The Inquiry into Hyponatraemia-related Deaths

Summary of Findings in relation to

HSCB 'Investigation Report on Whistle Blower's concern in relation to searches and evidence relevant to the Hyponatraemia Inquiry' (12 December 2017).

Sir John O'Hara

18 June 2019

Context

1. On 9th October 2017 Mr Alphy Maginness, Chief Legal Advisor to the Directorate of Legal Services ('DLS'), alerted me to concerns raised by a whistle-blower within the Health Social Care Board ('HSCB') and relevant to the Inquiry into Hyponatraemia-related Deaths ('IHRD'). These were said to relate to information concerning the adequacy of searches made by the Western Health Social Services Board ('WHSSB') in 2004 for documentation relevant to the Inquiry and a subsequent attempt to dispose of IT equipment secured for the purposes of the Inquiry. The whistle-blower claimed that these concerns had been raised before but not investigated. Specifically, he/she requested an immediate investigation into whether this Inquiry had been misinformed by HSCB in 2013 in relation to the searches conducted in 2004. I asked that Mr Maginness place this information in writing, which he did. He also informed me that HSCB would conduct an investigation into the matters raised.

2. The concerns raised were of considerable interest and potential import because the WHSSB had been the Board engaged in the aftermath of the deaths of both Lucy Crawford and Raychel Ferguson but had been unable to provide adequate documentary evidence of its involvement with Lucy's case.

3. Accordingly, I sought detailed particulars from Mr Maginness of the HSCB investigation. On 30th November 2017 he informed me that the appointed Investigation Panel had concluded its inquiry and submitted a draft report which he summarised. He advised that their investigation had found no basis for the allegations raised. Unfortunately, I found that his summary of the draft report raised more questions than it answered. I circulated our exchange of correspondence with the interested parties and requested that the draft report, final report and all relevant and supporting papers be forwarded me by 19th January 2018.

4. I received both the draft and the final HSCB 'Investigation Report on the Whistle Blower's concern in relation to searches and evidence relevant to the Hyponatraemia Inquiry' (12th December 2017). However, and

notwithstanding the specificity of my request, supporting documentation was withheld on grounds of confidentiality. I was accordingly obliged to engage in extensive correspondence over the course of almost four months and exercise my statutory powers on two separate occasions to compel full production of these materials.

5. I have now reviewed the papers, transcripts of oral testimony and other evidence supplied me. The same documentation as was before the Investigation Panel has been made available to me. I have received almost the same oral testimony but by way of digital recordings and transcript. In light of this material I have analysed the final HSCB 'Investigation Report on Whistle Blower's concern…' and here summarise my findings in relation to the investigation and report.

HSCB Preparation for Investigation.

6. 'Terms of Reference' were fixed for the investigation into the whistle-blower's concerns in order:

(i) To establish if there has been any deliberate attempt to remove evidence from the consideration of the public inquiry into Hyponatraemia.

(ii) To consider if there has been any deliberate attempt to destroy evidence or equipment contrary to the instructions regarding the need to preserve evidence for further consideration by the inquiry.

(iii) To determine if the officers of the Board and previously WHSSB did undertake a comprehensive search of all material relevant to the work of the inquiry and if not how that might have been deficient or had any impact on the evidence provided by the HSC Board.

(iv) To establish what actions, if any, were taken by management to investigate any previous allegations made by the whistle-blower in relation to the matters at 1-3 above.

Notwithstanding that the terms allow scope for inquiry, they do not address all of the whistle-blower's concerns.

7. The Investigation Panel was appointed by the HSCB Chief Executive. I am concerned that there was insufficient distance between the three panel members and the matters under review and that the appointments were compromised by the potential for a perception of conflict of interest.

8. In addition, the panel lacked appropriate experience, training or support. It was a complex task and no advice was available on how to investigate. However, drafts of the HSCB's 'Whistle Blowing Framework and Model Policy' were provided referencing the important distinction between complaint and whistleblowing, namely "…*the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it."* It was not clear to me that the Panel understood this.

The Investigation.

9. Twelve witnesses were identified and interviews arranged. However, I am concerned that the interviews were not all conducted appropriately nor were they all properly investigative.

(i) The order of interviews does not appear to have been adequately considered. The whistle-blower ought to have been interviewed first in order that the concerns be understood and the questioning of others thereby informed.

(ii) A number of key witnesses were formally interviewed and 'informal meetings' conducted before the Investigation Panel was fully constituted.

(iii) There is reference to undocumented 'informal meetings' with some key witnesses but not others.

(iv) Whilst most interviews were digitally recorded, some were not.

(v) The Panel would appear to have conducted some interviews without adequately considering the documentation briefed.

(vi) Oral evidence was not probed sufficiently and interviewees were sometimes led in their evidence.

The HSCB 'Investigation Report on Whistle Blower's concern in relation to searches and evidence to the Hyponatraemia Inquiry'.

10. I consider the 'Introduction' unsatisfactory in that it purports to place the work of the whistle-blower investigation within the context of IHRD but fails to state that both Lucy and Raychel were treated at hospitals within the WHSSB area of responsibility, that their deaths were both reported contemporaneously to the WHSSB and that IHRD was examining allegations of 'cover-up' in relation to their deaths. The Report merely notes only that "*all five children were treated at the Royal Belfast Hospital for Sick Children, although a number had been transferred from other hospitals."* Furthermore, and whilst indicating that the investigation Panel had been "*asked to consider the information contained in the whistle blowing letter",* the report does not exhibit the 'letter'. Accordingly the report suffers limiting de-contextualisation.

11. The 'Executive Summary' of the HSCB Report states:

"*The Panel did not find any information or corroboration to substantiate the concerns reported*…

The Panel found that there are fact based explanations for each of the concerns raised…"

Given the evidence before the Panel I consider these findings to be wrong.

The Concerns as considered by the HSCB Report:

Concern (I): "Reversal of Position".

12. The whistle-blower correctly outlined events in 2013 whereby:

(i) An HSCB employee ('A') provided an e-mail statement describing his/her role in the 2004 search within the WHSSB for documentation relating to the deaths of Lucy Crawford and Raychel Ferguson,

(ii) This statement was then incorporated into written advices furnished by the HSCB and DLS to IHRD informing as to the identity of those conducting the 2004 searches and the extent of their searches,

(iii) 'A' subsequently co-signed a further e-mail statement which retracted his/her earlier instructions as to his/her role in the 2004 search (the so-called 'reversal of position').

It was this retraction of information previously given to IHRD which prompted the whistle-blower to voice concern *"in respect of the information provided to the Inquiry by HSCB in 2013"* and to ask whether "*the inquiry* [was] *misled or misdirected by HSCB in 2013 as to the searches conducted in 2004."* The evidence confirmed that HSCB brought this change of instruction to the attention of a junior DLS solicitor at the time. It was not however conveyed to IHRD.

13. The Investigation Panel, having examined the issue, concluded however that there had been **no** '*reversal*' of 'A''s instructions noting that *"the net outcome… was that there was no change in the description of A's roles and involvement"*. This was clearly not so. The implication of this finding was that there could have been no new information to give IHRD who could not thus have been misled, that the HSCB and DLS were blameless and the whistle-blower's assertion that he/she had raised these matters previously was academic.

14. In reaching this conclusion the Panel not only failed to take some evidence into account but misread and misconstrued other evidence.

(i) Oral evidence received from relevant HSCB management witnesses indicated the **opposite** of what was found.

(ii) The Report states that "*the Panel carried out two interviews with 'A' to account for the change of description in their role and they said that they had written the email 9 years after the searches and that their memory had let them down and that once reminded they were able to fully recall the extent of their role.*" In fact, the panel interviewed 'A' only once, did not ask about the inconsistent statements and made no record of the testimony referred to.

(iii) The Report concludes that "*the net outcome of the exchange of emails relating to the extent of involvement in the 2004 searches for information was that there was no change in the description of A's roles and involvement."* However, the Report quoted only one e-mail to illustrate this exchange but unfortunately misquoted so as to allow a change in meaning.

(iv) The Report notes that in discussion with one relevant HSCB witness and two named DLS solicitors (individuals other than the solicitor referred to above) "*the panel was able to confirm that the confusion experienced by 'A' was not considered to be of any material concern at the time, or at any time since."* This is inconsistent with a Panel note of the 'discussion' which reveals that the solicitors were seemingly unaware of the issue and, rather than confirming that it was not of any material concern to them, recorded that they "*would like to see A's explanation as to why there is a variation in [his/her] recollection of [his/her] role in the search conducted in 2004."*

15. Importantly, the lead member of the investigation panel has since acknowledged that the panel's understanding of the e-mails was incorrect and DLS has since accepted "*that the Inquiry ought to have been informed*

of A's revised recollection of A's role in the carrying out of searches in 2004."

Concern (II): Comprehensiveness of 2004 search.

16. The HSCB Report concluded that *"the Panel… found no evidence that suggests or indicates that officers of the Board and previously WHSSB did not undertake a comprehensive search of all material relevant to the work of the Inquiry*." However in my view the Panel overlooked evidence strongly suggestive of gaps in the 2004 search and furthermore that doubts had been expressed within the HSCB in 2013 as to the thoroughness of the 2004 search.

17. The Report addressed the fundamental issue of 'missing documentation' by stating that *"in interviews with the former WHSSB administrative staff, the panel noted variability in the information management practices... At that time emails were routinely erased when in-boxes became full, that files considered at that time to be unimportant were discarded rather than being archived and that hard copy documents were periodically weeded and shredded when filing cabinets became full… such activity was established procedure… in the period up to 2004… the… practice at that time was to periodically weed files (paper and electronic)…"* and whilst "*it is not valid to assume that the intention of this procedure was to deny access to and scrutiny of specific documents at a later date… it is subsequently recognised that this may have become an unintentional consequence."* However, I could find no trace of the evidence for these practices as detailed in the HSCB Report. Given the central importance of explaining the scantiness of documentation in light of the Panel's conclusion that there was no *"deliberate attempt to remove evidence from the consideration of the Hyponatraemia Inquiry,"* it would appear that the Panel may have resorted to assertion.

18. In addition, the Panel failed to pursue indications of unusual and possibly suspicious, circumstances surrounding the 2004 searches for hyponatraemia-related documentation. Conflicting accounts, contradictions and unwillingness to commit were all revealed.

19. If the situation in 2004 had been, as the evidence would suggest, that the search for documentation was not comprehensive, it is hard to understand how the Chairwoman of the WHSSB could have accurately assured the Permanent Secretary of the Department of Health, Social Services and Public Safety (DHSSPS) that "*As required*, *I have taken steps to secure and keep safe all documentation held by the Western Health and Social Services Board pertaining to the deaths of Lucy Crawford and Raychel Ferguson… Board staff have carried out searches of the minutes of Board, Committee and other meetings and of filing systems, Checks have also been carried out on information held electronically".* Either the Permanent Secretary and by extension IHRD were misled or there was an attempt to mislead the whistle-blowing investigation.

Concern (III): Failure of Management to Address Whistle-Blower's Concerns.

20. In expressing his/her concerns the whistle-blower asserted that

"*This matter has been raised with Management by me previously*

(i) I provided evidence of my concerns to an investigation panel in relation to workplace behaviours… My concerns were not addressed.

(ii) I raised concerns with line management on numerous occasions...

(iii) I raised concerns in 2013 at the point statements were changed..."

21. The Investigation Panel however concluded that *"There is no record of* [the whistle-blower] *informing senior management of* [his/her] *suspicions and concerns about how the WHSSB carried out its responsibilities in regard to the Hyponatraemia Inquiry".*

22. In this connection I find that their Report did not give due regard to evidence that:

(i) The whistle-blower informed his/her line manager and another manager as to his/her concerns contemporaneously.

(ii) The whistle-blower provided the HSCB initiated Workplace Behaviours Investigation in 2016 with a paper entitled 'Hyponatraemia Inquiry Information Searches' particularising both chronology and evidence from 2013 in relation to his hyponatraemia documentation concerns.

Concern (IV): Securing the IT Equipment.

23. The whistle-blower stated that 'A' had sought the disposal of electronic equipment secured for IHRD. The Report found no evidence to support the contention that *"…on multiple occasions, 'A' attempted to undermine a decision in respect of retaining electronic equipment by attempting to elicit authorisation from others."*

24. Notwithstanding that the evidence before me does not permit a determination of this issue and the equipment itself remains secure, I consider that the analysis presented by the Report is inadequate in that it fails to acknowledge all relevant evidence.

Conclusion.

25. I consider that the whistle-blower was correct to raise the matters he/she did and in the way he/she did. His/her concerns were of genuine import and he/she is to be commended for whistle-blowing. Not only was it in the public interest that he/she raise these matters but it was manifestly in the public interest that they be properly examined.

26. However, there was a serious failure to address these concerns, whether to investigate them properly or judge them fairly. The wrong conclusions were reached. This was a failure at leadership level within the Healthcare Service. Not only was the whistle-blower failed but so too was the Service. Confidence in the critically important systems of whistle-blowing depends upon fairness and professionalism. These were absent.

27. It is unsettling to be compelled to this conclusion given the many reassurances urged upon me by senior HSCB officials in open IHRD session. Whilst it is for others to determine why this particular whistle-

blower's concerns were not accorded proper response, I reiterate my recommendation that the highest priority be accorded the development and improvement of leadership skills within the Healthcare Service.

28. In the event, the whistle-blower's interjection brought valuable additional perspective to IHRD. On the basis of the evidence made available and on the balance of probabilities, I consider that the Investigation Panel ought to have concluded that:

(i) There were gaps in the WHSSB search for documents in 2004.

(ii) Mr Gowdy, Permanent Secretary of DHSSPS, and by extension IHRD were accordingly misled in 2004 as to the completeness of the searches undertaken within the WHSSB for documentation relating to the deaths of Lucy Crawford and Raychel Ferguson.

(iii) There was a failure by the HSCB in 2013 to bring relevant information to the attention of IHRD. This was an omission which left IHRD misinformed.

29. That the WHSSB should have failed to conduct appropriate searches and misled as to the extent of those searches is profoundly unsatisfactory and is to be criticised.

30. I am however satisfied that the failure of the HSCB, and by extension DLS, to provide partial correction of information previously given IHRD about those searches, did not constitute a deliberate attempt to mislead. In this connection the evidence reveals that the HSCB acted in good faith to bring this matter to the attention of DLS and the papers disclose a general professional intent on the part of DLS to relay instructions to IHRD. However, on this occasion, because it was believed that the amended instructions made little substantive difference to the information already given or the evidence to be submitted, it was genuinely, if wrongly, thought to be of limited importance. It would be harsh in the circumstances to criticise.

31. Nevertheless, had IHRD been informed in 2013 that previous advices given in relation to the 2004 searches had been retracted and that doubts had been raised within the HSCB as to the completeness of those searches – it is almost certain that further questions would have been asked and the issue of missing WHSSB documentation more fully examined at public hearing.

32. However, a counter-factual analysis of what might thus have been revealed does not assist. The evidence persuades that the focussed HSCB search for documentation in 2013 was both thorough and genuine. The IT equipment was examined and all extant files and minutes scrutinised. Those searches failed to locate 'missing' documentation. Accordingly, there is no additional evidence for me to consider and no likelihood of any further evidence becoming available.

33. Notwithstanding, the PSNI continues to investigate matters relating to the hyponatraemia-related deaths considered by me. Accordingly, the IT equipment referred to above and now located at Gransha Park House should be secured until such time as all criminal inquiries and investigations are complete. The HSCB should give relevant undertakings to the PSNI.

34. In addition, I now consider it necessary to formally recommend that all concerned in the investigation and consideration of whistle-blower's concerns within the Healthcare Service be adequately trained.

35. I make no amendment to the essential findings of my report as published.