

Directorate of Legal Services

Practitioners in Law to the Health & Social Care Sector

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By e mail

Strictly Private and Confidential

Mr Justice O'Hara
The Inquiry into Hyponatraemia-Related Deaths
Arthur House
41 Arthur Street
BELFAST
BT1 4GB



Date:

Our Ref:

30 November 2017

GA H99/85

Your Ref: JOH/0460/17

Dear Judge

RE: REGIONAL HEALTH AND SOCIAL CARE BOARD – WHISTLEBLOWING CORRESPONDENCE

I refer to the above matter, and previous correspondence, ending with yours of 22nd instant.

I can confirm that I met today with the investigators appointed by the Board, who have concluded their inquiries. They have prepared a draft report, which is being finalised and I can now confirm to you the outcome of the investigation.

The investigation panel comprised the following:

- Dr Sloan Harper, Director of Integrated Care, the Regional Health and Social Care Board
- Mr Jon Gillies, Associate in the HSC Leadership Centre.
- Mr Edmond McClean, Deputy Chief Executive/Director of Operations in the Public Health Agency.

There were four terms of reference for the investigation panel and I provide below the conclusion against each of those terms. The focus of the whistleblowing allegations centred on the searches for relevant documents conducted in Gransha Park House (GPH) in 2004 and 2013 in relation to the Hyponatraemia Inquiry. The investigation panel reviewed the documents secured in the 2004 and the later 2013 searches. In addition the panel reviewed a range of e mails and other documentation, including that provided by interviewees, including the whistleblower (WB).

The panel carried out interviews with 12 relevant individuals from the Board, the Directorate of Legal Services and the Health and Social Care Leadership Centre (two individuals who had **Providing Support to Health and Social Care**







carried out a previous workplace investigation in August 2016). WB was interviewed on two occasions.

Based on the information I have received, I believe a full and comprehensive investigation was carried out by the investigation panel.

Terms of Reference

1. Establish if there has been any deliberate attempt to remove evidence from the consideration of the Hyponatraemia Inquiry.

There was no evidence to indicate or infer that the GPH document handling procedures were implemented in order to deny information to the Hyponatraemia Inquiry or indeed to render information unavailable for any reason. With the exception of WB none of the individuals interviewed had ever formed an opinion that information may have been destroyed to prevent it being found in the search conducted in 2004. It was also noted that WB fell short of stating that information had been destroyed in order to prevent it being found in the 2004 search. The investigation panel found that the information management practices in place at GPH in 2004 were such that e mails were routinely erased when inboxes became full, that files considered at that time to be unimportant were discarded rather than being archived, and that hard copy documents were shredded when filing cabinets became full.

The panel concluded that there is no evidence to suggest there has been any deliberate attempt to remove evidence from the consideration of the Hyponatraemia Inquiry.

2. To consider if there has been any deliberate attempt to destroy evidence or equipment contrary to the instruction regarding the need to preserve evidence for further consideration by the Inquiry.

WB made direct reference to one member of staff ("A") relating to perceived attempts to destroy IT equipment that WB had been instructed to secure in the event that it was required at a later date. The investigators established that there were numerous e mails from "A" showing repeated requests relating to access to the room in which the IT equipment was stored; in some of these e mails "A" asked when the IT equipment could be removed. A senior manager then sent an e mail to both WB and "A", which made it clear that the security of the IT equipment was a priority and that WB was responsible for ensuring the security of the IT equipment. There was a further (exchange of e mails in December 2013; "A" stated an intent to tidy the IT storeroom on the ground floor and arrange for the IT equipment to be disposed of once the Inquiry had concluded; "A" asks "do you have any sense of the timeline for the Inquiry?." "A" is advised by WB in an e mail that "it is advisable to maintain the status quo". "A" then replied stating "subsequent advice from IG (Information Governance) staff was that no equipment should be moved or disposed of pending the end of the Inquiry which I totally understand". A further e mail from a senior manager on the 5th December 2013 stated that "the key to the store should be retained by (WB) until all associated processes with the Inquiry has (sic)concluded".

The investigators conclude that "A" fully understood that the equipment was to be retained until it was cleared for disposal after it was confirmed that it was no longer needed in connection with the Inquiry. It is also clear that "A" did not make any request to destroy or dispose of the IT equipment until after it was no longer required.

"A" confirmed to the investigators that clarity was sought about when the IT equipment could be moved because "A" needed access to a room that could only be accessed through the room in which the IT equipment was being stored. The investigation panel visited that room and was able

to confirm that "A" would indeed need access to the room in which the IT equipment was stored in order to access a room required for "A's" role.

The investigation panel found that WB was mistaken in perceiving that "A" was attempting to undermine a decision in respect of retaining electronic equipment and concluded "there is no evidence to suggest there has been any deliberate attempt to remove evidence from the consideration of the Hyponatraemia Inquiry".

3. 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.

The focus of WB's allegation was that the description of the role of "A" during the 2004 search for information that was set out in an e mail dated 29th August 2013 was not the same as the description of "A's" involvement provided in an e mail to the senior manager on the 12th March 2013. WB described this as evidence of a "complete reversal" of "A's" position which WB described as a cause for concern.

The investigation panel read all of the e mails provided by WB in support of those concerns. The panel also interviewed relevant staff and were able to confirm that the e mail of 29th August 2013 did set out an inaccurate account of "A's" role. However, the panel also heard from a senior manager that "A" was asked for clarification the next day and on that day (i.e. the next day) "A" replied to the senior manager and acknowledged the error and reverted to the original account as described in the 12th March 2013 e mail.

"A" was asked by the investigation panel to account for the change of description in roles and "A" said the e mail was written 9 years after the searches and memory had let "A" down and that once reminded at the time was able to fully recall the extent of the role. Further, in discussion with the senior manager and with 2 solicitors in the Directorate of Legal Services, the investigation panel was able to confirm that "A's" confusion was not considered to be of any material concern at the time or at any time since.

The actual variation between the accounts provided by "A" dealt with who conducted the search of the Board and Committee minutes. The clarification provided by "A" simply advised that "A" did not conduct the search of the Board and Committee minutes as previously "A" thought. There is no suggestion that the Board and Committee minutes were not searched. "A" was confused about the extent of the role in the 2004 searches and assumed responsibility for an aspect of the search that "A" did not carry out.

The panel found that this "short lived confusion" did not cause any concerns to be raised by any of the senior managers at that time, nor was it a source of concern for any of the DLS personnel involved at that time.

The panel concluded that it found no evidence in the course of its investigations that indicated or suggested that officers of the Board, and previously WHSSB, did not undertake a comprehensive search of all material relevant to the work of the Inquiry.

4. Establish what actions, if any were taken by management to investigate any previous allegations made by WB in relation to the matters at 1 to 3 above.

WB advised having previously provided the HSCB with a detailed account of WB's concerns during an external investigation into workplace behaviours. This investigation concerned the

working relationship between "A" and WB and dealt with interactions between them that had occurred over a number of years. The workplace investigation was conducted by two consultants from the HSC Leadership Centre in the period August to October 2016 and the associated report was published in November 2016.

The workplace investigation report did not deal with the concerns regarding allegations that "A" made numerous attempts to interfere with WB's requirement to secure IT equipment, neither did it deal with the alleged attempts to destroy the IT equipment for which WB had been made responsible. Those concerns have been investigated by this investigation panel and the findings are as set out above. The workplace investigation endeavoured to deal with the friction filled difficult relationship that characterised how "A" and WB interacted in the workplace. The external consultants from the Leadership Centre that conducted the investigation considered the information provided by WB in the context of the terms of reference for that investigation.

The investigation panel has also spoken with all of the senior staff present at the time and found no evidence to substantiate WB's assertion that "serious concerns were raised amongst senior staff" in regard to "A's" actions.

The investigation panel has concluded that until receipt of the e mail dated the 2nd October 2017, there is no record of WB informing senior management of suspicions and concerns about how the WHSSB carried out its responsibilities in regard to the Hyponatraemia Inquiry.

As you can see from the above, the investigation has found no evidence to support WB's contentions. It has found no issues of concern in relation to the search for documents by the Board (or its predecessor the WHSSB) to assist the Hyponatraemia Inquiry. The findings of the investigation panel would suggest that WB's concerns are linked to difficult workplace relationship issues.

Accordingly, you may wish to reconsider whether it would be beneficial to circulate the correspondence in relation to this investigation with all Interested Parties, on the basis that the issues giving rise to this investigation are more properly linked to workplace management.

I trust this is of assistance to you, and I would be happy to discuss further, should you so wish.

Yours faithfully

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