**MEMORANDUM ON OUTSTANDING WHISTLEBLOWER ISSUE**

1. In late 2017 I was informed by the Director of Legal Services, representing the Health and Social Care Board, that a member of the Board staff had sent an email pursuant to the Board's Whistleblowing Policy. As more information was provided it emerged that concerns had been raised about the extent of searches carried out for documents in 2004 and about information then provided to the Inquiry about the results of those searches. Those searches had been within the Western Health and Social Services Board and related to documentation relevant to the deaths within the WHSSB area of Lucy Crawford and Raychel Ferguson.

2. I decided not to delay the publication of the Inquiry Report which went ahead on 31 January 2018. With the agreement of the Permanent Secretary of the Department of Health my investigation of the whistleblowing incident has continued.

3. During the Inquiry's extensive oral hearings during 2012 and 2013 witnesses gave evidence on various matters. That evidence was analysed in the Inquiry Report and accepted or rejected as I thought appropriate. Chapter 4 deals with the aftermath of Lucy's death. It contains extensive criticism of what were then the Sperrin Lakeland Trust, the Western Health and Social Services Board and the Royal Belfast Hospital for Sick Children and individuals working there. As is clear from Chapter 4 I concluded that the poor care Lucy received was deliberately concealed, opportunities to learn lessons were lost and the continuing use of Solution 18 placed Raychel at risk when she was admitted in 2001 to Altnagelvin Hospital.

4. Later in the Report in Chapter 7 there is criticism of the Department of Health and individuals there for, among other things, not knowing or having a system of finding out what was happening at hospitals. Chapter 8 of the Report looked at the extent to which advances had been made since the deaths of the children with whom the Inquiry was concerned. It was as a result of continuing concerns about identified failings that the recommendations made in Chapter 9 of the Report were prepared.

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5. I have concerns from the documents which I have received about a number of aspects of this whistleblowing matter. However, my view at this stage is that it is not proportionate or necessary to resume any public hearings of the Inquiry especially given the time and money which that will require. Accordingly, I intend to proceed in the following way:

   (i) I invite responses to this memorandum on the way forward from the Health and Social Care Board and other parties by 14 November.

   (ii) I will send my provisional findings to the Health and Social Care Board on or about 21 November.

   (iii) I will require a response from the Health and Social Care Board on or about 12 December before I will publish my final paper as an addendum to the Inquiry Report on or about 9 January 2019.

30 October 2018

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