy

2.1. The policy applies to all staff who are employed on a permanent contract with the Trust whose current or future role is no longer tenable because of:-

a) changes in the provision of service delivery. This includes changes to skill mix, the contraction or cessation of a service or other organisational change which results in a reduction to the number of employees required. The policy also covers employees who are the subject of a TUPE transfer out of the NHS who wish to retain their NHS terms and conditions. TUPE transfers within the NHS do not fall within the scope of this policy

b) capability issues arising from health problems. This includes any employee who, on medical advice, is unable to remain in their current position due to a health related problem.

Reference should be made to the NHS Injury Benefits Scheme if the employee is suffering from an injury, disease or condition sustained during NHS employment.

To comply with the principles of the Disability Discrimination Act (DDA), priority consideration (including consideration of reasonable adjustments) will be given to staff whose disability, as defined by the Act, results in their continued employment in their current post becoming untenable.

c) capability issues arising from poor performance. Where it has been determined under the scope of the Trust's Capability policy that an employee should be redeployed into an alternative post although there is no automatic right for an employee under these circumstances to be considered for redeployment.

2.2 The policy is not intended to cover the needs which may arise as a result of market testing of services in accordance with 'Best Value' principles.

3. Staff consultation

3.1 The Trust is committed to full negotiations and to consult with staff side representatives over changes in service delivery and then to consult individually with all affected employees and their representatives throughout the application of this policy.

3.2 Staff are entitled to be accompanied by a trade union representative, work colleague or friend not acting in a legal capacity at any stage in this process.

3.3 Where a long term service change, such as a retraction or closure of a service, has been identified, agreement will be reached in consultation with staff side representatives to determine precise timescales for implementing this policy. This will include identification of the date of entry onto the Redeployment Register from when the active search by both parties for suitable alternative employment must commence. This period will not exceed four years.

4. Entry onto the Redeployment Register

4.1 Subject to paragraph 3.3 above, staff who are judged to fall under the scope of this policy will be placed on the Redeployment Register as soon as it is identified that their employment in their current post is no longer tenable due to one of the reasons detailed in section 2 above. Any search for suitable alternative employment within the employee's current Directorate will occur simultaneously with their entry onto the Redeployment Register and will take place under the terms of this policy.

4.2 Staff whose employment in their current post is no longer tenable due to health related issues will only be placed on the register on the advice of Occupational Health in accordance with the Trust's Sickness Absence Policy. Where it is known following Occupational Health advice that an employee will not be able to return to work in any capacity, they will have no entitlement to be considered for redeployment.

4.3 "At risk" staff are defined as "those staff whose post(s) cease to exist or whose post(s) are substantially altered as a result of service changes".

4.4 Any member of staff identified as "at risk" will be individually counselled by his/her line manager and a member of the Personnel Department where requested. The member of staff may be accompanied by a Trade Union representative, colleague or friend not acting in a legal capacity should they wish. The purpose of the counselling session(s) will be to discuss the reasons for the redeployment and to explain the purpose of the Redeployment Policy and to determine the individual's circumstances.

4.5 During the counselling session the employee will be assisted in the completion of an application to the Register (appendix1). This form should be supported with a letter from a relevant specialist adviser (e.g. Occupational Health) where appropriate, together with any other information which will assist in the matching process.

4.6 Under the requirements of the DDA, managers are required to provide details of any adjustments which may need to be considered as part of the redeployment process. Such details should be attached to the application to the Register if appropriate.

4.7 The completed form and attachments should then be forwarded to the appropriate Group Personnel Manager who will ensure that the employee does fall within the scope of this procedure. The form will then be forwarded to the Redeployment Co-ordinator.

4.8 Where there is a major reconfiguration, retraction or closure of a service which affects a group of staff, the Personnel Manager will complete a summary of the details of those 'at risk'. This summary will be sent to the Redeployment Co-ordinator.

4.9 The Redeployment Co-ordinator will compare the Trust's vacancies (proposed and advertised) against the details of staff held on the Register on a weekly basis.

5 Informal Interview

5.1 Once an initial match has been made, an informal interview should take place involving the line manager and the employee. The Personnel Manager will advise the employee's representative of the interview arrangements but the employee's representative will not be present at the interview itself. A Personnel Manager from the Directorate in which the vacancy has occurred should either be present or their advice sought prior to any decision being made.

5.2 The purpose of the interview will be to ensure that the employee meets the minimum criteria for the job, as determined by the Person Specification, or that they will be able to meet these criteria within a reasonable timescale if provided with appropriate training.

5.3 Where the employee is being redeployed as a result of a health related issue, advice must be sought from the Occupational Health department on the suitability of the post.

5.4 Unless either the manager or the employee can clearly justify that the post is not suitable, an offer of employment will be made subject to a 28 day trial period. Any extension to the trial period will be subject to agreement by both parties.

5.5 During the trial period, the employee will be provided with appropriate support and the relevant training to enable them to undertake the role. The provision of support and training will be the responsibility of the new line manager where the trial is being undertaken.

5.6 During the trial period, the employee will be paid by the department in which the trial period is being undertaken. The receiving department will also fund any additional training required.

5.7 Where an employee is redeployed successfully and is subsequently entitled to protection of earnings, arrangements will be made to ensure that the receiving department does not suffer a financial disadvantage.

6. Identification of Suitable Alternative Employment

6.1 Where a group of employees is affected by an organisational change, a list of posts which may be suitable alternative employment will be drawn up jointly by management and staff organisations and sent to the redeployment Co-ordinator. All posts on the list which become vacant will automatically be held for consideration. (See appendix 2).

6.2 In other cases, the search for suitable alternative employment will be undertaken by the Group Personnel Department and by the Redeployment Co-ordinator. On a weekly basis the requirements of individuals on the register will be reviewed against all vacancies which have become available across the Trust prior to advertisement. This will be done by checking the VF1 forms submitted for advertisement. In addition, the

Trust will ensure that each edition of the Trust's internal recruitment bulletin is made available to employees on the Register.

6.3 Should a vacancy occur which is a potential match, the vacancy will be held from advertisement for further investigation of suitability. Where a vacancy is a potential match for more than one employee on the register, the Directorate in which the vacancy has occurred will be responsible for interviewing all such candidates to select the best employee based on the candidates' suitability against the criteria laid down in the Person Specification. Where the manager is unable to determine who the 'best' candidate is following the interview, length of service may be used as a justifiable criteria to separate two evenly matched applicants. (For the purposes of length of service, staff who have taken formal career breaks will be able to have their break included in their service provided that they undertook their two week training during each year of the career break).

6.4 Employees with a disability which falls within the scope of the DDA will be given preferential consideration including the consideration of reasonable adjustments. In all other cases, the principles of the Trust's Equal Opportunities policy will apply.

6.5 In all other cases, the 'matching process' will be conducted as detailed in the framework illustrated in Appendix 3. The responsibility for co-ordinating the matching process will be with the Group Personnel department from whom the employee originates.

6.6 Should a vacancy be identified which has already been advertised, the recruitment process will be suspended and the matching process conducted as in 5.3 above unless the interviews have already been arranged and shortlisted candidates informed. Where the interviews have already been arranged, the employee will be considered on the same terms as other shortlisted candidates provided that they meet the minimum criteria laid down in the Person Specification.

6.7 The definition of suitable alternative employment will be:

- Located within six miles of the employee's home or it involves no additional travelling expenses. If the new post is at a greater distance, the fact that assistance will be given with extra travelling expenses will normally outweigh any added difficulties in travel in line with Whitley.
- Where possible at the same grade as the employee's substantive post and should carry broadly similar levels of responsibility. However, suitable alternative employment may be offered at a different grade when salary protection is offered and the individual's qualifications and ability to perform have been considered.

6.8 Protection of salary and terms and conditions of service will apply on the following basis:

In cases where the employee's job is "at risk" as a result of organisational change the Trust's Protection arrangements will be applicable.

In cases where the redeployment has resulted from an incapacity to continue in the current role due to either ill health or performance, there will be no protection of

salary. However, where the ill-health is as a result of an industrial injury which has been appropriately reported and documented, protection may apply.

Where, following discussion with staff side representatives, it has been agreed that staff falling within the scope of a TUPE transfer may be placed on the Redeployment Register, as per paragraph 2.1.a. above, there will be no entitlement to protection of salary. However, where it has become apparent that an individual does not have an identified position to transfer into, protection may be granted following discussion between senior management and staff organisations.

6.9 Should an employee unreasonably refuse the offer of suitable alternative employment on three occasions, they will be removed from the Register and will not be considered for any other suitable alternatives. In such cases, the employee's employment will be terminated with appropriate notice (see section 8 below). This decision to remove an employee from the Register will only be taken after full consideration of all the relevant factors following advice from the Group Personnel Manager. Where the employee is "at risk" due to organisational change (other than a TUPE transfer), this may result in a loss of entitlement to any redundancy payment.

6.10 Where an employee disagrees with the manager that the employment offered is suitable, the employee will have a right of appeal using the Trust's Individual Grievance Procedure.

7. Evaluation of trial period

7.1 It is vital the employee is fully supported during the trial period. This will include the provision of an adequate induction and appropriate on the job training. Progress must be actively reviewed through out the trial period.

7.2 Where there is concern by either party that the post may not be suitable for the employee, this must be discussed prior to the conclusion of the trial. All reasonable attempts should be made to ensure that the trial is successful, including the provision of additional training where necessary.

7.3 On conclusion of the trial, if successful, the employee will be confirmed in the post on a permanent basis. Where the trial has been unsuccessful and it is agreed that the post is not suitable, the employee will return to the Register subject to the agreed length of time (see section 8 below). The Group Personnel Manager must ensure that the Redeployment Co-ordinator is informed promptly of any re-entry to the Register.

8 Length of time on the Register

8.1 Where an employee has been placed on the Register due to a health related capability issue, they will remain on the register for the duration of their pay, subject to paragraph 6.9 above. Should the search for alternative employment prove unsuccessful, the employment will be terminated on the grounds of incapacity due to ill-health. The employee's notice period will run concurrently with the period of half pay.

Only in very exceptional circumstances, at the discretion of the Director of Personnel and Operations, may an individual may be permitted to remain on the register after their pay has been exhausted.

Appendix D – Interviews

The following current and former members of the health board's staff were interviewed.

Current staff (MHLD delivery unit):

- Service Director
- Nurse Director
- Head of Psychology and Therapies
- Head of Specialist Services
- Head of Nursing (Locality)
- Service Manager (Acute Assessment and Treatment Units)
- Unit Manager (Unit A)
- Quality and Safety Manager
- 11 members of staff from Unit A (registered nursing staff x3 and unregistered nursing staff)

Other current staff:

- Assistant Director of Workforce and Organisational Development
- Workforce Manager (POWH)
- Workforce Manager (MHLD)
- Assistant Director of Nursing (with responsibility for safeguarding)
- Deputy Head of Safeguarding, Corporate Safeguarding Team
- Safeguarding Specialist, Corporate Safeguarding Team
- Nurse Director (Morriston Hospital)
- Investigating officer for Mr W's case
- Disciplinary officer for Mr W's case
- Authors of the internal desktop review report (x2)

Former staff:

- Clinical Director (LD directorate)
- Directorate General Manager (LD directorate)
- Head of Nursing (LD directorate)
- Head of Nursing (Mental Health Directorate)
- Consultant Psychiatrist – Lead Clinician (LD directorate)
- Associate Clinical Director – Tier 2 Services (LD directorate)
- Associate Clinical Director – Tier 3 Services (LD directorate)
- Service Development Consultant – Tier 2 Services (LD directorate)

Former Executive Board members (ABMUHB):

- Chief Executive
- Chief Operating Officer
- Executive Director of Nursing and Patient Experience
- Medical Director
- Interim and Deputy Medical Director

Cwm Taf University Health Board and Cardiff and Vale University Health Board staff:

- Director of Nursing (until Summer 2018: Cwm Taf University Health Board)
- Assistant Director Patient Safety and Quality; Lead Nurse (Cardiff and Vale University Health Board).

Appendix E

Outline chronology of events

March 2001

Mr W started work in the health board's IT department.

July - December 2004

Mr W was on sick leave.

17 December 2004

Mr W started work at the LD directorate (unit A).

2005 - 2012

Mr W worked as a care assistant based at Unit A.

December 2011

21 December	22 December	24 December
It is recorded in the care notes that Ms X became physically and verbally aggressive towards staff and made allegations of inappropriate contact by Mr W.	It is recorded in the care notes that Ms X that Mr W had inappropriately touched her.	It is recorded in the care notes that Ms X became verbally aggressive making allegations of inappropriate conduct against Mr W.

January 2012

It is recorded in the care notes that Ms X referred to her previous allegations against a 'male member of staff' and said that she was upset that no-one believes her.

13 January	17 January	19 January	24 January
Ms X's care manager was reviewing the care plans and escalated the documented allegations of abuse to Unit Manager. A VA1 form was completed and the HON (LD directorate) was informed.	1st POVA strategy meeting (allegation 1) took place.	Mr W was placed on special leave.	2nd POVA strategy meeting (allegation1) took place. The police started a criminal investigation.

16 February 2012

The police completed interviews with 6 members of staff and Ms X. She later withdrew her allegation. The decision was made to proceed to non-criminal investigation by the health board.

March 2012

12 March

An initial assessment report (under the health board's disciplinary procedures) found no evidence additional to that identified by the police.

13 March

A Final POVA Strategy meeting (allegation 1) was held. The decision was that there was insufficient evidence to proceed with an investigation under the disciplinary procedures.

April 2012

Mr W returned to work at Unit B.

October 2012

2 October

A second allegation was made against Mr W by Ms Y, a former patient at Unit A. This allegation related to events which took place during June-July 2010.

8 October

Staff visited Ms Y to discuss the allegations. A VA1 form was completed.

12 October

1st POVA strategy meeting (allegation 2) was held. The police started a criminal investigation.

13 October

Mr W was advised about the allegation and placed on special leave until further notice.

December 2012

6 December

Having concluded the criminal investigation, the police notified the health board that the CPS would not be taking the matter further.

20 December

2nd POVA strategy meeting (allegation 2) was held and noted the decision concerning the criminal investigation. The health board would undertake an initial assessment under its disciplinary policy.

February 2013

2 February	6 February	11 February	20 February	26 February
A third allegation against Mr W was made by Ms Z during a previous inpatient stay at Unit A between May and June 2011. A VA1 form was completed.	A second DLM was appointed from outside the LD directorate.	1st POVA strategy meeting (allegation 3) was held.	The Initial Assessment report under the disciplinary policy about allegation 2 concluded that full investigation would not achieve anything further.	The second DLM sought permission for Mr W to be formally suspended.

7 March 2013

Mr W was formally suspended pending the outcome of the investigation.

12 April 2013

2nd POVA strategy meeting (allegation 3) was held. The police confirmed that they were nearing the end of their investigations and would be submitting a file to the CPS relating to all three allegations. The police confirmed that the health board's internal investigations could commence.

19 August 2013

3rd POVA strategy meeting (allegation 3) was postponed pending outcome of the CPS decision.

22 January 2014

3rd POVA strategy meeting (allegation 3) was held. The police confirmed that the file on the allegations had been passed to the CPS but their decision was not to proceed to prosecution. The police confirmed that they had significant concerns about KW. Mr W remained suspended and the health board would investigate under its own disciplinary procedures.

February 2014

5 February	10 February
It was decided that someone external to LD and MH Directorate would undertake the disciplinary investigation into the incidents.	The police confirmed that they would release all interview records and statements to be used in the health board's disciplinary investigation.

14 August 2014

A Senior Manager external to the LD directorate was appointed as the Investigating Officer for the case.

2 February 2015

The Investigating officer forwarded the draft investigation report to the health board's HR department.

25 March 2015

The finalised version of the investigation report was available.

June 2015

The agreed date for the disciplinary hearing was 30 July.

22 July 2015

A representative for Mr W requested deferment of the hearing due to Mr W's ill health.

September 2015

An occupational health assessment took place. It confirmed that Mr W was fit to attend a hearing but not to attend work.

2 December 2015W

The disciplinary hearing took place.

There was an adjournment to seek additional information about points raised by Mr W's representative during the hearing. It was planned to reconvene on 10 December but this was deferred the day before due to the need for additional enquiries.

There were subsequent difficulties in arranging a time for the continuation of the hearing when all witnesses were available to attend.

March 2016	
7 March	**30 March**
Mr W was arrested on suspicion of murder. The Disciplinary process was still to be concluded.	The Disciplinary Panel met to consider the evidence. A decision of gross misconduct was made.

April 2016	
21 April	**27 April**
A letter was sent to Mr W informing him of the outcome of the disciplinary hearing and formally terminating his employment.	A final POVA strategy meeting was held; the outcome was that all three allegations were found to be 'proven'.