SUMMARY REPORT

ABM University Health Board

Quality and Safety Committee

Date of Meeting: 17th August 2017
Agenda item: 4.3

Report Title
Desktop Review Lessons Learned Report

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Purpose

The purpose of this paper is to inform the Quality and Safety Committee on the findings and action plan from the Desk Top Review Lessons Learned exercise.

Decision
Approval X
Information X
Other

Corporate Objectives

<table>
<thead>
<tr>
<th>Corporate Objectives</th>
<th>Healthier Communities</th>
<th>Great Patient Outcomes &amp; Experiences</th>
<th>Sustainable &amp; Accessible Services</th>
<th>Strong Partnerships</th>
<th>Fully Engaged &amp; Skilled Workforce</th>
<th>Effective Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Executive Summary

In March 2016 an employee of the Health Board, Mr Kris Wade, was arrested and later convicted on a charge of murder. The circumstances of the crime were unconnected and outside of his employment.

At the time of his crime, he was suspended from his employment in relation to allegations of sexual assault relating to former learning disability patients.

Since Mr Wade’s conviction, a number of questions have been raised internally and by interested external parties about processes followed by the Health Board when the allegations of sexual assault were first raised in 2012.

The Health Board commissioned a review to consider:

- Mr Wade’s employment history, including a review of the relationship between Kris Wade and his father, the then Mental Health and Learning Disabilities Clinical Service Director, with regards to potential conflicts of interest
- The management of allegations raised by patients
- The health Board Governance processes
- Opportunities for learning and improvement
### Key Recommendations

To receive the completed securely redacted lessons learned Desktop Review Report (*Appendix 1*)

To receive the formulated Action Plan, which includes progress against the actions. (*Appendix 2*)

To note the update on dates and times with relation to Desk Top Action Log completion and final update dates.

### Assurance Framework

The Health Board is reporting progress against this Action Plan through the Board’s Workforce and Organisational Development Committee and the Quality and Safety Committee.

### Next Steps

To complete the outstanding actions of the review.
SITUATION

The purpose of this paper is to share with the Quality and Safety Committee Redacted the securely redacted and Action Plan from the Desktop Review and Lessons Learned Report.

BACKGROUND

In March 2016 an employee of the Health Board, Mr Kris Wade, was arrested and later convicted on a charge of murder. The circumstances of the crime were unconnected and outside of his employment.

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- The management of allegations raised by patients
- The Health Board Governance processes

Opportunities for learning and improvement
ASSESSMENT

The scope of this review was determined by taking into consideration a number of internal factors and representations made externally to the Health Board by Welsh Government representative and other interested parties. The review has considered the following specific areas:

- Employment history
- Management of Allegations Raised by Service Users
- Governance Processes
- Lessons Learned and Actions Undertaken

RECOMMENDATIONS

The report emphasised the relevance of the Health Boards Values and Behaviours Framework throughout.

The report specifies a number of findings, which has resulted in the formulation of an action log against key finding headings:

- Recruitment Processes
- Safeguarding Processes
- Incident reporting and Escalation Procedures
- Culture and Staff Attitude
- Patient Experience
- Restructure and Governance

ACTIONS

A Desktop Review and Lessons Learned Action Log (Appendix 2) was created, as a result of the review. This action log includes 18 actions against the key findings specified above.

As of August 2017, fifteen actions have been completed and three actions are outstanding.

Personal Relationships at Work Policy

Due to an extensive consultation period for the Personal Relationships at Work Policy, the revised date for ratification of this Policy is 25th of September, at the Health Board Partnership Forum.
Expected completion: September 2017

The participation in the all-Wales review of vulnerable adults and children policies

The scope of the audit being conducted by the Cardiff and Vale Safeguarding Board is extensive.
Expected completion: Q3 2018
To centralise Human Resource Investigations
An option appraisal paper has been written for the consideration of the Executive Team.

NEXT STEPS

This paper including an update on completed actions will be presented to the Workforce and Organisational Development Committee in September 2017.

This paper including an update on completed actions will be presented to the Quality and Safety Committee in October 2017.
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Health Board
Lessons Learned
Desk Top Review

Abertawe Bro Morgannwg University Health Board

Report authors:

August 2017
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Executive Summary</td>
<td>3 - 6</td>
</tr>
<tr>
<td>2. Background</td>
<td>7</td>
</tr>
<tr>
<td>3. Review Scope</td>
<td>8 - 9</td>
</tr>
<tr>
<td>4. Overview</td>
<td>10 - 25</td>
</tr>
<tr>
<td>7. Findings</td>
<td>26 - 38</td>
</tr>
<tr>
<td>8. Conclusion</td>
<td>38 - 39</td>
</tr>
<tr>
<td>9. Lessons Learned and Service Improvements</td>
<td>39 - 46</td>
</tr>
</tbody>
</table>
CONFIDENTIAL
KW Review Report

Executive Summary

In March 2016 an employee of the Health Board, Mr Kris Wade, was arrested and later convicted on a charge of murder. The circumstances of the crime were unconnected and outside of his employment. At the time of his crime he was suspended from his employment in relation to allegations of sexual assault relating to former learning disability patients.

Since Mr Wade’s conviction a number of questions have been raised internally and by interested external parties about processes followed by the Health Board when the allegations of sexual assault were first raised in 2012. The Health Board commissioned an internal review to consider the following;

- Mr Wade’s employment history, including a review of the relationship between Kris Wade and his father, the then Mental Health and Learning Disabilities Clinical Service Director; with regard to potential conflicts of interest
- The management of allegations raised by patients
- Health Board Governance processes
- Opportunities for learning and improvement.

Main Findings

The review concludes there were a number of issues relating to Health Board processes and responses to the allegations that needed to be improved. The review does not however consider that the issues identified could have otherwise predicted or prevented Mr Wade’s future conduct and behaviour outside of his employment. The review concludes that notwithstanding the delays and issues identified, all allegations were referred to the Police who conducted criminal investigations. The
decision not to prosecute Mr Wade was a decision made by the Crown Prosecution Service, following which internal disciplinary proceedings were initiated. Whilst there were delays in reaching a final conclusion of dismissal, Mr Wade remained suspended and away from his employment and patients whilst proceedings took place.

Despite police being informed of all sexual abuse allegations, the review concluded that the Health Board’s internal reporting procedures had not been followed robustly enough. This did not relate to any deliberate attempt to conceal the allegations, but was more a reflection of a wider culture within certain healthcare settings to base actions on the believability of patients, rather than the use of safeguarding processes.

The review found that the Clinical Service Director took no part in any of the investigations into allegations involving his son Kris Wade. The review also found no written evidence that suggests the Health Board’s management of investigations involving Kris Wade were overtly influenced by the Clinical Service Director. However, it is not possible to say whether the fact the relationship existed could have had a bearing on the decision-making of others, either consciously or sub-consciously. The fact that the Health Board’s reporting procedures were not followed robustly enough, leaves the decision-making process of those involved open to criticism and lack of candour.

**Learning and improvements**

Mr Wade was first employed by the former Bro Morgannwg NHS Trust in 2001. Since that time there have been a number of improvements in processes including the establishment of the NHS Wales Shared Service Partnership (NWSSP) which has a robust standard operating process for recruitment.
Other improvements include revisions by the Health Board to its internal Safeguarding procedures (formally known as Protection of Vulnerable Adults, POVA). The Designated Lead managers (DLM’s) responsible for the oversight of the safeguarding process now have more in-depth mandatory training and formal supervision to increase their competency. Families are also now involved in safeguarding strategy meetings. An increase in the number of safeguarding referrals being made within the now Mental Health and Learning Disability Service indicate a positive cultural change with regard to patient safeguarding.

Improvements have also been made to the Health Board’s electronic incident reporting system. In addition, in January 2015, the Health Board established a Serious Incident Investigation Team with responsibility for monitoring new incidents, ensuring reporting to Welsh Government, where appropriate, is undertaken without delay. The team of investigators also provide a central/corporate oversight of serious incidents/allegations from an independent perspective.

Other improvements by the Health Board over the last three years include the development and implementation of our core values which underpin the way the Health Board cares for each other and our service users.

The Health Board has introduced a variety of different mechanisms, making it easier for staff, patients and relatives to raise concerns and receive a timely response. These include; improved complaints handling processes i.e. ‘Let’s Talk’, ‘Friends and Family’, ‘Care Opinion’ and the introduction of Patient Advisory Liaison Services.

The Health Board’s service management structure has also been revised, with clearer governance structures in place. This change has resulted in the development of the newly amalgamated Mental Health and Learning Disabilities
Service Delivery Unit which is divided into three locality teams. Each locality has a senior locality manager and a clearly defined governance structure which reports up to the senior management team of the service. The senior management team in turn report to the Board’s Quality and Safety Committee to give assurance about its services, ensuring issues are dealt with locally where appropriate but escalated and supported corporately when necessary. In addition, the service now has a dedicated Quality and Safety Team.

The Health Board is also in the process of agreeing and implementing a ‘Relationship Policy’ which provides advice and guidance to managers when dealing with matters of staff employment when friends and family are involved. The final stages of this policy are currently out for consultation. The policy is expected to be operational in the autumn of 2017.

Standardised quality assurance audit tools are now used across the Health Board using the Health Care Standards and are undertaken on a monthly basis. The Mental Health Learning Disability Service now have a programme in place for Multi Disciplinary Team ‘15 step challenges’ across all services.
1. **BACKGROUND**

Kris Wade was first employed by the former Bro Morgannwg NHS Trust in 2001. He remained employed by Abertawe Bro Morgannwg University Health Board (ABMU) when the Health Board formed in 2009 as a result of NHS Wales’s re-organisation of former Trusts and local Health Boards. In March 2016 Kris Wade was arrested on suspicion of murder and later convicted and sentenced for this offence to life imprisonment on 22 September 2016. Whilst on remand and awaiting trial Kris Wade was dismissed for gross misconduct in April 2016.

Prior to Kris Wade’s arrest for murder in 2016, three separate allegations of sexual assault dating between July 2010 and December 2011 were made against him. These allegations were reported by former female ABMU learning disability patients. All three allegations were referred to South Wales Police for investigation but no criminal charges were brought.

At the time of Kris Wade’s arrest in March 2016 he was already suspended from his employment with ABMU, pending the outcome of the Health Board’s internal disciplinary process in relation to the allegations raised, following conclusion of the police investigation.

Following Kris Wade’s dismissal and conviction for murder, ABMU Health Board commissioned an internal review to consider his employment history with specific regard to the management of the allegations raised against him by service users. The purpose of the review is to consider the processes followed by the former Bro Morgannwg NHS Trust, the Health Board and the timeliness of the actions taken. The purpose of this review is to identify where lessons can be learned and improvements made.
2. REVIEW SCOPE

The scope of this review was determined by taking into consideration a number of internal factors and representations made externally to the Health Board by Welsh Government representative and other interested parties. The review has considered the following specific areas:

Employment History

- Review of positions applied for under the former Bro Morgannwg Trust and the application process followed; Vacancy, selection, recruitment, references, Disclosure Barring Service/Criminal Records Bureau Check (DBS/CRB).
- Review of circumstances surrounding redeployment to the role of Health Care Support Worker in 2005 within the former trust
- Review of any performance or conduct management issues throughout employment
- Review of the relationship between Kris Wade and the then Clinical Service Director, with regard to potential conflicts of interest

Management of Allegations Raised by Service Users

- The risk assessments and actions undertaken with regard to Kris Wade when allegations were raised
- Review of the HR processes followed when each allegation was raised
- Review of external referrals made to Police and Welsh Government
- Review of the internal investigations/disciplinary process including timings
Governance Processes

- Review of the former Learning Disabilities Directorate management of these incidents including any escalation to corporate management and communications between the directorate and the Health Board
- Review of Datix reporting
- Review of safeguarding reporting
- Review of Protection of Vulnerable Adult process (POVA)
- Review of communication with Welsh Government
- Review of communication with other external agencies
- Review of the communication with service users and families
- Review of the collation of information and documentation from various processes

Lessons Learned and Actions Undertaken

- Review of what learning has been identified
- Review of the actions undertaken to implement lessons learned

On the basis that all three allegations raised by former service users were referred to and investigated by South Wales Police, this review did not consider a causative link existed between any lessons learned on behalf of the Health Board and the actions of Kris Wade in the community. The review did however consider the timeliness and effectiveness of the communication between both organisations when allegations were first raised.
3. OVERVIEW

Employment History

4.1 Kris Wade was first employed by former Bro Morgannwg NHS Trust in March 2001, he commenced his employment on 19 March 2001 as a trainee developer in the Information Management and Technology Directorate (IM&T), based at Neath General Hospital IT Department.

4.2 The contract of employment was a fixed 6 month full time post, due to end 14 September 2001. Kris Wade’s HR folder contains a letter stating he successfully completed his probationary period on the 19 June 2001. Kris Wade’s employment ended on 14 September 2001; however he was afforded an honorary appointment in order to complete a software development project as part of his degree. The honorary appointment commenced on the 24 September 2001 with an end date of 1 June 2002.

4.3 Kris Wade’s application form for the fixed term post is dated 8 March 2001 and only contains three lines of supporting information. Also included is a request for pre-employment screening checks which pre-dates his application form by 1 day (7 March 2001). Kris Wade’s HR folder also contains two separate character references both dated 30 January 2001, and both addressed to the [Redacted]. Kris Wade’s staff requisition form is marked to indicate no Criminal Records Bureau (CRB) checks were required for this post.

4.4 No further employment information is held in Kris Wade’s HR folder until October 2004 where there is a letter from the Occupational Health
Department stating he had been off work since the 2 July 2004 with “[redacted]”. The presence of this letter, addressed to the Information Management Directorate, suggests Kris Wade was by this time re-employed by the former Trust in a substantive role within IM&T. There is however, no record in Kris Wade’s HR folder how he came to be re-employed, under what contract and in what capacity. No information regarding application or recruitment is held.

4.5 The documentation in Kris Wade’s folder identifies that he was, by 2004, employed by the former Bro Morgannwg Trust within IM&T. In October 2004 Kris Wade’s sickness was reviewed where it is highlighted he had “exhausted” his sickness entitlement. By December 2004 the occupational health department was supporting Kris Wade’s redeployment into the Learning Disabilities Directorate. The Occupational Health Department states “[redacted]”.

[Redacted]
4.7 Kris Wade’s HR folder contains a vacancy form, dated 10 January 2005, for the post of Nursing Assistant (Grade B) based at [redacted]. The form states that Cardiff Local Health Board had made funds available for additional staffing and the post was to be filled from the redeployment register. The section of the form relating to CRB checks was marked to show that an enhanced CRB disclosure was required prior to appointment; however no person specification and job description are attached. The form is signed and dated by the manager, manager and the manager all on the same day.

4.8 However, despite the instruction on the form for an enhanced CRB check, the review team having now made enquiries, cannot find evidence that a CRB check was undertaken by the former Bro Morgannwg Trust. Kris Wade’s HR folder does not have any record of when the check was completed or what the result of the check was. Additional enquiries with former Bro Morgannwg Trust Human Resources employees identified the existence of an Excel password protected database at that time, where details of all CRB checks undertaken for the Trust’s employees were held. No record of a CRB check for Kris Wade during the duration of his employment can be found. Further enquires have been made with the Disclosure and Barring Service to identify what, if any, checks Bro Morgannwg have requested since 2001, and also any enquires since by ABMU Health Board. At the time of writing this report no response has been received.
4.9 Review of Kris Wade’s record of employment has not identified any matters of concern relating to his performance.

4.10 Kris Wade worked as a Care Assistant based at [redacted] between 2005 and 2012. In December 2011, allegations of sexual assault were raised against Kris Wade by a female patient of [redacted]. In response to the allegations, Kris Wade was placed on special leave on 18 January 2012 whilst police and internal Health Board investigations were undertaken. The reason documented for special leave is with regard to concerns surrounding Kris Wade’s wellbeing.

4.11 South Wales Police informed the Health Board on the 16 February 2012 that no case would be referred to the Crown Prosecution Service and no further action would be taken. On the 16 February 2012 the Health Board commissioned an initial assessment under the All Wales Disciplinary Policy to consider whether a further investigation was required. On the 12 March 2012, the investigating officer produced a fact finding report which concluded that nothing different from the police investigation had been identified and no further investigation was required.

4.12 On the 4 April 2012 Kris Wade returned to his [redacted] post in an alternative learning disability setting ([redacted]) as he was unable to return to [redacted] as the service user who raised the allegation was still in residence.

4.13 On the 2 October 2012, further allegations of sexual assault by Kris Wade were raised by another female service user, stating she had been
sexually assaulted by Kris Wade whilst a resident at [redacted] in 2010. On the 13 October 2012 Kris Wade was contacted by telephone and advised he was being placed on special leave as a result of the new allegations made. The matter was referred to South Wales Police who undertook their own investigations. On the 6 December 2012, South Wales Police advised the Health Board that the matter would not be taken forward and no further action would be taken. On 20 December 2012 the Health Board commissioned an initial assessment under the All Wales Disciplinary Policy to consider whether further investigation was required.

4.14 On the 20 February 2013, the initial assessment concluded that whilst there was some evidence to support the allegation, there was more evidence against. On this basis it was concluded that no further investigation would be required. However, on the 2 February 2013 a third allegation of historic sexual abuse from another former female [redacted] was made. On the basis of the third allegation Kris Wade was suspended from duty on the 7 March 2013 having not returned from his period of special leave. South Wales police were advised of the allegation and were part of the POVA process.

4.15 In June 2013 South Wales Police informed the Health Board a file of evidence had been submitted to the Crown Prosecution Service (CPS) relating to the allegations made. In January 2014 South Wales Police advised that papers relating to the allegation had been submitted to the CPS who in turn decided the evidence did not pass the evidence code test. The police informed the Health Board they had challenged the decision of the CPS not to prosecute but the decision was unchanged.
CONFIDENTIAL
KW Review Report

No further action was taken by the police; they did however express significant concerns about Kris Wade.

4.16 On the 6 February 2014 the Health Board informed Kris Wade that an internal disciplinary investigation was to be undertaken. Kris Wade remained suspended whilst the Health Board conducted their investigations. On the 26 March 2015 the final disciplinary investigation report was submitted to the disciplining officer where a decision to hold a disciplinary hearing was made.

4.17 In December 2015 disciplinary proceedings were commenced and on the 21 April 2016, Kris Wade was dismissed from his employment after a finding of gross misconduct. However, Kris Wade was by this point in custody on remand having been arrested on the 7 March 2016 on suspicion of murder.

Allegations Raised by Service Users

Allegation 1

4.18 On [redacted] 2011 service user ZZ, who was [redacted], informed night staff that she had previously been assaulted by a member of staff. Registered staff made the following entry in her medical records; “[redacted]”. In addition, [redacted] was provided. The review team has established no further action or escalation occurred with no VA1 completed or Datix incident raised.
4.19 On the 2011 service user ZZ made allegations of concerning Kris Wade. Night staff documented the conversation in her medical records and . The review team has established no further action or escalation occurred with no VA1 completed or Datix incident raised.

4.20 On the 2011 service user ZZ is said to have become . The allegation is documented in her medical records where the reporter documents, “. In addition was provided. The review team has established no further action or escalation occurred with no VA1 completed or Datix incident raised.

4.21 On the 2011 service user ZZ was reported in the nursing notes to have become making allegations against a member of staff Kris Wade alleging he had . The entry states, ZZ keeps changing her allegations and that "". The entry states that ZZ wants to report Kris Wade and speak with a female member of staff. The entry does not state whether this occurred. The review team has established no further action or escalation occurred with no VA1 completed or Datix incident raised.

4.22 On the 2012 service user ZZ verbally raised concerns with a member of staff relating to allegations against Kris Wade. No record of
these concerns/allegations are made in ZZ’s clinical records. The review team has established no further action or escalation occurred with no VA1 completed or Datix incident raised.

4.23 On the [redacted] 2012 ZZ’s [redacted], whilst reviewing her nursing care plans, identifies the allegations documented in [redacted] 2011 and escalates the concerns to the [redacted] who completes and submits a VA1. The VA1 however, only documents the allegations raised by ZZ on the [redacted]. In addition to the VA1, the [redacted] was informed. On the [redacted] 2012 a POVA threshold assessment was undertaken by the [redacted] where it was assessed that threshold had been met. The first strategy meeting took place on the 17 January 2012.

4.24 Kris Wade remained in work until the 19 January 2012 where he was then placed on special leave because of concerns around his wellbeing [redacted]. A Datix incident was not however created until the 20 January 2012 and was graded ‘minor’ as defined by Welsh Government incident framework guidelines.

4.25 On the 24 January 2012 the first POVA strategy meeting was held, the outcome of which was that South Wales Police would undertake further investigations.

4.26 On the 26 January 2012 a ‘Serious Incident’ notification was sent to Welsh Government. This was acknowledged by Welsh Government on the 27 January 2012.

4.27 On the 16 February 2012 South Wales Police advised officers had interviewed 6 staff members and service user ZZ and that ZZ had
withdrawn the allegation, refusing to attend court if requested to do so. The police advised they would not be putting the case forward to the Crown Prosecution Service. However, following confirmation from the police that no further action was being taken a meeting was held with Kris Wade on the 22 February 2012 (7 days later) where managers reviewed his current period of special leave and offered him opportunities to return to work in a non clinical role whilst the criminal investigation was being undertaken. In addition, the Health Board commissioned an initial assessment under the ‘All Wales Disciplinary’ policy.

4.28 On 12 March 2012 an initial assessment report did not find anything different to the police investigation and no further investigation was required. Despite this conclusion, the question on the paperwork of whether there is to be an investigation is marked ‘yes’. The review team has not had sight of any terms of reference or scope with regard to the remit of the initial assessment. A further strategy meeting was held on 13 March 2012 to officially receive the initial assessment report where it was agreed that no further action would be taken, on the basis there was insufficient evidence to proceed. The review team notes the document is entitled ‘Notes Re Fact Finding for POVA Investigation – ZZ’. The policy identifies a distinct difference between an initial assessment under the All Wales Disciplinary policy and any investigations commissioned under POVA. No differential appears to have been drawn between the processes.
4.29 On 4 April 2012 Kris Wade returned to work at an alternative setting as service user ZZ was still unwell. Kris Wade worked from this time forward at [redacted] which is another learning disabilities care environment.

Allegation 2

4.30 On [redacted] 2012 former [redacted] YY sent a text message to an [redacted] Nurse reporting she had been sexually assaulted when at [redacted] by a [redacted] known as ‘Kris Wade’ who was working on the unit. YY was a [redacted] between [redacted] 2010. The member of staff contacted the [redacted] who reported the matter to the Health Board the following day in addition to contacting the police and social services for advice. No VA1 was submitted at this point with staff instead making arrangements to visit YY on the [redacted] 2012 to discuss the allegations. A VA1 was subsequently raised on 8 October 2012.

4.31 On the 12 October 2012 a POVA strategy meeting was held where police agreed to investigate. Kris Wade was subsequently advised on the 13 October 2012 of the situation and placed on special leave until further notice. The review team considers there was a delay in removing Kris Wade from the workplace after the second allegation was made, allowing him to work a further 4 shifts; 7, 8, 9 and 10 [redacted] 2012. The rationale unpinning this decision is later documented in an initial assessment report under the All Wales Disciplinary policy dated 20 February 2013, where it states on page 3, “Following a risk assessment it was agreed that Kris Wade would be allowed to work his four night
shifts that he was down to work from the 2012 as the female service user who was living at the setting at the time did not require any support with her personal care……..

4.32 A Datix incident report was submitted on the 14 October 2012 graded minor, 12 days after the allegation was made. A serious incident form was then completed by the dated 2 November 2012; however, there is no record this was submitted to Welsh Government. Health Board records show no record of acknowledgement from Welsh Government.

4.33 On the 6 December 2012 South Wales Police notified the Health Board that the CPS would not be taking the matter forward and that no further police action would be taken. A reconvened strategy meeting was held on the 20 December 2012 where police shared the findings of their investigation. The police advised the POVA group they had submitted their reports to the CPS, but advised that the case would not be taken further. The POVA group decided assessment under the All Wales Disciplinary Policy was required and would be undertaken by the .

4.34 On the 20 February 2013 submitted her initial assessment report concluding whilst there was some evidence to support the allegation made by ZZ, there was more evidence that did not support the allegation. The initial assessment recommends a decision regarding whether or not a full investigation under the All Wales Disciplinary policy would be required, but states “she would struggle to see what a full investigation would identify that this initial assessment and the full investigation by the police haven’t identified”. The review team have not found evidence any further investigation was commissioned or the
rationale for the decision not to. Whilst the review team acknowledges the conclusions of the initial assessment, a third and completely separate allegation of indecent assault was made against Kris Wade; this allegation was made by service user QQ on the [redacted] 2013. The fact a third and separate allegation had been made by the time the initial assessment into the second had been concluded, should have triggered a further full investigation. The conclusion of the initial assessment into the allegation does not make reference to allegation three.

**Allegation 3**

4.35 On the [redacted] 2013 [redacted] inpatient QQ disclosed to staff she had been sexually assaulted by Kris Wade during a previous admission to [redacted] between [redacted] 2011. On this occasion staff [redacted] created an incident and a VA1 was completed within one hour of the allegation being made.

4.36 On 6 February 2013 the POVA [redacted] formally requests to the [redacted] that a new [redacted] be appointed from outside of the Learning Disability Directorate. Subsequently [redacted] for Mental Health was asked to take over responsibility. On 11 February 2013 the first strategy meeting was held in respect of the allegations raised by QQ. South Wales Police attended the meeting and informed that a criminal investigation would be undertaken.

4.37 On the 26 February 2013 the [redacted] sought permission from the Health Board’s [redacted] for Kris Wade to be formally suspended. On 7 March 2013 Kris Wade was formally suspended from duty pending the outcome of the ongoing investigations.
4.38 On 12 April 2013 a second strategy meeting with regard to allegation 3 was held. At the meeting South Wales Police advised they were nearing conclusions of their investigation and that they were likely to be submitting a file to the Crown Prosecution Service (CPS) relating to all allegations made by the three separate service users. During the meeting the police advised the Health Board that any internal investigations could commence with immediate effect and that Health Board internal processes did not need to be postponed pending the outcome of the police investigation. By this time a formal letter of complaint had also been submitted by [redacted] of QQ.

4.39 In August 2013 a planned third strategy meeting due to take place on the 19 August 2013 was postponed pending the outcome of the CPS decision. The third strategy meeting was not reconvened until the 22 January 2014. At this meeting South Wales Police apologised for the length of time the investigation had taken. The police reported the investigations into allegation 1 and 2 had been concluded and would not be progressed due to insufficient evidence. However the police advised allegation 3 had been presented to the CPS but a decision not to take further action had been taken and that charges would not be brought at this time. The police also advised the case had been referred via the charging appeal process and further reviewed by a senior Crown Prosecutor who did not feel it would be appropriate to overturn the original decision. The police did however emphasise that they had significant concerns regarding Kris Wade.

4.40 On 5 February 2014, [redacted] sought and was given confirmation that a person external to both the Mental Health and Learning Disabilities
Directorates had been asked to undertake the investigation into the alleged incidents.

4.41 On 10 February 2014 South Wales Police wrote to stating they would release all Police interview records and statements to be used in the internal disciplinary investigation.

4.42 On 14 August 2014, the internal investigator appointed to the case, wrote to Kris Wade, who was suspended and not in work, confirming that she would be undertaking the investigation. The estimated date for the conclusion of the process was not known.

4.43 On 2 February 2015 a draft investigation report was submitted to the Human Resources department. On 25 March 2015 the final disciplinary report was submitted by the internal investigator. The first proposed date for the Internal Disciplinary hearing was set for 29 June 2015 however this did not go ahead as the Investigating Officer was not available.

4.44 On 22 July 2015, the representative for Kris Wade sent an email to request a deferment in the hearing scheduled for 30 July 2015, due to Kris Wade’s ill health. On 8 October 2015 the Occupational Health Department wrote a letter declaring Kris Wade fit to attend a hearing but not to attend work. Measures were to be put in place for Kris Wade due to and he was to be accompanied and supported by another individual during the hearing. The Occupational Health Department stated a reasonable period of notice should be given to Kris Wade before a hearing takes place.
4.45 On 2 December 2015 the Disciplinary hearing process commenced. The hearing was then adjourned pending receipt of additional information. It was planned to reconvene the panel on 10 December 2015. [REDACTED] officer [REDACTED] emails the [REDACTED] representative to confirm that the rearranged hearing would not take place on 10 December 2015; the reason cited was that the panel met on the 8 December 2015 and “following deliberations it was felt there were some pieces of the jigsaw that needed to be completed, intention is to reconvene full hearing calling three [REDACTED] as witnesses and the [REDACTED].

4.46 On 21 December 2015 Kris Wade was again assessed regarding his fitness to attend a hearing. Following this assessment HR were instructed to arrange a reconvened hearing to include calling a further 4 witnesses. Meetings to be arranged after 11 January 2016 due to Disciplining Officer being on annual leave. Due to difficulties in coordinating the meeting no further meeting was arranged prior to Kris Wade’s arrest.

4.47 On 7 March 2016 Kris Wade was arrested on suspicion of murder.

4.48 On 23 March 2016 there was a telephone conversation between [REDACTED] (POVA Team) and [REDACTED] a Governance Lead [REDACTED] regarding progressing the case. [REDACTED] updated that the disciplinary process was not concluded but the staff member involved was no longer available for work as he was by then on remand in prison awaiting criminal trial. [REDACTED] advised there were implications for the closure of the POVA cases and it required a reconvened strategy.
meeting to discuss. There was also a need for a replacement to be identified as the original was no longer available.

4.49 On 24 March 2016 a Senior Nurse agreed to take over as the conflict of interest had by then been removed as the Clinical Service Director had retired.

4.50 On 30 March 2016 the Disciplinary panel met to update. Panel members have confirmed this as the date a decision was made regarding a finding of gross misconduct. On 21 April 2016 a letter setting out the outcome of the Disciplinary hearing was sent to Kris Wade in prison.

4.51 On 27 April 2016 there was a POVA strategy meeting where all three cases were reviewed together and the outcome was confirmed as `Proven`.

4.52 By August 2016 all individual cases involved in the incidents had been assessed to determine feedback method. One individual had proceeded and the family declined individual contact. One service user received direct feedback in the presence of their family. Clinical advice was sought for the third individual with consideration of method and timing of feedback. The has deferred this feedback until concrete information can be provided to this individual on re-dress.
5 FINDINGS

5.1 Kris Wade’s first employment with the former Bro Morgannwg NHS Trust was obtained with a standard application form used at that time but only contained three lines of supporting information. The application lacks adequate supporting information for the post. In addition there is a documented request for pre-employment screening checks that pre-dates the application form by 1 day. This would indicate that the application filed in Kris Wade’s employment record was completed in retrospect and that a decision to offer employment may have already been made by this point. In addition, both character references filed in Kris Wade’s employment record are not addressed to any member of the organisation or in fact written for any NHS application. The references pre-date the application by three months.

5.2 Kris Wade’s employment record shows that following his honorary appointment in September 2001 further full time substantive employment was offered by the former Bro Morgannwg NHS Trust and accepted by Kris Wade, however there is an information gap between September 2001 and July 2004 where no information is held regarding how Kris Wade came to secure a full time substantive contract, in what capacity and no information regarding recruitment or application is held or known.

5.3 Kris Wade’s employment folder evidences that by December 2004 he had exhausted his sickness payment entitlement and that the Trust’s Occupational Health Department was supporting Kris Wade’s redeployment to the Learning Disabilities Directorate due to the “[REDACTED]”. Whilst the Trust would have had a duty of care and a statutory obligation to support a
redeployment into another role, there is no evidence that consideration was given to the redeployment into a unique specialist care environment such as Learning Disabilities was in both service users and Kris Wade’s best interests because of his health problems.

5.4 In January 2005, when Kris Wade was allocated a Nursing Assistant (Grade B) post the vacancy requisition form indicates an enhanced Criminal Records Bureau check was required. The review team have been unable to locate any evidence that this was undertaken. Whilst enquiries are still being made to the Disclosure Barring Service, a review of the former Bro Morgannwg Human Resource databases indicate the likelihood is, no CRB check was ever undertaken.

5.5 When the first allegation against Kris Wade was raised by a service user in 2012, the directorate responded by placing him on Special Leave. The scope of the Special Leave Policy was not appropriate for the circumstances surrounding the requirement for Kris Wade to be removed from the workplace. In addition, Kris Wade’s employment folder states special leave was granted due to concerns surrounding his wellbeing. Notwithstanding the questionable use of the special leave policy, the evidence suggests that the focus of decision making was on Kris Wade’s associated health concerns, rather than any consideration for the safety and wellbeing of service users. This raises two issues; the first is that the priority should always be the safety and welfare of patients whilst protecting employee rights and secondly, if Kris Wade’s health were significant enough to warrant removal from the workplace, was he actually well enough to be in work prior to the allegation being raised? Frequent reference is made throughout Kris
Wade’s employment record to “[REDACTED]”, this again raises the question, was such an unpredictable and often challenging environment such as learning disabilities a suitable placement for Kris Wade. [REDACTED]

5.6 Allegation 1 was first raised by service user ZZ on [REDACTED] 2011. Whilst the allegations were documented in the nursing records no incident form was created or VA1 raised. There is no evidence that the allegation was escalated. ZZ again informed staff of her allegation on [REDACTED] and whilst the allegations were documented in the nursing records, no incident form was created or VA1 submitted with no evidence the allegation was escalated. ZZ again informed staff of her allegations on [REDACTED] and whilst the allegations were again documented in the nursing records, no incident form was created or VA1 submitted with no evidence the allegation was escalated. On this occasion it is documented by nursing staff that ZZ wished to speak to a female member of nursing staff to report Kris Wade but examination of ZZ’s nursing notes do not demonstrate that this was facilitated.

5.7 Whilst on each occasion the allegation was documented, no further action was taken other than to provide ZZ [REDACTED]. Whilst the review team acknowledge that [REDACTED] might have been required in the circumstances, the safeguarding policies would
have required further reporting and escalation. Regardless of any individual’s opinion, each and every allegation should have been formally recorded, reported on Datix and a VA1 submitted immediately. Sufficient processes exist to have been able to establish a false or unfounded allegation had that been the case by following the process. This lack of compliance with policy and reporting procedures ultimately exposes service users to increased levels of risk, a position that cannot be acceptable given the amount of measures in existence to protect vulnerable adults.

5.8 On [redacted] 2012 ZZ again attempted to raise her concerns with another [redacted] and a [redacted] member of staff. Despite this, no record was made within ZZ’s nursing notes, no incident created and no VA1 submitted and no evidence of escalation. ZZ’s repeated allegations were only identified incidentally on [redacted] 2012 when the Unit Manager happened to be reviewing ZZ’s care plans, following which a VA1 was submitted the same day. A POVA threshold assessment was undertaken on 16 January 2012 by which point Kris Wade had remained in work for 26 days since the allegation was first raised. Kris Wade was not removed from the unit until the 18 January 2012 [redacted] Earlier consideration should have been given to the removal of Kris Wade from a direct care role or from the workplace entirely. This case highlights the importance of accurate and timely reporting when such allegations are raised. Whilst the allegations raised by ZZ were in fact the first time such allegations were made against Kris Wade, it is the case that further allegations were later made. Had the allegations raised by ZZ not been incidentally identified by the [redacted] the opportunity to co-ordinate and
triangulate information from later events, when further allegations were raised, would have been missed.

5.9 Following the conclusion of the investigation into Allegation 1, Kris Wade returned to [Redacted] in an alternative learning disability inpatient setting. Whilst there is information relating to the outcome of both the criminal investigation and the Health Board’s internal initial disciplinary assessment which underpin the decision to return Kris Wade to work, [Redacted] Notwithstanding the outcome of the investigations into allegation 1, the decision to place Kris Wade back into an unpredictable patient environment could be questioned.

5.10 The concerns regarding the timeliness of reporting incidents of allegations raised by ZZ continue when a second allegation of sexual assault was raised by another inpatient [Redacted]. Whilst there is evidence that the nature of the allegations were documented and acted upon, the VA1 was not submitted until [Redacted] 2012, six days after the allegation was made. There is evidence that the [Redacted] contacted the service user on the [Redacted] and made arrangements to meet with her on [Redacted], “in order to gather some facts”. The review team has therefore considered whether the completion of the VA1 was delayed pending further fact finding and finds this is less likely, on the basis the VA1 was completed at 0815 hours on the [Redacted], when the home visit to the individual who raised the allegation did not occur until 1100 hours. The procedures require a VA1 to be submitted at the earliest opportunity as delay could contribute to further exposure of risk and timely investigation of allegation.
5.11 On 12 October 2012 a PoVA Strategy meeting was convened where South Wales Police advised they would undertake a criminal investigation. Kris Wade was subsequently placed on a period of Special Leave from the 13 October 2012. Notwithstanding further inappropriate use of the Special Leave Policy, it also took 11 days to remove Kris Wade from the workplace during which time he had been allowed to work a further four night shifts. The rationale unpinning this decision is documented in an initial assessment report under the All Wales Disciplinary policy dated 20 February 2013, where it states on page 3, “Following a risk assessment it was agreed that Kris Wade would be allowed to work his four night shifts that he was down to work from the 2012 as the female service user who was living at the setting at the time did not require any support with her personal care….”. There are a number of potential flaws in this assessment; firstly there is assumption that Kris Wade only posed a potential risk (allegation only this stage) to female inpatients and that he was not opportunistic in his actions. The evidence later obtained however would suggest the alleged offences took place at times when Kris Wade was not necessarily required to have been with the service user. Whilst acknowledging that hindsight is of benefit in reaching these findings, there were sufficient policies and procedures in place for a different conclusion to have been reached had the policies been followed, and that Kris Wade should not have been in contact with service users until the allegations had been fully investigated. Whilst there is evidence a risk assessment was undertaken, the decision reached is open to objective challenge.
5.12 Although there is evidence the Health Board informed Welsh Government colleagues of the initial allegation raised by ZZ, it has been established that no further notification was provided to Welsh Government when Allegation 2 was raised. Whilst there is a copy of a completed Serious Incident form relating to Allegation 2, this was not processed or submitted to Welsh Government failing to comply with Welsh Government reporting requirements.

5.13 When South Wales Police advised the Health Board in December 2012 no further action would be taken in respect of Kris Wade, the Health Board commissioned an initial assessment under the All Wales Disciplinary Policy. There is however no evidence that a further investigation was commissioned following the initial assessment report dated 20 February 2013. However the review team considers a full investigation should have been considered in view of the fact that by the time the initial assessment was produced, a third allegation had been raised by another service user representing a missed opportunity to undertake a full investigation. Despite the third allegation being raised on the day 2013, the initial assessment report into allegation 2 makes no reference to the existence of a further allegation. Whilst it could be argued the initial assessment commissioned following allegation 2 was specifically about the circumstances around allegation 2, a more holistic approach to all allegations raised by this point was required.

5.14 Although several documents and correspondence make reference to “PoVA investigations” the evidence suggests that, aside from any criminal investigations undertaken, the internal action undertaken by ABMU HB were initial assessments under the All Wales Disciplinary
CONFIDENTIAL
KW Review Report

Policy. It is clear no investigations under PoVA, the Serious Incident Framework or the Disciplinary Policy have been undertaken. There is also an apparent lack of understanding between the differing processes and what the purpose of each process should achieve. In this context the PoVA process is primarily designed to ensure the safety of the patient/s but appears in this instance to have been used as a process to facilitate all work streams i.e. employment, incident management and governance. Therefore, insufficient oversight and coordination of each separate work stream has occurred.

5.15 When allegation 3 was raised on [redacted] 2013, a VA1 was completed and submitted within 1 hour of the allegation being made and a PoVA process commenced. By [redacted] 2013 the [redacted], formally requested to the [redacted] a new [redacted] be appointed from outside of the Directorate due a conflict of interest existing between herself, the Directorate and the then Clinical Service Director’s immediate [redacted] relationship (OCC) with Kris Wade. Whilst this was appropriate and a matter of good governance, this should have been considered for the management of the process relating to allegation 1 and 2.

5.16 The Clinical Service Director was not involved in any of the investigations into Kris Wade. Whilst this review has not identified written evidence which suggests that the Health Board’s management of allegation 1 and/or 2 were overtly influenced by the then Clinical Service Director, the fact the relationship between Kris Wade and the Director existed could possibly had a bearing on decision making, whether consciously or sub-consciously. That said, all matters were referred to and investigated by South Wales Police who would have been
The fact that the required policies were not initiated leaves the decision making open to criticism and lack of candour.

5.17 The review team have established no communication was made with Welsh Government colleagues when allegation 3 was raised, further breaching Welsh Government reporting requirements.

5.18 On 26 February 2013 the newly appointed [REDACTED] sought permission from the Health Board’s [REDACTED] for Kris Wade to be formally suspended. Kris Wade was subsequently suspended on 7 March 2013. On 12 April 2013, at a second strategy meeting regarding allegation 3, South Wales Police advised the Health Board that any internal investigations could commence with immediate effect and did not need to await the outcome of the police investigations. However, an investigating officer was not appointed until 14 August 2014 representing a significant delay.

5.19 On 22 January 2014 South Wales Police informed the Health Board that no further action against Kris Wade would be taken. South Wales Police also highlighted that they remained significantly concerned about Kris Wade. The new [REDACTED] and [REDACTED] and [REDACTED] Managers attempted to identify an appropriately independent person to undertake these investigations. Whilst acknowledging that a request for information from South Wales Police regarding their investigations was not forthcoming until 10 February 2014, there was still a significant time delay before the internal investigator was appointed. Given the nature of the allegations raised, and with the welfare of the service users and Kris Wade in mind, six months to start the investigative process is not
proportionate and fair to all concerned, particularly when permission to continue with internal processes had been given by South Wales Police in April 2013.

5.20 A report produced as part of the initial assessment under the All Wales Disciplinary Policy was submitted on the 25 March 2015. The content of the report found that that this did not meet the threshold for a full disciplinary investigation per se. The methodology applied thereafter was in the form of a `table top review` of all processes undertaken, including the investigation documents used by South Wales Police and Health Board to that point. Whilst acknowledging that this represented a significant piece of work and the review of various witness accounts, no new enquiries or evidence gathering was undertaken. The position therefore is that the Health Board has not undertaken any investigation/s regarding allegations by all three service users. What the Health Board completed was an initial assessment under the All Wales Disciplinary Policy for allegations 1 and 2, and a table top review of existing information following allegation 3 which took into account the information relating to all three allegations. Whilst this is not a criticism of the work undertaken, it is however important to be clear about the context of the reports produced and the evidential limitations this will have had on the process.

5.21 The report produced by the investigating officer sets out (in page 5) the scope of the investigation, stating “Due to the similar nature of the three allegations being made by the three individuals, an investigation under the All Wales Disciplinary Policy was initiated in June 2014”. Notwithstanding the review teams finding that this process did not
achieve investigative standards, the following scope set out in section 3 of the report Introduction is of more concern. Section 3 states “the member of staff under investigation is Kris Wade, the investigation undertaken considers whether Kris Wade has been the victim of inappropriate and unfounded allegations and/or whether the complaints made by three patients, apparently unknown to each other, making substantially similar allegations discloses an unacceptable course of conduct.” Regardless of the investigators opinion when undertaking this investigation, this statement undermines the impartiality and integrity of the process and defies the fundamental purpose of an unbiased investigation. The statement firstly suggests that Kris Wade was the victim of inappropriate and unfounded allegations and the purpose of the process was to uncover this. Furthermore the statement questions the integrity of the actual victims by stating “three patients apparently unknown to each other”. The use of language in producing reports of any nature, but in particular, for such serious and sensitive matters is paramount in demonstrating that the process is fair to all involved. Furthermore, the report did not set out the scope and remit of its enquiries.

5.22 The timing of the disciplinary hearing following the submission of the report produced by the investigating officer on 25 March 2015, suggests that whilst there were delays in starting and concluding the process, some of these delays were outside of the control of the disciplinary panel. There is evidence that Kris Wade himself was partially responsible for the timings. Whilst acknowledging
there are inevitably logistical difficulties in arranging more complex disciplinary hearings where numerous witnesses and other key contributors are required to come together, 12 months from the time of submission of the report to an outcome is excessive, and will have an adverse bearing on all parties involved. Better co-ordination and support to the disciplinary panel members may have had a more positive influence on timescales.

5.23 With regard to the date upon which the decision to dismiss Kris Wade on a finding of gross misconduct was made, the evidence identifies that the decision was reached by the panel on 30 March 2016 when the panel met to consider its conclusion. The disciplinary panel confirmed that whilst the hearing had taken place in December 2015, further additional enquiries were required based upon the representations made by Kris Wade’s formal representative at the hearing. It is therefore established that the decision to terminate Kris Wade’s employment was not taken by the time of his arrest on suspicion of murder. Based on the facts available to the review, the termination of Kris Wade’s employment at any earlier point in time would not have had a bearing on the circumstances of his crime. In this regard, all allegations raised by service users were reported and investigated by South Wales Police. The decision not to progress these matters and for Kris Wade not to be charged was a decision made by the Crown Prosecution Service, a decision ultimately challenged by South Wales Police unsuccessfully. Despite the learning opportunities identified thus far from a Health Board perspective, the review team has not identified evidence to suggest that the Health Board failed in any way to provide information or facilitate enquires on behalf of the police or the CPS which had a negative bearing on the criminal investigation.
6 CONCLUSION

6.1 The review concludes a number of process issues have occurred with regard to the employment and redeployment of Kris Wade during his time working for the former Bro Morgannwg NHS Trust. Whilst the investigation has not determined that the process issues identified directly relate to Kris Wade’s relationship with the Clinical Service Director, the issues identified do indicate that processes were not followed and/or deficient in several areas.

6.2 The review concludes incident reporting procedures were not robustly followed when serious allegations were raised by service users. Whilst comments made by service users were on occasions documented, no further escalation or exploration of the allegation took place, until the documented comments were incidentally read by another member of staff. Delays in initiating PoVA processes occurred as a result of this escalation. The review concludes on the balance of probability that the failure to escalate or explore the initial concerns does not relate to any deliberate attempt to conceal the allegations, more a reflection of a wider culture within certain health care settings to base actions on believability of service users rather than the use of safeguarding processes.

6.3 The review concludes that whilst a number of issues relating to governance, adult safeguarding, recruitment, culture and incident reporting have been identified, the review does not consider that Kris Wade’s future conduct and behaviour outside of his employment could have been predicted or prevented. The review considers that notwithstanding the delays and issues identified, all allegations were
referred to the Police who conducted criminal investigations. The decision not to prosecute Kris Wade was a decision made by the Crown Prosecution Service, following which internal disciplinary proceedings were initiated. Whilst there were delays in reaching a final conclusion of dismissal, Kris Wade remained suspended and away from his employment whilst proceedings took place.

6.4 The review concludes that several areas of learning have been identified and these are addressed further in the action taken/recommendation section of this report.

7 LESSONS LEARNED AND SERVICE IMPROVEMENTS

Patient Safety Look Back Exercise

- The Health Board commissioned a governance assurance review to review all in-patient case notes for patients who were [redacted] during Kris Wade’s employment at the facility. 59 individual patients were identified by the review and all records have subsequently been reviewed by senior clinical staff looking for evidence of documented concerns relating to Kris Wade and/or any other member of staff, which had not been escalated or appropriately addressed at the time or since. The review did not identify any new matters of concern.

Recruitment Processes
During this period there have been numerous changes.

- Changes in Disclosure and Barring Service (DBS) Process post Shared Services:
As part of the creation of NHS Wales Shared Services Partnership (NWSSP) a standard process known as the standard operating process (SOP) was introduced in June 2012. Since this point all recruitment is managed directly through Shared Services. This includes an agreed level of checking with DBS being one of the mandatory checks undertaken.

On 17 July 2013, the DBS stopped issuing certificates to the counter signatory and only issue one certificate to the applicant. Now, if the electronic result states ‘wait for certificate’ it means there is information on the certificate and the Health Board request sight of the original certificate, which is either posted in or brought in by appointment.

In June 2014, NWSSP implemented the use of electronic DBS applications across Wales. The service is provided by Capita. Capita’s ebulk online applications are now only used by the Workforce Teams for ad hoc and volunteer DBS checks due to the implementation of Trac in April 2015, whereby all DBS checks processed through Trac are countersigned by Trac and processed and tracked through Trac also. As a consequence of undertaking self assessment of the ‘Jimmy Saville enquiry’, the Health Board identified an action to develop a DBS policy which has now been fully implemented into practice.

- Centralisation of Recruitment:
  In line with the introduction of central recruitment services hosted by NWSSP, all recruitment processes are standardised and processed in the same way. This in turn reduces the ability to deviate away from agreed practice when advertising, short listing, interviewing, appointing and undertaking pre-employment checks. This set process limits the opportunity for process to be circumnavigated.
Policy Development:
The Health Board is currently developing a Relationship Policy which will provide advice and guidance to managers when dealing with matters of HR when friends and family are involved. The policy will ensure transparency where relationships are identified within the same service.

Safeguarding Processes

The Health Board has revised and improved its internal Safeguarding processes (formally PoVA) and its adherence to the All Wales procedures. The number of managers designated to investigate such cases has been reduced so that they deal with more cases, have in-depth, mandatory training and formal supervision and therefore improve their competency, confidence and experience. Families are now involved in safeguarding strategy meetings and investigations so that their views are heard and taken into account as part of this process. The Health Board has also introduced audits to provide assurance about compliance with All Wales processes. Audits within the Mental Health Learning Disability Service highlight a positive increase in the number of reports generated. The service is able to identify themes and trends from the audits which directly influence the services improvement plans and development.

In addition, six newly appointed Designated Lead Managers (DLM’s) have been trained and appointed within the Mental Health Learning Disabilities Service. In their role as DLM for the safeguarding processes, a more consistent approach in keeping with up to date training is now provided when matters of safeguarding are raised within the service.
• Improvements have been made to the Health Board's incident reporting framework within Datix. In December 2014 a new question was added to the approver form. Now if an approver considers an incident relates to Safeguarding Adults then they select yes to this question. This is a mandatory field and when yes is selected an automatic email will be sent from the Datix to the Safeguarding Adult Team who will be prompted to review.

Incident Reporting and Escalation Procedures

Focused work on increasing compliance with all mandatory training including safeguarding training has been undertaken with staff working within Mental Health and Learning Disabilities. From April 2017 additional training on safeguarding in services for people with learning disability has been implemented with support from University of South Wales. The additional training supported by the University of South Wales will particularly address the issues regarding why staff may not believe service users and what steps they must take to overcome this. The training is based on research undertaken by Professor Ruth Northway and colleagues at USW. Investigation training has also been rolled out across the Mental Health Learning Disabilities Delivery Unit.

• In January 2015 the Health Board also introduced a central Serious Incident Investigation Team which works across all Managed Units of the Health Board. Part of the responsibility of the SI team is to facilitate serious incident and 'no surprise' notifications to Welsh Government. The SI Team are responsible for the monitoring of new incidents and work proactively with the senior teams of each managed unit in order to achieve more timely reporting. The central team provides the opportunity for all Health Board services to
refer serious matters for independent advice and guidance and in some instances an independent investigation.

**Culture and Staff Attitude**

- The Health Board has developed and implemented ‘*Our Values and Behaviours Framework*’. The organisation’s Values were developed with the involvement of 1,831 patients, carers and the public and over 4,000 staff in identifying key issues through detailed discussions and detailed survey responses. Our patients, carers, children and young people and their parents / guardians and patient and voluntary sector groups told the Board about their experiences of care within ABMU. Our staff told us, good and bad, what it was like providing services and working in the organisation.

From this a set of values and underpinning behaviours, both those the organisation expects to see and those it does not were defined with these stakeholders and refined to ensure they accurately reflected their views. This Values and Behaviours Framework has been rolled out across the organisation since its launch in 2015 and is already being used in induction for new staff, recruitment and appraisal processes and increasingly to underpin all that the Health Board does.

- In addition, the Health Board introduced the ‘See It Say It’ initiative. A poster campaign which was introduced throughout all ABMU hospitals in 2014 giving staff and patient’s easy ways to report concerns 24/7. This included encouraging them to speak directly to staff, or to text, email, or leave a phone message anonymously if they preferred. After the initial 9 months following the publication of Trusted to Care the number of issues being reported via *See It, Say It* had reduced significantly and it was agreed with the ABM
Community Health Council, patient groups, carers and the third sector that this poster campaign should be replaced. As a result these groups and the Health Board’s Stakeholder Reference Group established the Let’s Talk campaign as an approach to encourage more feedback on services, both positive and negative, again using text, phone messages and email with a response within 24 hours in most instances.

At the same time the All Wales whistle blowing policy was replaced with the Raising Concerns policy and so the Health Board worked with staff side through the ABMU Partnership Forum to develop a new Raising Concerns poster campaign highlighting how staff could raise issues anonymously / through a process which did not involve communication with their line management. These were introduced in 2015 and continue to be routine ways in which issues can be raised by staff when they have concerns and can be acted on quickly.

- In addition, the Learning Disabilities Service has delivered presentations on the lessons learned from the Winterbourne report to the Health Board’s Safeguarding Committee.

**Patient Experience**

- Learning from this report will be fed into wider work being undertaken by the Health Board to improve its ability to actively listen and engage with all client groups, with specific focus on service users who have additional needs and requirements. Review of Health Board policy is on-going with regard to ‘Putting Things Right’ to ensure guidance is provided on how to best support patients’ and members of the public who require reasonable adjustments and support to raise concerns.
The Health Board’s Patient Experience Team has adapted the ‘Friends and Family’ questionnaire to incorporate more diverse groups so that these groups are able to actively participate in the feedback process.

**Restructure and Governance**

The Health Board has since been restructured to six Operational Delivery Units. Four of the new Delivery Units are based around the main hospitals - Princess of Wales, Neath Port Talbot, Singleton and Morriston Hospitals. In addition there is a Delivery Unit for Mental Health and Learning Disability Services and one for Primary and Community Services which span the whole Health Board.

Each of these delivery units is led by a new management team comprising a Service Director, Unit Medical Director/Associate Medical Director and Unit Nurse Director/Associate Nurse Director and the teams to support them are now being recruited.

As part of the new organisational arrangements Mental Health and Learning Disabilities have been amalgamated into one service which is divided into three locality teams. Each locality has a senior locality manager and a clearly defined governance structure which reports up to the senior management team of the service. The senior management team in turn report to the Board’s Quality and Safety Committee to give assurance about its services, ensuring issues are dealt with locally where appropriate but escalated and supported corporately when necessary. In addition, the service now has a dedicated Quality and Safety Team.
• Standardised quality assurance audit tools using the Health Care Standards are now undertaken on a monthly basis, and a programme is in place for Multi Disciplinary Team ‘15 step challenges’ across all services. These audits result in ward action plans and the Mental Health Learning Disabilities Service have recently agreed action plans developed from this year’s processes. These will be reported into their health and safety committee to ensure there is senior team oversight, greater transparency and so that progress can be tracked.

• Within the newly configured Mental Health and Learning Disabilities Service, a Learning and Development Committee has been established together with a strategic framework for learning and development. The framework reinforces our view that learning and development is a strong force for positive change and as a mechanism for supporting improved outcomes for people. The framework sets out how improved outcomes for people are achieved through a well-developed workforce, with the right skills, knowledge and behaviours to provide new models of care.

• The Human Resources Department is currently considering the merits of introducing a centrally/corporately based investigation team who would be tasked with undertaking HR investigations which reach a certain threshold. The purpose of such a team would be to improve the timeliness and standard of investigations.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation/Improvement Identified</th>
<th>Actions Taken/underway</th>
<th>Further Action Required</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1. The establishment of NHS Wales Shared Services Partnership (NWSSP) to ensure a robust standardised operating process for recruitment. This includes changes in Disclosure and Barring Services (DBS) checks. In July 2013 Electronic DBS records were started. This involved the issuing of certificates to applicants only. Employers would need to request sight of a certificate from central services. The June 2012 centralisation of all recruitment includes a mandatory DBS check and this is monitored through this centralised recruitment service.</td>
<td>NULL</td>
<td>Director of Nursing &amp; Patient Experience Acting Director of Human Resources</td>
<td>June 2012</td>
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<tr>
<td></td>
<td></td>
<td>1. Reviewed lessons learned following the Jimmy Saville Independent Enquiry. 2. Developed a Health Board DBS policy.</td>
<td>NULL</td>
<td>NULL</td>
<td>The DBS Policy was circulated in July 2015, and ratified in January 2016 by the Health Boards Safeguarding Committee.</td>
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<td></td>
<td>To provide clear guidance in relation to the appointment of staff who are related to pre-existing employees.</td>
<td>1. To develop, consult on and implement a Health Board Relationship Policy.</td>
<td>The Policy consultation is in progress. The Policy is due to be ratified in September 2017 by the Health Board Partnership Forum.</td>
<td>Acting Director of Human Resources</td>
<td>September 2017</td>
<td>NULL</td>
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<td></td>
<td>Revision of the Health Board internal safeguarding procedures to increase competency of Designated Lead Managers (DLM) and their engagement with families.</td>
<td>1. Reduced the number of managers designated to investigate Safeguarding issues so that they deal with more cases 2. Provided more in-depth, mandatory training, and formal peer supervision to improve competency, confidence, and experience of DLMs. 3. Involved families in safeguarding strategy meetings and investigations so that their views are heard and taken into account as part of this process. These actions were reported to the Health Boards’ Safeguarding Committee.</td>
<td>NULL</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>February 2017</td>
<td>NULL</td>
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<td></td>
<td>To ensure adherence to all-Wales Safeguarding procedures.</td>
<td>1. To participate in the all-Wales review of vulnerable adults and children policies and procedures. A Health Board lead has been identified and nominated from the Corporate Safeguarding Team.</td>
<td>NULL</td>
<td>Director of Nursing &amp; Patient Experience</td>
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<td>NULL</td>
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<td></td>
<td>To increase compliance with Health Board wide Mandatory Training</td>
<td>1. Service Delivery Units report their mandatory training compliance for safeguarding to the Safeguarding Committee on a bi-monthly basis.</td>
<td>NULL</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>July 2017</td>
<td>NULL</td>
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<tr>
<td>Incident Reporting and Escalation Procedures</td>
<td>To ensure a robust process and consistent, independent approach in the investigation of Serious Incidents and Never Events. To ensure the central co-ordination of notifications to Welsh Government within required timescales.</td>
<td>1. Established a central Serious Incident (SI) Investigation Team which works across all Managed Units of the Health Board. This was established in January 2015. 2. The SI team facilitate serious incident and ‘no surprise’ notifications to Welsh Government on a weekly basis. 3. The SI Team monitor new incidents and work proactively with the senior teams of each managed unit in order to achieve more timely reporting on a weekly basis. 4. Continued reporting Serious Incident compliance, themes and performance through the Health Board Quality &amp; Safety Committee on a bi-monthly basis.</td>
<td></td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>January 2015</td>
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<tr>
<td>Incident Reporting and Escalation Procedures</td>
<td>To enhance the incident reporting systems to provide more robust data.</td>
<td>1. Reviewed and added additional information to Datix which automatically triggers any Safeguarding incidents to the Safeguarding team. 2. Continued reporting of adult and children safeguarding data incidents and themes to the Health Board and Quality &amp; Safety Committee on a bi-monthly basis. 3. All Safeguarding incidents are reported to the Safeguarding Committee on a bi-monthly basis, and the Quality &amp; Safety Forum through performance Scorecards.</td>
<td></td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>December 2014</td>
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<td>1. Introduced the ‘See It Say It’ initiative. This included; -a poster campaign throughout all ABMU hospitals giving staff and patient’s easy ways to report concerns 24/7 to encourage them to speak directly to staff, or to text, email, or leave a phone message anonymously if they preferred. 2. Reviewed and evaluated the impact of ‘See it, Say it’ initiative following publication of Trusted to Care, with the involvement of ABM, CHC, patient groups, carers and third sector parties. 3. Acted on the findings of the evaluation. This resulted in replacing ‘See it, Say it’ initiative with the establishment of the ‘Lets Talk’ campaign to encourage more feedback on services using text, phone messages and email. These are responded to within 24 hours in most instances. This data is now logged on Datix to capture themes/actions.</td>
<td></td>
<td>Chief Executive</td>
<td>Q2, 2014</td>
<td>Q1, 2015</td>
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<tr>
<td>Theme</td>
<td>Recommendation/Improvement Identified</td>
<td>Actions Taken/underway</td>
<td>Further Action Required</td>
<td>Lead</td>
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| Culture and Staff Attitude | To provide staff with the tools to raise concerns anonymously in a different mechanism to the existing all-Wales Whistleblowing Policy. | 1. Developed and implemented a 'Raising Concerns' policy with the involvement of staff side through the ABMU Partnership Forum.  
2. Developed a new Raising Concerns poster campaign highlighting how staff can raise issues anonymously through a process which does not involve communication with their line management.  
3. Improved the Health Boards ability to actively listen and engage with all client groups, with specific focus on service users who have additional needs and requirements.  
Learning from this report has been fed into wider work being undertaken by the Health Board to improve its ability to actively listen and engage with all client group, with specific focus on service users who have additional needs and requirements. The above actions were introduced in 2015 and continue to be routine ways in which issues can be raised by staff/service users when they have concerns which can be acted upon quickly.  
Review of Health Board Policy is on-going with regard to 'Putting Things Right' to ensure guidance is provided on how to best support patients and service users who require reasonable adjustments and support to raise concerns. | Chief Executive | 2015 |
|                        | To apply a Values Framework with the involvement of Patients, service users, relatives, carers and staff. | 1. Developed the 'Our Values and Behaviours' Framework following detailed discussions of surveys with stakeholders, patients and service users. The organisations Values were developed with the involvement of 1,831 patients, carers and the public and over 4,000 staff in identifying key issues through detailed discussions and detailed survey responses.  
Our patients, carers, children and young people and their parents/guardians and voluntary sector groups told the Board about their experiences of care within ABMU. Our staff told us good and bad, what it was like providing services and working in the organisation.  
2. Continued monitoring of the effectiveness of 'Our Values and Behaviours' through reporting to the Health Board Values Steering Group on a monthly basis.  
3. The 'Our Values and Behaviours' Framework has been rolled out across the Health Board. Since its launch in 2015 this is already being used in inductions for new staff, recruitment and appraisal processes and increasingly to underpin all that the Health Board does. | Chief Executive | 2015 |
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<thead>
<tr>
<th>Theme</th>
<th>Recommendation/Improvement Identified</th>
<th>Actions Taken/underway</th>
<th>Further Action Required</th>
<th>Lead</th>
<th>Timeline</th>
<th>Completed</th>
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<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td>To enhance participation of feedback from more diverse groups.</td>
<td>1. Developed and implemented a ‘Friends and Family’ questionnaire to incorporate more diverse groups so that these groups are able to actively participate in the feedback process. The questionnaire was instigated in 2014 to continue to provide valuable feedback which is acted upon, as appropriate. Outcomes are monitored and reported through the Health Board Quality and Safety Committee on a bi-monthly basis.</td>
<td></td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>2014</td>
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<td><strong>To standardise Quality Assurance Tools to ensure a consistent audit process throughout the Health Board.</strong></td>
<td></td>
<td>1. Utilised the Health Care Standards to standardise Quality Assurance Audit Tools, which are audited on a monthly basis. 2. Developed an audit programme for Multi-Disciplinary Teams in the form of 15 step challenges across all services. 3. These audits result in action plans and the Mental Health and Learning Disabilities Service has recently agreed that action plans developed from this year’s processes will be reported into their Health and Safety Committee to ensure there is senior team oversight, which enables greater transparency and monitoring.</td>
<td></td>
<td>Mental Health and Learning Disabilities Management Team</td>
<td>2014</td>
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<td><strong>Structure of managerial roles and responsibilities</strong></td>
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<td>1. Restructured services within six Service Delivery Units (SDU). Four of the new Service Delivery Units are based around the main hospitals - Princess of Wales, Heath Port Talbot, Singleton and Morriston Hospitals. In addition, there is a Service Delivery Unit for Mental Health and Learning Disability Services and one for Primary and Community Services which span the whole Health Board. 2. Ensured the recruitment of senior management teams to operationally manage each SDU. Each of the restructured units is led by a new management team comprising of a Service Director, Medical Director and Nurse Director. These arrangements are based on the principle that the aim should be to develop an organisation in service of its front line staff based on the organisations values framework. 3. Ensured there is a Governance Structure within each SDU. As part of the new organisation structure, each Service Delivery Unit has a clear governance structure locally which regularly reports to the Boards Quality and Safety Committee to give assurance about its services and ensure that issues are dealt with locally where appropriate but escalated and supported comparatively when necessary. 4. Continued monitoring of the performance of the SDU’s.</td>
<td></td>
<td>Executive Team</td>
<td>2015</td>
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<td>Theme</td>
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<td>Restructure and Governance</td>
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<td>5. Amalgamated Mental Health and Learning Disabilities into one service. The amalgamation has taken place and is now one service which is divided into three locality teams which have their own Locality Manager and a clearly defined Governance structure which reports to the senior management team. The senior management team reports to the Health Boards’ Quality and Safety Committee to provide assurance about its services. The service also has a dedicated Quality and Safety team. 6. Established, within the Mental Health and Learning Disabilities Delivery Unit, a Learning and Development Committee. This Committee has been established together with a strategic framework for learning and development, which provides improved outcomes for people, through a well developed workforce, with the right skills, knowledge and behaviours. 7. The Mental Health and Learning Disabilities Delivery Unit team have delivered presentations on the Lessons Learned from the Winterbourne report to the Health Boards’ Safeguarding Committee.</td>
<td>To be discussed at Executive Team Meeting.</td>
<td>Mental Health and Learning Disabilities Management Team</td>
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<td>Structure of managerial roles and responsibilities</td>
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<td>Acting Director of Human Resources</td>
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<td>To centralise HR investigations</td>
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<td>1. To consider the merits of introducing a centrally/corporately based investigation team who would be tasked with undertaking HR investigations which reach a certain threshold. The purpose of such a team would be to improve the timelines and standard of investigations.</td>
<td>To be discussed at Executive Team Meeting.</td>
<td>Acting Director of Human Resources</td>
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*Current position RAG’d against IMTP Profile. Where there is no profile, the national or local target has been used.*