GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Board **Date of Meeting** 30 July 2026 **Agenda item:** *3.5*

Sexual Health Incident – Update Report	
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Approval/Scrutiny route:	Public Health Wales Sexual Health Incident Management Team Business Executive Team

Purpose

The purpose of this paper is to provide assurance to Public Health Wales (PHW) Board members in relation to the Sexual Health Incident. It provides and update on our response to the issues identified and the next stages of the response

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	x

The Board is asked to:

- **Receive assurance** in relation to the development and progress of the management of the sexual health incident
- **Receive assurance** in relation to the actions to review and improve service delivery

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	4 - Delivering Excellent Public Health Services
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	No decision is requested from the board. Therefore no Equality of Health Impact Assessment is required.
Risk and Assurance	This is being managed as an enhanced incident. The risks posed by the incident is recorded on the appropriate risk register.
Health and Social Care (Quality and Engagement) (Wales) Act	This report sets out a number of issues where the Duty of Quality and Duty of Candor are relevant. Public Health Wales has made proactive press statements in relation to this incident and is committed to transparency with impacted service users.
Financial implications	There are no direct financial implications of the report. Financial implications of the response to the incident are not covered in this review.
People implications	There are no direct people implications of the report. People implications of the response to the incident are not covered in this review.

1. Purpose / situation

A report was tabled at the Public Health Wales Board Meeting on 26 March 2026 covering the Sexual Health Service Incident. An update was tabled in May 2026. This paper provides a further update to the Public Health Wales Board on the current position on the different areas of the investigation.

The purpose of this paper is to provide assurance into the ongoing response to the incident.

2. Background

The background to the Sexual Health Service was provided in the previous paper.

There are currently three main areas of focus for the Sexual Health Incident. These are:

- Child and Adult Safeguarding
- Patient Safety Concerns in relation to Hepatitis C testing
- Information Governance and Data Protection issues

As of 13 July 2026 the incident remains at a routine incident. The Incident Management Team (IMT) is assessing the progress against pre-agreed closure criteria, and expects the incident to close at the end of July. Any remaining actions, recovery and quality improvement activities to business as usual governance arrangements.

3. Description/Assessment

3.1 Child and Adult Safeguarding

The March report set out the actions that had been taken in relation to Public Health Wales failure to discharge its safeguarding responsibilities appropriately.

Robust safeguarding arrangements have been in place since December 2025 and have demonstrated that they are effective at identifying concerns and reporting them to appropriate authorities.

A review was established which divided the affected young people into three cohorts

- Cohort 1 – Children and Young People who used the service between August 2022 and December 2025, who remained under the age of 18 as of 6 March 2026

- Cohort 2 – Children and Young People who used the service between August 2022 and December 2025, who were over 18 as of 6 March 2026
- Cohort 3 – Children and Young People who used the service during the pilot phase, and following national role out to July 2022.

Public Health Wales, along with other bodies has a legal duty to report where there is reasonable cause to suspect that a child is at risk. The MDT process put in place in response to this incident provides assurance that:

- Safeguarding risks were systematically reviewed on a case-by-case basis.
- Where safeguarding information had not been received locally by Health Boards at the time, proportionate retrospective safeguarding review of available information to support decision-making was undertaken through MDT oversight.
- Statutory Duty to Report (DTR) responsibilities were enacted where safeguarding concerns were identified, including retrospectively where appropriate.
- Children and young people remained at the centre of decision-making, with careful consideration given to harm, benefit and proportionality.

Where safeguarding information had not been received by Health Boards, these cases were escalated to the MDT for decision-making. In the majority of these cases, Health Boards also undertook lateral checks to confirm whether the child or young person was already known to sexual health and/or safeguarding services. Where the Duty to Report criteria were met retrospective Duty to Report actions were progressed by Health Boards and/or PHW via the MDT, with local authority safeguarding teams providing statutory oversight, professional judgement and advice.

Across both cohorts 1 and 2, the reviews found that safeguarding risks were generally identifiable within the system, but that there were significant weaknesses in the interpretation, escalation and sharing of safeguarding information. In some cases, disclosures of serious concerns, including sexual assault, exploitation, coercive relationships and other indicators of vulnerability, were not shared with Health Boards because they did not trigger automatic escalation processes within the online system. This created missed opportunities for timely intervention and support.

Retrospective review for cohort 1 identified eleven cases where safeguarding information had not been received by Health Boards. Lateral checks against information held resulted in four additional Duty to Report referrals (three by the PHW MDT and one by a Health Board). The MDT concluded that following the

review all cases had received robust review and that statutory safeguarding responsibilities had ultimately been discharged.

Cohort 2 found thirty-eight cases where safeguarding information had not been shared at the time. Further review led to three retrospective Duty to Report referrals by Health Boards. The MDT found no evidence requiring wider retrospective contact with individuals, concluding that further intervention would often be disproportionate and could risk causing harm.

A consistent finding across both cohorts was the importance of sexual health services as a key safeguarding disclosure point. Young people were more likely to disclose contextual risks and vulnerabilities than explicitly identify abuse. The reviews highlighted the need for stronger professional curiosity, improved interpretation of safeguarding indicators, more consistent information sharing, better integration between sexual health and safeguarding services, and consideration of age-verification processes within digital services.

The reviews concluded that the historic safeguarding failure has now been addressed through extensive case review, multi-agency collaboration, strengthened governance and the introduction of a new service model from December 2025.

As of 13 July 2026:

- the review of Cohort 1 is complete. Findings and lessons learned have been shared with partners
- of the review of Cohort 2 is complete, the report has been shared with local health boards and will be shared with wider partners in due course

The MDT has recommended that a non-urgent desktop review is conducted by the National Safeguarding Service for cohort 3. This review will

- **Provide proportionate assurance on historic safeguarding risks** within Cohort 3 (2018–July 2022), recognising that all individuals are now adults and that no current statutory child safeguarding duties apply. The review aims to confirm whether the key learning and assurance gained from Cohorts 1 and 2 remain applicable to earlier cases.
- **Apply a risk-based and legally appropriate approach**, as the available information is predominantly historic disclosure data and is insufficient to determine whether individuals currently meet adult safeguarding thresholds or require intervention. The review therefore focuses on system assurance rather than individual case action.
- **Build on the strong evidence already obtained from Cohorts 1 and 2**, which consistently demonstrated that risks were generally identifiable

within the system, that failures related to interpretation and response rather than detection, and that no widespread unidentified safeguarding risk remains.

- **Ensure resources are directed to areas of greatest safeguarding value**, as a full case-by-case review of older, less complete records is unlikely to identify additional actionable concerns or materially alter the overall findings. A targeted desk-based analytical review will provide assurance, identify any emerging themes, and allow escalation of any specific concerns that emerge.

The final report on the National Reportable Incident related to safeguarding has been approved and submitted to NHS Performance and Improvement. The MDT is now closed.

3.2 Patient Safety Concerns in relation to Hepatitis C testing

In February 2026 it was identified that service users ordering a specific combination of tests who self-declared as HIV positive were not tested for Hepatitis C in line with national guidelines. The ordering platform implied that Hepatitis C was part of the test and when negative results were received for other tests the message stated "all results negative" so did not confirm Hepatitis C was not part of infections tested.

An expert sub-group group of the Incident Management Team was convened to investigate the issue and provide specialist advice and guidance on an appropriate solution.

As part of its review the IMT sub-group sought legal and independent ethical advice on its actions. The ethical advice received recognised that there was a balance between transparency and the potential harm that contact with affected people may cause. In making the decision on whether to contact people who whose tests were affected, but where there is no impact (e.g. when they were told they were negative and they were negative) it was recognised that there was a risk of 'paternalistic decision making' and advised seeking views representative of those who may be affected (e.g. from 3rd sectors groups). The sub-group consulted with third sector representatives who were supportive of the approach agreed.

Following a review of the data Public Health Wales identified 588 tests undertaken by 254 individuals that were affected by the issue. These were divided into 3 cohorts

- Cohort A – 131 service users with unknown Hep C status at the time of the test . All proportionate efforts have been completed to contact those in offer them a repeat test if they want it.
- Cohort B – 114 service users who have a negative HCV antibody test recorded after their affected test, and therefore would have been negative if the test had been appropriately performed. In line with legal and ethical advice described, no action will be taken with these stakeholders.
- Cohort C – 8 service users with known positive Hepatitis C status. These service users will be informed and assessed as part of their usual care.

As of 13 July 2026:

- Where appropriate efforts to contact service users or their usual care providers are now complete.
- A final report will be prepared for the incident management team and the National Reportable Incident report will be submitted by the end of July.

3.3 Information Governance and Data Processing Issues

The IMT identified a number of concerns relating to data processing and information governance. These have been investigated, and where appropriate referred to the Information Commissioners Office.

As of 13 July 2026:

- Implemented improvements in clinical record keeping systems through migration of some recording to Tarian.
- The sexual health service has implemented a number of upstream improvements to reduce the number of manual tasks and reduce the risk associated with them

A plan is being developed to increase the automation of data processing within the service. Progress in implementation of digital improvements which are essential to improving the safety and resilience of the service has been slow. Over 7 months since the identification of the incidents the service is still reliant on complex manual handling and storage of data in excel spreadsheets. These processes have been identified as the root cause of many of the failures within the service, and the ability to implement significant change and service improvement is constrained by these systems. The significant patient safety and information governance risks associated with these processes remain.

The work to support improvement in this area has been included in the IMTP addendum and is not proposed to be complete until March 2027.

4. Communication

In order to ensure that all stakeholders are appropriately informed Public Health Wales has established:

- a fortnightly stakeholder briefing that is sent to all partners across NHS and Local Government.
- A regular weekly SitRep for Welsh Government to provide assurance on actions taken

5. Incident Governance and Oversight

The incident management team is reviewing progress against the IMT closure criteria with an aim of closing the incident by the end of July.

As of 13 July 2026:

The incident closures criteria are partially met. Further action is needed to transfer remaining actions and risks to business-as-usual governance withing Health Protection and Screening Services Directorate.

A debrief and lessons learned exercise will be undertaken, supported by the Emergency Planning team after incident closure has been completed.

5.1 Best Practice Advisory Group

In order to support continued improvement an advisory group has been established to support the service. This group will have cross sector representation and will seek to provide advice on best practice in running similar services to ensure that the service develops in line with strategic ambitions for delivery of Excellent Public Health Services.

It has been challenging to recruit external expertise for the Best Practice Advisory Group. Initial discussions have been held with services outside Wales. Whilst recruitment is ongoing work has started on prioritising the areas for expert analysis. This is being achieved by identifying areas of consensus where best practice is clear, focus of the group can then be on reviewing the areas where there are discordant opinions on the appropriate actions.

5.2 External Independent Review

An external review has been commissioned. The terms of reference have been agreed. The chair has been appointed and work is commencing in August.

The external review will report its draft initial findings in October.

5.3 Internal Governance Review

A Public Health Wide Service Governance Review is ongoing and forming part of a wider programme of internal assurance to ensure that lessons are shared across all public facing services.

As of 13 July 2026 Public Health Wales is committed to:

- Reflect on the how transparency and how this may be balanced with harms associated with contacting individuals affected without warning.
- Learn from independent external review of the service
- Work with experts to improve the sexual health service in line with best practice
- Complete the review of all relevant service areas across Public Health Wales

6. Risk Assessment

The Incident Management Team continues to review the risk assessment for the service. At present the risk assessment remains that the benefits associated with suspending or stopping the service whilst issues are resolved, are outweighed by the harm that would be caused to vulnerable service users.

This recommendation is made on the following assumptions

- No serious risks are identified which cannot be mitigated appropriately
- Intended mitigations can be delivered in a timely way and deliver the intended risk reductions.
- Sufficient wrap around capacity is available to deliver on required actions whilst maintaining a safe service

7. Recommendation

The Board is asked to:

- **Receive assurance** in relation to the development and progress of the management of the sexual health incident
- **Receive assurance** in relation to the actions to review and improve service delivery