Meeting Date	18th April 2019	**Agenda Item**	**5.3**
Report Title	Kris Wade Action Plan following HIW Special Review		
Report Author	Nicola Edwards, Head of Nursing - Safeguarding		
Report Sponsor	Gareth Howells, Director of Nursing and Patient Experience		
Presented by	Gareth Howells, Director of Nursing and Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This paper will advise the Committee of the Health Board Action Plan developed following the publication on the 29th January 2019 of Health Inspectorate Wales Special Review of Abertawe Bro Morgannwg University Health Board's (ABMUHB) handling of the employment and allegations made against KW		
Key Issues	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 recommendations for Abertawe Bro Morgannwg University Health Board and the subsequent Health Board Action Plan are detailed in Appendix 1. Progress in relation to the Action Plan will be monitored by the Health Board Safeguarding Committee.		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • **NOTE** the contents of this report and the associated Action Plan.

HEALTHCARE INSPECTORATE WALES KW SPECIAL REVIEW AND ACTION PLAN

1. INTRODUCTION

This report provides an overview of the recent Healthcare Inspectorate Wales Special Review of Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against KW and the Action Plan developed in response to the Recommendations.

2. BACKGROUND

Between 2011 and 2013 three patients within the Heath Board's Learning Disability (LD) Directorate made allegations of sexual abuse against the same member of staff (KW). In 2016, KW was arrested and convicted of murder, at the time of the arrest, KW was still a Health Board employee. KW had been suspended from work in 2012 pending the outcome of an internal disciplinary investigation following the abuse allegations. In July 2017 an internal desktop review of documentary evidence concluded, this 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 KW's actions could not have been 'predicted or prevented'.

Healthcare Inspectorate Wales (HIW) independent review of the Health Board's actions that was published on the 29th January 2019 found that the decision to undertake a review that only considered documentary evidence meant that the effectiveness of the review was limited. Whilst HIW reported that the Health Board's conclusions were not unreasonable, based on the limited evidence considered, the conclusion that KW's actions outside of his employment could not have been predicted or prevented were felt not to be based on evidence that either supported or refuted this. HIW stated that having considered a wider range of evidence, there was nothing in training, supervision or occupational health records that would have indicated KW was unsuitable to work in a care setting.

HIW's review considered how the allegations against KW 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 KW from clinical duties. Whilst the safeguarding procedures were followed, in the latter part of the safeguarding process in this 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. This process took an excessively long time, it was noted that the Health Board did not provide any additional resources to support the disciplinary investigation.

HIW identified weaknesses in the Health Board quality and safety governance arrangements and noted this had been highlighted previously in other national reports (including Trusted to Care in 2014). Acknowledgement was given to changes to improve the Health Boards governance and reporting structure, both in terms of the escalation of concerns to Board level and the sharing of Learning at an operational level. However, HIW expressed a concern that progress has been slow, stating the governance structures within the Health Board relating to quality and safety are still not clear. HIW is concerned that this does not give assurance about the quality of current processes for scrutinising safeguarding concerns and that the Board may not be sufficiently sighted on what is happening at operational level.

HIW also noted that KW did not have a Disclosure and Barring Service (DBS) check when employed. They also found that there were a number of employees within the Mental Health and Learning Disability Directorate that did not have a DBS check as their employment had predated the requirement for those checks. DBS checks are also not updated on a regular basis. This, they state is an unacceptable safeguarding risk.

The Review noted that the Wales Safeguarding Procedures are currently under review, recognising the importance of this work. Acknowledgement was given to the need for this work to be progressed quickly to ensure that Wales has an effective and consistent approach to adult safeguarding.

HIW reported 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.

3. GOVERNANCE AND RISK ISSUES

Progress against the Action Plan in response to HIW Special Review will be reported to and monitored by the Health Board Safeguarding Committee which in turn will be reported to the Quality and Safety Committee.

4. FINANCIAL IMPLICATIONS

Safeguarding is a core duty of care for the Health Board. Financial implications to meet the statutory safeguarding requirements are within existing budgets

5. RECOMMENDATION

Members are asked to:

- **NOTE** the contents of this report and the associated Action Plan.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	X	**X**		**X**	**X**		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		X					
Quality, Safety and Patient Experience							
N/A							
Financial Implications							
Financial implications to meet statutory safeguarding requirements are within existing budgets							
Legal Implications (including equality and diversity assessment)							
The Health Board has a statutory responsibility to make arrangements to protect and safeguard the welfare of children, young people and adults at risk.							
Staffing Implications							
N/A							
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)							
Improve Population Health through prevention and early intervention							

Report History	N/A
Appendices	Action Plan in Response to the Health Inspectorate Wales Special Review of Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against KW.