INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The Scottish Public Services
Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER
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Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: South Scotland

Case ref: **202107505**

NHS Organisation: **Borders NHS Board**

Subject: **Handling of a whistleblowing concern**

This is the report of the Independent National Whistleblowing Officer (INWO) on a whistleblowing complaint about the handling of a whistleblowing concern. It is published in terms of section 15(1) of the Scottish Public Services Ombudsman Act 2002 which sets out the INWO's role and powers. There is more information about this here *https://inwo.spso.org.uk/*

Supported by the confidential appendixes, it is a full and fair summary of the investigation.

Executive summary

1. The complainant (C) complained to the INWO about Borders NHS Board (the Board). C was involved in a whistleblowing investigation carried out by the Board under the National Whistleblowing Standards.
2. The complaint I have investigated is:
   - 2.1. the Board has failed to appropriately handle the whistleblowing concerns raised in accordance with the Standards. (*upheld*)
   - 2.2. the Board has failed to treat staff involved with the concern appropriately. (*not upheld*)
3. As a result of my findings, the Board have been asked to implement a number of recommendations and consider and reflect on other feedback, particularly in relation to compliance with the National Whistleblowing Standards.
4. My investigation also identified a number of areas of good practice by the Board, which have been included in my feedback.

20 September 2023

Publication

In the interests of transparency and sharing learning to drive improvement, the INWO makes public the details of findings and conclusions as far as she is able. The INWO cannot make public every detail of her report. This is because some information must be kept confidential because the Act says that, generally, reports of investigations should not name or identify individuals. In this context, in the report names have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

5. INWO is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland. INWO has a remit to consider complaints from whistleblowers about how their concerns have been handled.

6. INWO can also consider complaints from others involved in a whistleblowing case about whether an NHS organisation has followed the process under the Standards, and their treatment as an individual. In considering such complaints, INWO's role is not to reinvestigate or assess the merits of the original concern, but rather to focus on the process followed under the Standards.

7. In order to investigate C's complaint, the INWO:

    7.1. took evidence from C in written format and by telephone

    7.2. obtained and reviewed the Board's stage 2 report and complaint file

    7.3. obtained comments and documentary evidence from the Board, and

    7.4. took evidence from witnesses through interview.

8. Evidence was assessed and analysed and from that, findings and recommendations made, and a decision taken. This report and supporting appendixes provide a summary of the evidence upon which I relied, and my findings and recommendations. A high-level summary of the evidence considered is provided in private Appendix A.

9. C and the organisation were given an opportunity to comment on a draft of this report.

Presentation of evidence and analysis

10. The evidence upon which I have relied in making my findings, decision and recommendations is summarised in a series of private appendices. These appendices also include analysis of the evidence.

11. The requirement for confidentiality, and need to protect the identity of C and others involved in the investigation means that none of these appendices are published, nor is it appropriate for people within the Board, to have sight of them, other than

those who need to know. This document includes a *Summary of documents that make up the full INWO report*, including a list of the appendices and the restrictions relating to their publication and sharing.

Findings and decision

Point 2.1 The Board has failed to appropriately handle the whistleblowing concerns raised in accordance with the Standards

12. C was involved in a stage 2 whistleblowing investigation under the Standards, carried out by the Board.[1] The local investigation identified no wrongdoing by C or any other person. Detailed background to the complaint is set out in private Appendix B.

13. C's concerns under this complaint are itemised in private Appendix C, but relate to, in summary:

    13.1. the Board's decision to consider the concerns under the Standards

    13.2. the level of support provided by the Board to C

    13.3. the Board's approach to evidence submitted by C

    13.4. delays in the investigation, and

    13.5. C's confidentiality.

14. In their responses, the Board recognised the sensitive and challenging nature of the case. They also highlighted the concerns occurred soon after the implementation of the Standards and during waves of the COVID-19 pandemic. In summary, the Board's position was that

    14.1. the Board had embraced and followed the Standards. However, the Board noted their arrangements for handling whistleblowing concerns were still in a process of change, in the context of the exceptional events at the time.

    14.2. the whistleblower's concerns, taken at face value, were such as required further investigation under the Standards.

    14.3. INWO guidance focuses on support for the whistleblower, and is not clear about how support should be offered to other parties involved in an investigation. (Nonetheless, the Board highlighted specific support that was offered to C through the process.)

    14.4. the investigator had maintained an open mind and a balanced, objective outlook during their investigation and had carefully considered all the evidence provided by C.

[1] *National Whistleblowing Standards | INWO (spso.org.uk)*

14.5. the investigation took place at an exceptionally demanding and busy time for the Board. They recognised they were unlikely to achieve the timescales and notified all parties in accordance with the Standards.

14.6. knowledge of the case was carefully restricted to the minimum number of officers, and those involved in the case maintained a high level of confidentiality.

15. To test and consider this, my investigation considered the evidence as summarised in private Appendix A and as discussed in private Appendix C. I also considered the Board's concerns-handling based on the expectations set out in the Standards more broadly. In doing this, I considered the evidence as summarised in private Appendix D.

2.1 Findings

16. I took into account written correspondence provided by the Board and the complainant, the complaint file from the Board and what witnesses told me (with details provided in private Appendix A and private Appendix C). I have set out my detailed consideration of the specific issues raised by C in Appendix C. My key findings are set out below.

17. I have found that some aspects of the Board's handling of C's whistleblowing concerns were compliant with the Standards and demonstrated good practice. In particular

17.1. I am satisfied that the Board had an appropriate basis to handle it under the Standards.

17.2. the (Board's) investigator took a thorough and detailed approach to gathering evidence to confirm the facts of the cases.

17.3. the (Board's) investigation was handled sensitively and carried out in good time, in particular, considering the complexities involved.

18. I have also identified areas where the Board were not compliant with the Standards and where they can make improvements and take learning from this case. In particular

18.1. while I recognise support was offered by the Board, I consider this could have been more actively provided given C's vulnerable position.

18.2. while I accept the Board took confidentiality very seriously and only a few people were aware of the investigation, I identified an instance where confidentiality could have been better protected.

19. It is also appropriate that I consider the Board's handling of the whistleblowing concern beyond C's specific concerns[2]. My consideration of the Board's handling of the matter (as provided in private Appendix D) identified the following shortcomings:

19.1. I recognise the case occurred at an early stage in the national implementation of the Standards. However, the roles carried out by different key officers within the Board, both during and after the investigation, did not follow the relevant descriptions in the Standards (the Confidential Contact, the manager responsibility for commissioning an investigation and responding to the concern at stage 2, and the INWO liaison officer).

19.2. there were inconsistencies in the way that the parties were informed of the outcome of the investigation.

2.1 Decision

20. The complaint I have investigated is that the Board has failed to appropriately handle the whistleblowing concerns raised in accordance with the Standards.

21. As set out in my findings, I have found there could have been improvements in how the Board supported C, and how they protected C's confidentiality.

22. I have also found that the roles of the people involved in handling the whistleblowing concern did not comply with what is set out in the Standards, and there was a lack of consistency in communicating the stage 2 outcome to the parties involved in the investigation.

23. In light of the various issues I have highlighted (and the impact this had on C), I find that there is sufficient evidence, on balance, to **uphold** point 2.1 of this complaint.

24. In making my decision, I recognise that the Board's implementation of the Standards was in its early stages and that some issues were likely to have been the result of the organisation finding its feet with a new procedure.

Point 2.2. The Board has failed to treat staff involved with the concern appropriately

25. C's complaint to the INWO raised a number of concerns about how they were treated by the Board, during and after the local investigation. These are detailed in private Appendix C, and in summary were about

25.1. how they were communicated with and treated by the Board during the concern, and

[2] Section 6A of the Act sets out the INWO's powers and duties in relation to whistleblowing complaints. This is wide-ranging and includes ensuring compliance with a model complaint handling procedure for whistleblowers' complaints – the National Whistleblowing Standards.

25.2. the Board's response to issues raised by C.

26. In their response, the Board

26.1. stated that C had been communicated with in a business-like and professional manner, applying the INWO Standards and advice available at the time.

26.2. disputed they had failed to treat C appropriately throughout their investigation.

26.3. provided an explanation of their approach.

27. To test and consider this, my investigation looked at the evidence as summarised in private Appendix A and as discussed in private Appendix C.

2.2 Findings

28. I took into account written correspondence provided by the Board and the complainant, the complaint file from the Board, and what witnesses told me (with details provided in private Appendix A and private Appendix C). I have set out my detailed consideration of the specific issues raised in Appendix C. My findings are set out below but are limited in detail to protect the privacy of all parties to the investigation. In summary

28.1. overall, the Board's treatment of and communication with C was reasonable.

28.2. the Board took the issues C reported seriously. They took advice and responded appropriately to that advice.

2.2 *Decision*

29. The complaint I have investigated is that the Board failed to treat staff involved with the concern appropriately.

30. It is important to note here that as the Independent National Whistleblowing Officer for the NHS in Scotland, I can only consider the Board's response to a whistleblowing concern, and their part in the situations C reported.

31. I have found no evidence that C was treated unfairly by the Board, therefore I am unable to uphold this complaint.

Additional Comments and Feedback

32. As acknowledged, the Board's investigation took place at a challenging time for them (and the NHS), and given the demands of the COVID-19 response, the Board did well to respond to the whistleblowing concern in the time that it did.

33. I also recognise the demand that this will have placed on the key whistleblowing staff concerned, in terms of time and resources.

34. My investigation was aided by the co-operation of the witnesses who were interviewed, C and their union representative. I am grateful to all of them for their assistance and their constructive and thoughtful engagement with the process.

35. Finally, it should be noted by the Board that the Standards place a continuing obligation on NHS organisations to provide support and protect those involved in a whistleblowing concern from detriment, and I encourage them to reflect on this case to identify opportunities for learning.

Recommendations

Learning from complaints

The Independent National Whistleblowing Officer expects all organisations to learn from complaints. The learning should be shared with those responsible for whistleblowing as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation.

36. I accept the Board has already taken action to address a number of issues identified.

What INWO is asking the Board to do for C

Rec. No	What INWO found	Outcome needed	What INWO need to see
1.	Under 2.1 I found: • that the Board could have been more active in providing support for C. • that the Board could have better protected C's confidentiality. • that there were shortcomings in the handling of the concerns in accordance with the Standards in regard to – the roles of whistleblowing staff and – the consistency of the outcomes communicated to C and the whistleblower.	Apologise to C for the shortcomings in provision of support for C, the breach of C's confidentiality and case handling. The apology should meet the standards set out in the SPSO guidelines on apology available at *www.spso.org.uk/information-leaflets*	A copy of a letter or other record confirming an apology was given to C. By: 18 October 2023

What INWO is asking the Board to improve the way they do things

Rec. No	What I found	Outcome needed	What INWO need to see
2.	Under 2.1 I found: • that the Board could have been more active in providing support for C. • that the Board could have better protected C's confidentiality. • there was a lack of consistency in communicating the outcomes of the local investigation to C and the whistleblower	Learning is identified from this case and actioned appropriately.	Evidence that the Board has identified and actioned (or plans to action) learning. By: 15 November 2023

What INWO is asking the Board to do to improve their compliance with the Whistleblowing Standards

Rec. No	What INWO found	Outcome needed	What INWO need to see
3.	Under 2.1 I found that there were shortcomings in the handling of the concerns in accordance with the Standards, in regard to the roles of whistleblowing staff.	Officers involved in handling whistleblowing concerns must discharge their roles in accordance with the responsibilities set out in Part 4 of the Standards.	Evidence that the Board has reviewed the roles of the staff involved in whistleblowing, in light of the findings of this investigation. By: 15 November 2023

Summary of documents that make up the full INWO report

Document Name	Description	Restrictions at final stage
Summary Report on complaint about the Board Reference: 202107505	Anonymised/ pseudonymised summary of complaint investigation and findings	None Published in full
Private Appendix A: High level summary of evidence relating to all points	Confidential summary of the evidence considered in this case.	• Complainant • CEO • Internal investigator • Director of Workforce • Chair • Whistleblowing Champion (Appendix must not be shared wider.)
Private Appendix B: Background to the complaint	Confidential summary of the background to the complaint	• Complainant • CEO • Internal investigator • Director of Workforce • Chair • Whistleblowing Champion • (Appendix must not be shared wider.)
Private Appendix C: Discussion of complaint 2.1 and 2.2	Confidential discussion of the points considered within complaint 2.1 and 2.2.	• Complainant • CEO • Internal investigator • Director of Workforce • Chair • Whistleblowing Champion • (Appendix must not be shared wider.)
Private Appendix D: INWO feedback on the case handling	Confidential discussion of aspects of the Board's handling of the concern	• Complainant • CEO • Internal investigator • Director of Workforce • Chair • Whistleblowing Champion • (Appendix must not be shared wider.)