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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Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: Mid Scotland and Fife

Case ref: 202301375

NHS Organisation: Forth Valley NHS Board

Subject: **Speak up culture, detriment, concerns handling**

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 public and confidential appendices, it is a full and fair summary of the investigation.

Executive summary

1. The complainant (C) complained to the INWO about NHS Forth Valley (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 failed to create and maintain a culture that values and acts on concerns raised by staff in the Women and Children's Directorate (upheld)
   - 2.2. The Board unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards (upheld)
   - 2.3. The Board failed to protect C from detriment associated with speaking up (including under business as usual arrangements) (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.

4. My investigation also identified a number of areas of good practice by the Board, which has been included in my feedback.

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 at a local level.

6. In this case, C complained to the INWO:

   6.1. about the handling of their concern

   6.2. about the speak up culture within the Board's Women and Children's Directorate, and

   6.3. that they had been treated unfairly for highlighting safety concerns under business as usual arrangements.

7. For something to be whistleblowing, it must be in the public interest, rather than primarily concerned with a personal employment situation. In this case, I was satisfied that there was a public interest in C's concerns because of the link to patient safety and the importance of a healthy speak up culture where staff feel safe to raise concerns, confident that they will be listened to and acted upon where necessary.

8. In order to investigate C's complaint, I (with the support of my officers):

   8.1. took evidence from C in written format and by telephone,

   8.2. obtained and reviewed the Board's stage 2 report and full complaint file, including notes from interviews with key staff members,

8.3. obtained comments and documentary evidence from the Board,

8.4. reviewed and assessed against relevant guidance,

8.5. obtained professional advice from an adviser with relevant experience, and

8.6. took evidence from witnesses through interview.

9. Evidence was assessed and analysed and from that, findings and recommendations were 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 public Appendix A.

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

Presentation of evidence and analysis

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

12. The requirement for confidentiality, and need to protect the identity of C and others involved in the investigation, means that not all 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 final 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 failed to create and maintain a culture that values and acts on concerns raised by staff in the Women and Children's Directorate

13. C raised a complaint with the INWO that the culture within the Women and Children's Directorate at NHS Forth Valley was not one that was supportive and encouraging of staff raising concerns. In order to demonstrate this, C provided two examples of incidents relating to patient safety and pointed to the Board's handling of the issues within the department.

14. The full background to the complaint is set out in private Appendix B where I discuss the details of the specific incidents C raised in their complaint. I have not included the full details here due to the sensitivity of the issues raised and in order to protect the identities of those involved.

15. The key issues considered under this complaint were C's concerns that:

15.1. unreasonable action was taken to cover up staffing issues on a ward, despite concerns raised by staff at the time, and

15.2. there was an unreasonable failure to take action to protect staff and patients from a risk of harm following multiple reports from staff about behavioural concerns within the Directorate.

16. The Board investigated C's concerns under the local whistleblowing procedure. Some of the detail of the Board's response is confined to private Appendix B. In brief summary, the Board's position was:

<u>Incident one</u>

16.1. Decisions around staffing arrangements on a specified shift were based on experience within the ward and followed normal practice.

16.2. There was no evidence of formal concerns about behavioural issues being raised to managers prior to the shift. No informal concerns had been accompanied by sufficiently robust evidence that would have enabled managers to investigate further.

16.3. Prompt action was taken to address the concerns and safeguard patients and staff. Action was professional and timely and in direct response to concerns highlighted by C at the time of the incident, and minimised the duration of the incident.

<u>Incident two</u>

16.4. The staffing on the ward was challenging and there were exceptionally high patient numbers and acuity on the day in question. Concerns raised at the time were acknowledged and mitigating measures were put in place to reduce the risk to patients. Although extremely busy, the ward was safe.

16.5. The mitigating measures included

16.5.1. regular monitoring

16.5.2. senior staff adopting a more clinical role, and

16.5.3. agreement with medical staff to pause inductions.

16.6. The care delivered by C during the shift was assessed as being excellent by a multidisciplinary group who reviewed the care of a patient on that ward during the relevant shift. C demonstrated professionalism, expertise and high standards of care.

16.7. There is an ongoing challenge presented by a national shortage of qualified midwives. The Board are taking a pro-active approach to recruitment and retention.

16.8. Managers and staff share the ambition to provide high quality care for women and babies in a safe and compassionate environment and considerable effort is being made to maintain and increase staff numbers, with registered nurses and support staff being recruited to support the midwifery workforce.

16.9. Some aspects of the concerns raised by C could not be looked at due to overlap with HR processes.

17. To test and consider this aspect of the complaint, my INWO investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B.

2.1 Findings

18. I took into account written correspondence and evidence provided by the Board and the complainant, the complaint file from the Board, witness interviews, and relevant policies and procedures. I also sought independent professional advice. I set out my detailed consideration of this advice and the background to the complaint in private in Appendix B. My key findings are set out below.

19. The focus of C's complaint to me was the way in which the two incidents were illustrative of a departmental culture that does not value and act on concerns

raised by staff. I have considered this carefully in light of the information gathered and the views expressed by staff during interviews.

20. In relation to the first incident linked to behavioural concerns, I found that there were missed opportunities to both act on and follow up on staff concerns raised prior to the incident that prompted C to raise concerns. There were also missed opportunities to raise and escalate concerns about behaviour witnessed by staff. To some extent this appeared to be because there was an assumption that the issue was already being addressed.

21. The information shared with me by the Board about the number of concerns raised and the degree of formality to the concerns, seemed at odds with the information my team gathered during interviews where a number of separate incidents were described, including how they were reported.

22. I acknowledge that the serious concerns raised by C during one particular shift were responded to swifty and appropriately. I also found that some supportive actions had been taken by the Board previously.

23. Despite this, there does not appear to have been a response to renewed concerns expressed by staff in the months and hours before the incident at the heart of the complaint raised by C.

24. I recognise that the particular circumstances were sensitive and difficult to manage, and that there were limitations to the amount of information that could be shared with staff.

25. In the second incident, C's concerns around staffing appear to me to have been responded to in a defensive rather than supportive manner.

26. The Board's own whistleblowing investigation commended C on their professionalism and level of care for their patients. This was further supported during the interviews my team carried out. This leads me to question why C's decision to raise concerns about the staffing levels was not received more supportively and constructively at the time. Instead C appears to have had to defend the facts surrounding their experience, rather than share them in an environment open to listening to them. This is not suggestive to me of a culture that values and acts on the concerns raised by staff.

27. It was also apparent during interviews that the way that C was treated has further damaged confidence in the speak up process amongst C and their colleagues.

28. My team conducted interviews during my investigation and asked general questions about the speak up culture within the department. From these I found that:

    28.1. there was a good understanding of the routes to raise concerns and confidence in doing so, if required, but

    28.2. that there was less confidence that concerns would be acted upon or that changes would be evident. Trust appears to have been damaged by the incidents above.

29. In response to my enquiries, the Board outlined a range of steps introduced to support the development of an improved speak up culture within the department. The steps included:

    29.1. an ongoing Culture Change and Compassionate Leadership Programme. All staff were supported to attend the relevant workshops and feedback sessions.

    29.2. staff attended ‘design workshops’ (following a focus group) with the aim of identifying potential solutions to help improve the experience of staff.

    29.3. the work included sessions with Nursing, Midwifery and AHPs (NMAHP) and feedback to teams in relation to a 5-step plan, which captures work on culture.

    29.4. the Board has a Whistleblowing Network represented by colleagues from the Women and Children’s Unit who also received training based on the tools designed by INWO.

30. These steps outline the work carried out since the time that C raised concerns with the Board.

2.1 Decision

31. The point of complaint I have investigated is that the Board failed to create and maintain a culture that values and acts on concerns raised by staff in the Women and Children's Directorate.

32. In making my decision, I recognise the challenges all boards face in creating a safe and trusted whistleblowing culture. I am mindful of the positive work that the Board has done more recently to develop and improve the speak up culture within the department. The evidence obtained during my investigation suggests that staff have a good understanding of the routes to raise concerns and feel comfortable doing so. This suggests that the Board's promotion of the speak up arrangements is having a positive impact.

33. However, I have underlying concerns about the culture based on the specific incidents I have reviewed during my investigation. My findings also suggest that staff confidence in the speak up arrangements has been damaged as a result of the incidents. While staff know how to raise concerns, they expressed doubts about whether those concerns would be acted upon and addressed.

34. In light of the various issues I have highlighted, I find that there is sufficient evidence, on balance, to **uphold** this point of the complaint. I have made a recommendation that takes into account the work the Board are already undertaking to understand and improve the culture.

Point 2.2. The Board unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards

35. The key issues considered under this complaint were C's concerns that:

    35.1. the Board's whistleblowing investigation did not gather the testimony of key witnesses

    35.2. although one witness was contacted for information in writing, the questions were very limited in scope, and

    35.3. the Board's stage 2 response letter contained inaccuracies.

36. In response to my enquiry, the Board shared their reflections on the investigation of C's concerns, including that:

36.1. the overlap between the whistleblowing concerns and related HR investigations made the process challenging. Although the National Whistleblowing Standards (the Standards) indicate that HR and whistleblowing processes can take place at the same time, in practice it can be difficult, particularly if the investigations both require input from the same witnesses.

36.2. It was evident throughout the process that C is conscientious, professional and cares deeply about patients.

36.3. engaging with potential witnesses presented a challenge due to shift patterns and annual leave. The short timeframe allowed for a whistleblowing investigation made this challenging. Where a statement was obtained, it appeared to disagree with the information provided by C.

36.4. numerous measures have been taken by the Board to address the issues raised in the concerns (particularly relating to staffing levels). There were no additional measures that could be recommended as a result of the whistleblowing investigation to further strengthen these measures.

37. To test and consider this element of the complaint, my investigation considered the evidence summarised in public Appendix A. I also considered the Board's concerns handling based on the expectations set out in the Standards more broadly.

2.2 Findings

38. Section 6A of the SPSO 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 complaints handling procedure for whistleblowers' complaints, the National Whistleblowing Standards. It also states that a whistleblower is entitled to have a concern handled in accordance with that procedure.

39. While C identified some particular issues, I would not expect them to know every detail of the Standards. I would, however, expect the Board to have knowledge of

the Standards and to have handled C's concern in accordance with them. It is, therefore, appropriate that I consider the Board's handling of the whistleblowing concern beyond C's specific complaints.

40. In order to address C's specific complaints about the handling of their concerns, I took into account documentary evidence provided by the Board and C, as well as the Board's complaint file, and what witnesses told my team.

41. My key findings are set out below.

42. The Board provided a good investigation file and a thorough investigation report, which outlined the evidence considered (including a note of meetings and interviews), the findings and the conclusions. The investigator was appointed promptly and took the concerns seriously. It was evident that they sought to progress the investigation quickly with a focus on patient safety.

43. The investigator met with C to understand their concerns at the start of the process and kept a good note of what was discussed. Their report (and subsequent reflection on the process) was detailed and empathetic.

44. The stage 2 response that was shared with the whistleblower demonstrated areas of good practice:

    44.1. the key areas of C's concerns were clearly identified and there was a good explanation of the findings under separate headings making it easy to understand

    44.2. there was a focus on patient safety and the measures in place to mitigate risk and improve issues with staffing, and

    44.3. the letter thanked C for raising the concerns and demonstrated sympathy for their experience.

45. There were some aspects of the stage 2 response that could have been better.

    45.1. Although there was signposting to the INWO, the letter did not include the full contact details and signposting text outlined in the Standards. While this is not mandatory, it is good practice to provide comprehensive and up-to-date information to whistleblowers on the next steps available to them.

45.2. The findings were clearly explained but the letter did not set out the Board's conclusions; i.e. whether the concerns were upheld or not upheld. It is important to ensure that whistleblowers understand fully the outcome of their concerns.

46. The investigator spoke to two witnesses with relevant management insight and attempted to arrange interviews with a number of staff members suggested by C. They found it difficult to arrange interviews with the latter group and ultimately concluded the investigation without speaking to the majority of those witnesses. The Board told me that it had not been possible to arrange interviews within the timescales outlined in the Standards.

47. While I recognise the concerns about meeting timescales, the Standards are clear in that they make provision for the timescale to be extended beyond the 20 working days allowed for an investigation if there are justifiable reasons. They say:

47.1. 'The organisation should aim to provide a full response within 20 working days, but this is not a target or performance measure. **It should carry out a thorough investigation that leads to good outcomes, even if that takes longer than 20 days**. The timescale is there to make sure that organisations take prompt action, and that there is an **ongoing focus on investigating and addressing the concern**, while keeping everyone involved updated on the progress of the investigation.'[1]

48. Only one of C's witnesses provided input to the investigation and this was in the form of a short written statement, responding briefly to three questions asked by the investigator.

49. It appears that the content of the written statement was misinterpreted when it was reviewed. The investigation report indicates that no formal or informal concerns had been raised by that person, when in fact the statement said that an informal concern had been raised.

50. My impression is that this was a genuine but unfortunate error in the interpretation of the statement. It led the Board to conclude that there was no evidence to

[1] *The National Whistleblowing Standards*, Part 3, paragraph 34.

support C's version of events, when in fact the evidence suggested that there could have been.

51. The information in the witness statement was limited and should have triggered further exploration. My view is that it would also have been reasonable for the Board to extend the investigation timescales to enable all the interviews to be arranged, rather than conclude the investigation without the information.

2.2 Decision

52. The complaint I have investigated is that the Board unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards.

53. In making my decision, I recognise that much of the Board's handling of the concern was good and contains examples of good practice. C's concerns were taken seriously. I have observed some areas of good practice and although I noted some areas for improvement in the stage 2 response letter, it was generally helpful and detailed.

54. I found that the Board's investigation did not gather witness testimony from the staff members suggested by C because of a perception that there was not enough time. I also found that a written statement was misinterpreted and as a result, the evidence supporting C's version of events was not fully explored. It is possible that this could have altered the findings and conclusions of the Board's investigation.

55. In light of the issues I have highlighted, I find that there is sufficient evidence, on balance, to **uphold** this element of the complaint.

Point 2.3 The Board failed to protect C from detriment associated with speaking up (including under business as usual arrangements)

56. C complained that they had been treated unfavourably as a consequence of speaking up in business-as-usual contexts. They outlined a specific scenario where they believed that they were subjected to detriment.

57. The Board provided background information about the specific incident raised by C and, with C's consent, evidence gathered during an HR investigation. The Board told me that they did not investigate C's concerns about detriment under the whistleblowing procedure because of the need to ensure that there was no overlap

with a HR process. The investigator indicated that they had some concerns about the situation C described and expressed willingness to consider the concerns further at the conclusion of the HR process, if that was appropriate.

58. I have included a discussion of the evidence and my conclusions in confidential Appendix B. Due to the sensitive nature of the evidence, I have decided that all of the detail must remain confidential as it could risk identifying C and other staff if disclosed.

59. C and a restricted group of staff at the Board are aware of the evidence and findings on this element of the complaint.

2.2 Decision

60. The complaint I investigated is that the Board failed to protect the whistleblower from detriment associated with speaking up.

61. I found, on balance, that C was treated negatively as a result of raising concerns about staffing levels under business as usual arrangements and they experienced detriment in the form of the disproportionate application of HR procedures. For this reason, I **uphold** this element of the complaint. The circumstances of this case reflect poorly on the speak up culture within the department.

Additional Comments and Feedback

62. I recognise that the stage 2 response letter was issued prior to a number of improvements to the Board's process implemented in the second half of 2023. For this reason I have not included a recommendation but I encourage the Board to reflect on these findings.

63. My investigation was helped by the co-operation of C, the Board's liaison officer and the witnesses who were interviewed. I am grateful to all of them for their assistance and their constructive and thoughtful engagement with the process.

64. It should be noted by the Board that the Standards place a continuing obligation on NHS organisations to provide support and protection from detriment to those involved in a whistleblowing concern.

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.

What INWO are asking the Board to do for C

Rec. No	What INWO found	Outcome needed	What INWO need to see
1.	Under 2.2 and 2.3 I found: • There was an error in the interpretation of evidence that could have supported C's account of events; • The timescale for investigation was not extended to allow for interviews to take place; and • C was treated unfairly as a result of raising concerns under business as usual arrangements.	Apologise to C for the issues identified in the report. 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: 26 May 2025

What INWO are asking the Board to improve their improve the way they do things:

Rec. No	What I found	Outcome needed	What INWO need to see
2.	Under 2.1 and 2.3 I found: • The circumstances of this case reflect poorly on the speak up culture within the department.	The Board has a culture where staff feel safe to speak up without fear of detriment, confident that they will be listened to and actions, where needed, will be taken as a result. The Board use learning from whistleblowing cases to drive improvements in the speak up culture.	Evidence that demonstrates: • How the Board have reflected on the findings from this case in the context of their improvement work and identified any further areas for focus. • How the reflection process captured the views of staff involved in, or impacted by this case. • How the identified learning points from this case have been acted on, or have a clear timetable to be acted on. **Should the Board consider it necessary to share any confidential details in order to progress this work, they should consult with the INWO and the Whistleblower.** By: 23 June 2025

Summary of documents that make up the final full INWO report

Document Name	Description	Published/private
Summary Report Reference: 202301375	Anonymised/ pseudonymised summary of complaint investigation and findings	Published
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case	Published with the summary report
Private Appendix B: Confidential discussion of complaint points 2.1 and 2.3	Detailed discussion of the points considered within complaint points 2.1 and 2.3	Private

Appendix A: High level summary of evidence

1. This Appendix contains a high level summary of the evidence considered during the investigation, and to which elements of the complaint it was relevant.

2. The findings in the summary report reflect how this evidence was used. The purpose in listing it here, is to assure the complainant and others involved that a wide range of evidence was sought and considered.

3. **This appendix is not a confidential document and there are no restrictions on sharing it [once published].**

Document Name	Description	Restrictions at draft stage	Restrictions at final stage
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case.	• Complainant • CEO • Internal investigator • Whistleblowing Lead (Appendix must not be shared wider until final.)	None

Description	Relevant to:		
	2.1	2.2	2.3
1. National Whistleblowing Standards The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'. The Standards are available at https://inwo.spso.org.uk/national-whistleblowing-standards	Yes	Yes	Yes
2. Complaint and documents provided by C			
i. C's concerns submitted to the Board	Yes	Yes	Yes
ii. C's complaint to INWO	Yes	Yes	Yes
iii. Email correspondence	Yes	Yes	Yes
3. The Board's stage 2 report and complaint file The Board's complaint file, which included:			
i. The Board's stage 2 final report	Yes	Yes	Yes
ii. Correspondence relating to the concern	Yes	Yes	Yes
iii. Meeting notes with C	Yes	Yes	Yes
iv. Witness meeting notes	Yes	Yes	Yes
v. Reflective note from the Board's investigator	Yes	Yes	Yes
4. Additional evidence provided by the Board INWO made a number of detailed enquiries of the Board. We sought and obtained their comments on matters considered relevant to the investigation and any supporting evidence. Key items of evidence are listed below. The list is not exhaustive.			
i. Record keeping policies and procedures	Yes		Yes
ii. HR policies, files and supporting evidence (with consent from C)	Yes		
iii. Safeguarding and incident reports	Yes		Yes
iv. Decision making tools and templates	Yes		Yes

Description	Relevant to:		
	2.1	2.2	2.3
v. Staffing records	Yes		Yes
5. Interview testimony	Yes	Yes	Yes
6. Independent professional advice	Yes		Yes