Title:

Learning Within and Across Organizations: Investigating the Impact of Tribunals of Inquiry

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Abstract

This paper presents an exploratory, interpretivist case study of the institutional and organisational learning dynamics ensuing from two consecutive Public Tribunals of Inquiry. The focus of the two tribunals was the sourcing, production and supply of contaminated blood products by the then titled Irish Blood Transfusion Service Board (BTSB). While in its very early stages, the study explores the role played by the tribunal process as a mechanism mediating learning at both a micro organisational and macro institutional/network level. The paper also explores the appropriateness of formal public tribunals of inquiry as effective instruments for network and organizational learning.

Introduction

This paper outlines some initial exploratory investigations into the learning processes set in train within and across a range of organizations following the undertaking of two public inquiries. While there is an interesting body of research on tribunals and their findings, there has been little or no consideration of the learning effects of these bodies and their output on the focal organisations or wider organisational network. There appears to be an implicit assumption that the parties involve accept and internalise the findings and recommendations of tribunals and that these tribunal recommendations constitute “learning” and that others can, in turn, learn from this failure. However, there is some suggestive evidence that this is not the case and that learning from these tragic events is ineffective. For example, Walshe and Offen (2009) are critical in highlighting the clear comparability of findings from the 2001 Bristol Royal Infirmary Inquiry with that of the 1969 Ely Hospital in Cardiff. The case study investigated here is one involving a focal organization and its associated inter-organizational network that appear to have collectively learned and adapted to a major failure but in a diversity of ways. As such the core focus of this paper is to investigate the role of the tribunal process in facilitating and possibly hindering learning at both an organizational and inter-organizational level. In so doing I intend to include but look beyond the

tribunal report to examine what happened after its publication to try and discern the "learning effect" or otherwise of the process and to conceptualise this dynamic. To this end issues of interest in this study include:

- How the focal organizations responded to and institutionalized the recommendations contained in these reports?
- The nature of the learning dynamics are set in train by these reports and how is this learning best captured and shared?
- Do the tribunal recommendations change practice at an organizational or network level? If so, in what way and if not, why not?
- How to conceptualise the learning dynamic in evidence through the tribunal process.

On Tribunals

The primary focal issue of investigation here are public inquiries or more specifically investigatory inquiries, defined here as inquiries whose function it is to ascertain authoritatively facts and, where appropriate, to make recommendations to prevent recurrence. Tribunals of Inquiry are the most formal type of investigative inquiry and are presented as either the "gold standard" against which other forms of inquiry should be assessed or a "house of last resort" when other forms of inquiry have failed or are unlikely to succeed (Walshe, 2003:24).

Tribunals have been and are a regular feature of Irish and UK public life. In Ireland the final cost of public tribunals of inquiry undertaken in recent years is estimated to reach €1 billion (Sunday Independent 18 November, 2007). They have been established to inquire into such matters as policy issues; accidents or major disasters; allegations of corruption; or deaths of individuals, where the State and its institutions have been involved. In an Irish context these bodies are established under the *Tribunals of Inquiry (Evidence) Acts 1921 to 2004.* Similar legislative arrangements apply in the UK, Canada, Australia and New Zealand.

Generally, the purpose of an inquiry is to make sense of the causes and consequences of an event and to examine the behaviour of actors and organizations involved in the event (Gephart, 1993: 1474). Learning for the focal organisation (to learn from its mistakes and avoid reoccurrence) and for the wider institutional network (enabling other to learn from the mistakes made by the focal organisation) and policy makers is an important though not always dominant concern from the tribunal process. In this regard, the broad purposes or functions of a tribunal of inquiry include the following:

- To establish what happened, especially in circumstances where the facts are disputed, or the course and causation of events is not clear;
- To learn from what happened, and so helping to prevent their recurrence by synthesising or distilling lessons, which can be used to change practice. This includes identifying shortcomings in law or regulations.
- To establish accountability, blame, and retribution —holding people and organisations to account, and sometimes indirectly contributing to assigning blame and to mechanisms for retribution.
- To engage in a process if catharsis or therapeutic exposure (to aid reconciliation and resolution among the parties concerned)
- To provide public reassurance post failure sustaining or rebuilding public confidence following a major failure.
- To serve a wider political agenda for government – as public inquiries are typically Government established it is necessary to consider their role in fulfilling a political need such as being seen to be doing something

(Walshe, 2003; Irish Law Reform Commission, 2005).

It is also worth bearing in mind that some of these purposes can conflict with each other. The ultimate purpose and dominant orientation of a particular tribunal will be determined by its specific terms of reference. These are typically determined by Government and approved by Parliament.

While there has been considerable public debate and subsequent

Parliamentary legislative activity in Ireland associated with curtailing the length and costs of running tribunals, there has been virtually no examination of the actual outcomes of these tribunals at the level of the targeted organization and its wider organizational network nor on their levels of effectiveness as instruments of change and learning (e.g. how these recommendations are implemented and how organization functioning, structures and behaviour change pursuant to these reports and to what effect).

Tribunals: Existing Research and Theoretical Framing of the Study

There is a diverse set of literatures in which tribunal of inquiry feature. These range from the area of disaster studies (Turner, 1978), occupational safety (Pidgeon and O'Leary, 2000) public management (Walshe and Higgins, 2002) and latterly into organisational theory through crisis management (Shrivastava, 1987), high reliability organisations (Perrow, 1984) and sensemaking (Weick, 1993; Brown, 2000).

One of the central figures in advancing the conceptual understanding of industrial catastrophe and crisis as managerial and administrative in origin is that of Barry Turner (1976; 1978). Here, like many of the earlier contributors to this topic, tribunal reports are used as primary sources of data with the implicit assumption that they portray the unbiased "reality" of the event. Turner identified public inquiries as mechanisms through with considerable institutional and organizational learning occurs (Brown, 2000:47). Turner (1976) studied the text of three UK public tribunal reports to explore potential patterns of conditions under which gross errors occur in organisations leading to disastrous consequences. This focus on a failure of foresight or intelligence (due to issues such as false assumptions, poor communications, cultural lag and misplaced optimism) is clearly an important though partial contribution to understand and hopefully avoiding disasters but is not the primary area of interest of this study.

Turner briefly considers the recommendations from tribunals and sees them as an important component to prevent recurrence (1993:392). He presents these recommendations as part of a process of post-disaster cultural re-

adjustment when the ill-structured problems giving rise to the disaster are allowed to be absorbed into the culture in a well-structured manner. He does highlight a limitation in this process in that the recommendations in the reports he studied tended to deal with and present the underlying causal problems as they were later revealed (as relatively structured phenomena) rather than in the ill-structured manner in which they were originally encountered.

Implicit in the more functionalist-oriented block of literature on tribunals is the suggestion once clarity has been gained on institutional barriers to learning (e.g. information deficiencies and organizational politics) then organizational learning (rarely defined) becomes a realistic design goal (Pidgeon and O'Leary, 2000:21). Walshe and Offen (2001) focusing on the UK Kennedy Report (2001) into the Bristol Royal Infirmary claim that the affair and its attendant publicity has caused "…a sea change in medical and wider British societal attitude to professional self-regulation, clinical competence and healthcare quality improvements" (p.250) and has acted as a major catalyst for reform in this area. This view that organizations can learn more effectively from the errors of others would get some support from the high-reliability organization literature (see Baum and Dahlin 2007). This latter study also highlights the limited understanding we have of the underlying intermediate learning processes. Walshe and Offen (2001:255) also comment on how the tribunal and its attendant publicity has an emotional and narrative power. However, this emotional and narrative dimension of a tribunal would appear to be a double edged sword. One the one hand its emotive and narrative power is more likely to bring about change compared to that of a "rational" research report. However, as an emotional narrative, as we shall now explore, it is just that – one story among potentially many, a story that is contestable.

On this narrative theme, a highly fruitful and interesting avenue of research on tribunals has been to explore the link between sensemaking and tribunals/public inquiries. For example, Gephart (1993), adopting in large measure a textual approach, supplemented with some ethnographic data arising from his attendance at a tribunal, examines what goes on during a disaster inquiry in particular the complex sensemaking activities that go on

within and among inquiry participants with a view to understanding events and allocation of responsibility for critical organizational events. The work of Andrew Brown (2000) is one of the few recent pieces of research on the topic of tribunals continuing with a sense-making focus. His interpretivist, discourse analysis of a specific UK tribunal report (the Allitt Inquiry) investigates how inquiry reports "…support the legitimacy of social institutions and extend the hegemony of prevailing system-supportive ideologies" (Brown, 2000:48). He sees tribunal reports as contrived rhetorical products, artifacts created to persuade us to accept a contestable interpretation of events with a view to legitimising social institutions and ameliorating public anxieties in the focal organisation (Brown, 2000:67).

Following Brown (2000) there is clearly the potential for such a text based deconstruction of the two tribunal reports to analyse the breakdown in sensemaking within the BTSB and to explore why some of those involved continue to feel that the tribunal reports did not establish the "true" facts of what happened. Indeed, one could read into Brown's work a view of tribunals and their reports (with their concern to control, blame, absolve and legitimate) as 'against learning' and open meaning making – "…closing down rather than opening up competing plotlines; to curtail not to encourage sceptical questioning" (ibid:68). A counter point here might be the practical and indeed epistemologically impossibility of learning to avoid or learn from failures in the face of such a complex and contested set of ploy phonic narratives.

A final issue arising from this brief literature review concerns the intermittent references linking tribunal dynamics, effective organization learning and wider institutional learning and constraint. Cannon and Edmondson (2005:301) suggest that the establishment by regulators of task forces or investigative bodies to uncover and communicate the causes and lessons of large scale failure typically come too late for effective organizational learning. Pidgeon and O'Leary (2000:27) suggest that it may be impossible to insulate an effective intra-organizational learning system from the powerful and symbolic external legal and social blaming process ensuing from any disaster. They suggest that we know almost nothing about these important and powerful

societal variables. The claims by Walshe and Offen (2001) of widespread learning across the NHS arising from the Bristol Royal Infirmary Inquiry have already been mentioned. In addition, Brown highlights how public inquiries are interesting multi-level events in which micro-level sensemaking practices produce macro social order as a set of representative meanings. Here I try and extend this view by exploring the complex institutional and organisational learning processes set in train by the tribunal process but to do so by extending beyond the "text" to look at subsequent actions and inactions and the interpretations of those directly involved in the process and its aftermath. Tribunals as an artefact concerned with organizational and wider institutional learning but also constrained by this institutional setting.

While attracted to adopting a grounded approach to this study I considered that my level of prior reading of existing research on the tribunal process had somewhat contaminated the potential of this approach. However, my current framing of the theoretical home for this study has been clearly influenced by the initial unstructured interviews I have undertaken and, while clearly incomplete, continues to follow an emergent philosophy.

Following some initial interviews I was drawn to the potential contribution of neo-institutional theory (Meyer and Rowan, 1977; Scott and Meyer, 1983; DiMaggio and Powell, 1983, 1991) as a way of framing this challenging project. While institutional theory is typically associated with the way organisational structures emerge, it clearly has application beyond structures. As I read into the case I considered it feasible to envisage a tribunal as a creator of new institutional rules (coercive, normative and mimetic) and indeed as a form of institutionalized myth – rolled out where there is a major organizational malfunction in an institution of high public visibility. This view would reinforce the ceremonial nature of public inquiries expressed by Gephart (1993:1474). However, these new institutionalised rules not just institutionalised myths, not just ends in themselves but, in this case at least, have initiated and driven major change aimed at improving technical/organizational/managerial performance and at re-establishing public

confidence in a key element of the health system, rendering it more reliable and accountable (Meyer and Rowan, 1997).

While this argumentation does suggest an appropriate macro-level lens, the issue then becomes one of creating a link down to the necessary micro level of analysis. McKinley and Mone (2005:363), while acknowledging that institutional theory is typically classified as a macro perspective, suggest that aspects of this theory offer potential to span both macro and micro levels of analysis. Citing the work of the work of Berger and Luckman (1966), DiMaggio and Powell, (1991) Zucker (1977), Tolbert and Zucker, (1996) they focus on how institutional rules (Meyer and Rowan, 1977) come into being. They discuss how social reality gets constructed through habitual action and the abstraction of that action into “reciprocal typifications” (a specification as to how an activity is to be carried out or a process followed). Once these typifications or social institutions become reified they become an external constraint on the individuals and are continually re-enacted by these individuals in their daily interactions (Berger and Luckmann, 1966). In this way, it is suggested here that institutions and acceptable behaviours within them emerge from and reflect external institutional reifications thus creating a connection between organisational and broader institutional learning (and potentially down to individual cognitions, behaviour and practices).

At this early stage of the study I am unsure as to which micro-lens would be most appropriate and complimentary to use to examine the attendant macro-level influence of the tribunals at the level of the organization. Of potential relevance could be the relatively established social psychological subset of literature exploring how organizations learn from mistakes (e.g. Edmondson, 2004) or possibly using the sensemaking literature to explore how the tribunals may have altered sensemaking processes leading to improved learning (Weick, 1993). The passage of time in this particular cases could render this latter option somewhat infeasible.

Research Methods

The approach adopted here is one of an exploratory, interpretativist case study. I openly acknowledge the likely influence on the nature of the tribunal reports and subsequent actions and behaviours of the unique attributes and ideologies of the Irish public, legal and political context.

The research has and will be driven by an open iterative process of data interrogation, gathering, interpretation, re-interrogation, refinement, etc,. The aspiration of the researcher is to try and produce a plausible and defensible account of the type, level, directionality and dynamics of learning arising from or centrally revolving around the tribunal dynamic (process and final report) and its aftermath. The primary data source to date has been secondary source data including:

- A detailed review of the two tribunal reports (Finlay Report, 1997, and the Lindsay Report, 2002) and associate submission documentation (where available).
- Analysis of associated Irish parliamentary debates, newspaper, radio, t.v. and web archive reporting on the establishment of the tribunals, their proceedings and final reports.
- Analysis of the Report of the Expert Group on the Blood Transfusion Service Board (1995).
- Co-terminous and subsequent annual reports by the Blood Transfusion Service, National Drugs Advisory Board (NDAB) and its replacement the Irish Medicines Board, and the various patient interest groups involved in the process.

Primary data has also been obtained through in-depth, semi-structured interviews with two key strategic actors (a senior executive and senior laboratory manager) within the BTSB who had direct involvement in the tribunal processes and subsequent organisational transformation process. Other scheduled interviews include:

- A member of the board of the BTSB and a senior consultant haematologist both of whom were involved in the tribunal process.

- Two senior officials of the Irish Department of Health who were intimately involved with both tribunal processes.
- The heads of two Patient Interest groups – Action Positive and Transfusion Positive.
- Head of the Irish Haemopheliac Society
- An official of the Irish Medicines Board

Interviews were normally digitally recorded, transcribed and the narrative closely analysed using the software package Atlas Ti.

The study is somewhat historical in nature given that the core events happened between 1970 and early 1990s. A number of the key individuals involved have also died with the passage of time. Others had retired and for personal reasons were unwilling to be interviewed. While I acknowledge the possibility of loss of memory and danger of confused causality with the passage of time my experience with the interviewees to date is that the events are still vivid in their minds. Interviewee also had extremely detailed notes and documentation which they frequently called upon during my interviewing.

The case is somewhat unusual in that it is a monopolistic provider of blood products in Ireland. As such its highly technical systems and processes are relatively unique within the Ireland and there is very limited scope for others to learn from their mistakes at a technical level. As such I consider it to be a useful critical case to explore the notion that organizations learn from tribunals. Indeed, when one examines the aftermath of the investigative process and the tribunals in this case one finds considerable learning and change across the related institutional network. As such there seemed to be some validity to the view that the BTSB had indeed learnt from the Tribunals.

Case Study Background

The initial organizational target of the study is the Irish Blood Transfusion Service Board (IBTS) previously known as the Blood Transfusion Service Board (BTSB). Two public tribunals were held in relation to the production,

sourcing and supply of contaminated blood products leading to the contamination of hundreds of women with Hepatitis C and HIV and a sizable number of deaths.

The BTSB was a statutory corporation established by Order of the Minister for Health in 1961. It was charged with responsibility with organising and administering a blood transfusion service and making available blood and blood products. The BTSB sold its product and services to hospitals but has required ongoing financial subvention from the Department of Health on the capital side. In 1977 the BTSB was notified that six women had developed clinical jaundice some weeks after receiving Anti-D immunoglobulin. It subsequently transpired that these women had been infected with hepatitis C. A reliable test for this anti-body only became available in 1991. Following ongoing internal investigation into the matter one of the primary sources of the infected blood product was determined to be a plasma exchange patient who had become jaundiced. Plasma from this patient had been used in the production of Anti-D before the onset of her condition and after she had recovered. A national blood screening programme was introduced in February 1994 for women who had received Anti-D between 1970 and 1994. Of 56,273 women tested 1,037 were found to have antibodies for Hepatitis C, 455 of which were found to have the Hepatitis C virus.

In light of growing public concern with the emerging situation the then Minister for Health established an interdisciplinary Expert Group in March, 1994 to investigate the situation. The group made its report in January, 1995 (herein referred to as the Hedderman-O'Brien Report, 1995). The report made a number of specific recommendations in relation to internal work/testing practices within the BTSB, its organization and management of the BTSB and in relation to the licensing of blood products.

Following publication of the Expert Group Report pressure mounted on the Government to establish a public inquiry into the matter. A High Court case was also in progress, initiated by one of the infected women, a Mrs. Brigid McCole. There appears to have been a sense that further documents, testimony or other information, not available to the Expert Group, had now

become available and that a full public inquiry, with its attendant legal powers to compel the attendance of witnesses and the production of documentation, was now required. Under Judge Thomas Finlay this Tribunal commenced on 5th November 1996 and published its report in March 1997. Amongst its findings were:

* Plasma used in the manufacture of Anti-D was in breach of the BTSB's standards for donor selection.
* Medical staff at the BTSB failed to respond appropriately to reports that recipients of Anti-D had suffered jaundice and/or hepatitis (in terms of reporting, further investigations and product recall).
* The BTSB acted unethically in obtaining and using plasma from Patient X without her consent.
* The NDAB was deficient in carrying out a number of its functions in relation to its dealings with the BTSB.

(Finlay Report, 1977, chapter 17).

The government sent the Finlay Report to the DPP who responded on the 6th October 1997 and ruled that no criminal prosecutions would be forthcoming as a result of the report. A complaint was filed with the Irish police force and an investigation commenced in November 1997 resulting in two ex-employees of the BTSB - Dr. Terry Walsh and Ms Cecily Cunningham - being arrested and charged with seven counts of Grievous Bodily Harm. Dr. Terry Walsh has since died and the case against Ms Cecily Cunningham was recently dropped.

In June, 1999 following protracted negotiations with a range of patient representative bodies the Government established a further tribunal of inquiry into the infection with HIV and Hepatitis C of over 260 people suffering from haemophilia. The issue here concerned the importation and supply of commercially produced factor VIII and factor IX concentrate going back to the 1970s. In 1988 and early 1999 these blood derived products (factor 8 and 9) were replaced by synthetic or recombinant equivalents which are believed not to carry the risk of viral transmission. This tribunal (herein referred to as the Lindsay Tribunal, 2002) met over 196 days and inquired into the actions of the

BTSB, the Department of Health, the Drugs Advisory Board and the Irish haemophilia Society. The report had 8 main recommendations, two of which related to the by then renamed IBTS (on the need to maintain high production and safety standards and to introduce effective protocols for notifying donors when new tests for infective agents become available). The remaining recommendations focused on issues related to the wider medical treatment and support of haemophiliacs in Ireland.

Findings/Discussion

Starting in 1995, to a large extent following the Finlay tribunal report, a multi-million pound package was approved to support the re-organisation and re-development of the Irish blood transfusion service at a national level. The primary objective was to ensure that the IBTS was adequately resourced to provide a transfusion service in line with best international standards and to avoid the potential recurrence of a systems failure. Significant additional resources were made available to the IBTS to support the following programmes:

- provision of a new national headquarters at a cost of approximately €46 million, development of a new components processing laboratory and other improvements at the Cork centre;
- implementation of a new IT system at a total cost of approximately €9 million; the introduction of new technologies such as PCR testing and leucodepletion to improve the safety of the blood supply, at a total annual cost of €6 million; additional senior staff appointments, which have resulted in the establishment of new personnel and finance departments.
- the recruitment of additional medical consultants and additional quality assurance staff.
- Significant investment has been made in local donor recruitment initiatives. (Source: Minister for Education, Dail Debates, 23 October, 2002, p.113)

From a learning perspective it is clear that most of the processes, procedures and testing regimes in place during the contamination period had all been replaced prior to the first Tribunal having started. Indeed the key department in the BTSB involved in the manufacture of the contaminated product (the fractionating department) had been disbanded by the time the Lindsay tribunal started.

Speaking in Parliament following the publication of the Lindsay report the then Minister for Education outlined the following:

> In fact, the Irish Blood Transfusion Service has introduced major new testing programmes in advance of most other transfusion centres internationally and continuously monitors international developments in this regard. All of these developments will undoubtedly contribute to a modern and re-invigorated blood transfusion service to meet the challenges of the new millennium.

Indeed the first recommendation of the Lindsay report was that:
"Blood products supplied to persons with haemophilia should be of the highest standard and of the safest nature that are available. The Tribunal believes that this is the situation at present but this must continue to be the case." (p.236).

A press release issued by the IBTS following the publication of the Lindsay Report in 2002 in which they fully accept the findings of the report also suggested that the IBTS "…like many Transfusion Services worldwide have *learned the lessons* of this human tragedy"

The initial set of interviews have focused on the theme of learning at a very broad level but rather narrowly in relation to the now renamed Irish Blood Transfusion Service (IBTS). Relatively unstructured interviews were conducted with three key informants within the organization. The focus of these interviews was to encourage open dialogue around the interviewees' recollections and feelings in relation to the two tribunal processes and to seek

initial thoughts on whether they thought that the tribunals had encouraged organizational learning within their organization.

Both interviewees indicated that the IBTS is a radically different organization compared to the entity in place pre-tribual. It now has a fundamental concern with quality and patient safety.

“We were a cozy, informal and rather inward looking organization. We weren’t really doing anything wrong but we weren’t looking out to anticipate impending issues.”

“Well behind the international curve on research and awareness”
The organization is currently at the leading edge of best international practice and now engages in extensive external professional networking.

In the early 1990s the BTSB was the subject of intense public scrutiny and negative publicity associated with the contamination issue. It was the subject of constant media commentary. There were a number of books published on the failure and a dramatic t.v. movie (No more tears). There was also a high profile court case initiated by one of the infected women. Blood donations dropped off dramatically. The Finlay tribunal was held at the peak of this public anger against the organization.
Interview 2:
“…*because all this came-- hit the headlines in February 1994, the press had a field day I mean they literally had a-- I'm not condemning them for it, but they did have a field day. They had us the on the rack for months and hardly a day would go by without them publishing some aspect of the problem*.”
He went to to talk about how hard the negative publicity was on the staff of the BTSB “*It was hard, very hard on the staff here, because-- and it's not quite as evident now but there was a lot of fear and within the organization. Because if you asked somebody to vary some procedure they were doing, they would answer you kind of like “I'm not going to face a tribunal over this*”, you know.”

While casting a major shadow over the organization, the Finlay tribunal itself seemed to have a minimal impact on the ordinary worker in the BTSB in terms of doing his or her daily job.

"*It (the Finlay tribunal process) was pushed away from us. And in fairness to the organization, we just went ahead and did what we have to do and didn't concentrate on that because there this was custom built for our purpose and it was truly from the tribunal that we got the funding for this*."

Both interviewees attributed much of the initial change undertaken in the BTSB to Finlay's recommendations. While the Expert Group (1995) had outlined a major development plan for the BTSB, Finlay copper-fastened these needed changes in his recommendations (p.143), in particular the acquisition of a new purpose built building and new equipment.

Interviewee 2

"*Well the Finlay Tribunal came up with very definite recommendations of what should be done. And one of them was that we-- the building that we were using in Mespil Road was totally unsuitable for what we did. And I mean he triggered this establishment, this building...*"

Interviewee 1

"*this was custom built for our purpose and it was truly from the tribunal that we got the funding for this*."

Interviewee 2, when asked if he thought that the Lindsay tribunal had actually changed anything in the BTSB he responded as follows:

"*Well you see the Lindsay Tribunal (pause) No nothing really changed because the Lindsay Tribunal didn't set out to-- in my, I don't know, maybe I got this wrong but I don't believe they really set out to correct something. They were putting on record what had happened. And what it did was highlight the problem to the extent that any product that comes into the country has got to come in certified clear of HIV, that it has been properly inactivated. But that was happening anyway*."

Interviewee 1 suggested that the tribunals were perceived by a many in the BTSB as a "*public acknowledgement that they had made a mistake*".

Interviewee 2 – speaking with respect to the labs and their testing procedures he was completely satisfied that they did nothing wrong. He admitted clear mistakes in communicating positive test results back to the patients.
Finlay – did nothing wrong
"*Yeah, in February, I think it was the 21st or 22nd, 1994. We were all rocked on our heels because the press conference was called. … I was told there are certain things that are certain things going to be said at the press hearing. I started working on trying to see what we could do to improve our testing at that time, and there wasn't anything. I worked over the weekend, just to make sure that we hadn't missed anything from the testing point of view and we hadn't….. I really believe we did work with best practice. I went back and I checked. I'd been told what samples were likely to have caused the problem, and I went looking at those, and I didn't get any different results than we have found in previous years or months*."

Interviewee 2 was asked if there had been a collective sense within the BTSB that major errors had been made. He responded with regard to his sense of the laboratory staff: "I wouldn't know if it was a collective, because I don't know to what extent all of the staff understood what had happened. They did know that there was a problem with a particular unit in the organization. And they had no involvement in that, because, in general, the lab staff had no input into this particular department. I didn't either, even though I was fairly senior at the time. That department was almost protected, and I don't know the reason why it was."

When asked if he thought the tribunals had been in any way effective in encouraging learning within the transfusion service interviewee 2 offered a blunt appraisal: "No. They haven't been particularly effective."

While critical of the role and impact of the tribunals he did suggest that major changes in practice had derived from the events, particularly in the labs:

"I think practices have changed in the laboratory, because when we came down here, we decided that because of all we'd been through that we would come down here as a pharmaceutical plant, rather than as an open blood bank."

He then went on to discuss the major transformation in behaviour and culture attendant on the establishment of the new building. While these new practices were clearly enabled by the release of resources triggered by the Finlay Report the main reason advanced to date for this major change in laboratory practice and culture was negative findings against the National Drugs Advisory Board/Irish Medicines Board in the Finlay report. Finlay was very critical of the level of regulation and inspection of the IBTS by the then NDAB indicating a serious breakdown in the NDAB carrying out its proper and necessary functions during the period concerned. (Finlay Report, 1996:92). The Lindsay report added to this criticism. The BTSB appeared to anticipate a backlash from that organization post tribunal. Interviewee 2 put it this way: "Because we felt that the IMB, the licensing authority, they had got a rap on their knuckles, and they weren't going to be too easy on us in the future. And if they come in here and saw that we weren't doing it exactly the way the pharmaceutical industry was doing it, then they might have something to say to us about it, and withdraw our license or whatever. So they come in. ……And when they come in, they do cause minor heart attacks among the staff, because there's a lot of work to be done to prepare for them coming in. All the documents have to be in place, everything. ….. And they go to the pharmaceutical industry, and they see a particular process in use in there that they think might be of use to the blood bank and they come in to us and say, "Why aren't you doing that?" "We didn't know about it, Ron." "You should know about that."

At a slightly negative level both interviewees discussed a level of paranoia that crept into the organization post tribunals. While one would expect this of such a high reliability type of organization with it has come a level of conservatism and some degree of inertia and defensive behaviour.

"*Well it (the tribunals) also taught us that that we should never destroy any records, and when we did-- I mean, standard financial records, we destroyed after seven years. The mere fact that records were destroyed, rather than the content of them, hit the headlines….The records that were destroyed were dispatch documents and issue documents to the hospital. We could, at a push, I could find you maybe test sheets going back to the '50s. We have them in the store somewhere, so we don't destroy anything, especially anything that might be of significance, but the press don't pick up on that. They just sensationalize the destruction of records*."

Conclusions

Based on an initial review of the tribunal reports and the extensive published commentary thereon and the limited primary data gathered it would appear that extensive organizational learning has taken place both within the BTSB/IBTS itself and across its wider inter-organizational network following these organizational failures. However, an examination of the chronology of the key changes undertaken relative to the underlying contamination of blood products before, during and after the tribunal process would suggest a number of issues:

(a) That considerable organizational learning has taken place within the BTSB/IBTS preceding the blood contamination incidents.

(b) That much of this organizational learning does not appear to have directly arisen from the tribunal and report but seems to consistently pre-date or have worked ahead of the tribunal process.

(c) That the tribunals played a key role in accelerating, sustaining and institutionalizing the need for new behaviours, attitudes, procedures and practices to be adopted within the BTSB that were necessary to elevate the organization up to world-class standard.

(d) That the tribunals and the attendant threat of litigation against BTSB staff has somewhat hindered learning by creating a culture of extreme caution and defensiveness.

(e) That the tribunal process and reports did seem to be effective in giving rise to learning across the wider network of organizations interacting with the BTSB in a resourcing/support/regulatory manner.
(f) That this learning within the wider institutional network of the BTSB in turn facilitated the flow or resources and a new regulatory environment necessary for fostering ongoing learning within the BTSB.
(g) That some key learning within the BTSB arose indirectly from the Tribunal reports due to anticipated changes in behaviour from other organizations in the wider network.

It would appear that too much time had passed in this case for the tribunal itself to throw any additional light on the problems/errors for the BTSB. This would add support to the views of Cannon and Edmondson (2005:301) on the inadequacy of formal investigations from an organizational learning perspective due to the passage of time. While both tribunals were asked to review and evaluate the internal systems, practices and behaviours of the BTSB relevant to the manufacture, acquisition and supply of contaminated products, these investigations were to be done in a highly retrospective manner looking back 10 or 15 years and with the benefit of hindsight and major advances in medical knowledge and testing procedures in the interim period. However, the tribunals did play an important role in re-establishing the credibility and legitimacy of the BTSB in the eyes of the general public and in forcing a redesign and improvement of its external regulatory and resourcing environment.

It would appear that the driving motivation for the injured parties and their representative bodies was one getting to the truth, to seek out someone to blame and to have them held to account. Both tribunals seem to have been perceived as unsatisfactory in that regard. For example the shadow health spokesperson, Ms. Olivia Mitchell, in response to the then Minister of Health's statement in Parliament following the publication of the Lindsay report, had this to say:
"In fairness to the tribunal, we have a fairly painstaking account of who knew what and who did what at various times. However, following three years of an

inquiry and a cost of €12 million we still do not know why this happened. …we do not know why hundreds of sick, vulnerable, dependant and trusting people were fatally infected or had their lives destroyed by the actions of a State agency. In setting up a tribunal to discover the truth, surely the least we could expect is to find out the answer to that question. For those infected and their families the overriding question is: "Why did this happen to us?" The answer to that basic question just does not emerge, even from the most detailed reading." (Dail debates, vol. 556, 23 October, 2002, pp.123/4).

One reason advanced by the opposition spokesperson for this seeming failure to get to the truth and to ensure it didn't happen again was that the proceedings had turned out to be heavily adversarial despite its overtly inquisitorial terms of reference. In her view the "… need to be defensive and deny would always get in the way of establishing the truth." The earlier Finaly tribunal had also had difficult adversarial stages but, for some reason yet to be clarified, seemed to surmount this problem and produce a focused and unambiguous report at least in so far as the contamination by Anti D was concerned.

Conceptually, the paper has tried explore and elaborate on the connection and interplay between macro and micro-level learning dynamics. Here I have explored the peculiar interplay between learning at the institutional/network and more micro organizational level. The view was advanced of tribunals as the producers of "reciprocal typifications" – in this case views of how the blood service ought to be run, supported and monitored. Here it appears that individual, team and organisational and network-level learning has taken place on foot of the tribunal investigations. In addition, it appeared that impactful learning and associated changes arising from the two tribunal reports had also taken place at the inter-organisational level. As such the wider network did not learn from the focal organisation but learning ensued across the network and back to the focal organization because of its failure as highlighted by the tribunal.

Other interesting issues thrown up to date in this very preliminary study include:

- The time lag difficult – the role of the passage of time in hindering effective learning from failure and the limitation of formal public inquiries in this regard.
- The difficulties in trying to isolate the impact of a tribunal as key learning and changes were made at the organizational level prior to, during and after the final tribunal report. I would view this as a type of anticipatory learning – learning undertaken in anticipation of the tribunal findings and in anticipation of the behaviour/reaction of other parties post-tribunal?
- Tribunals as both an enabler and hindrance of organisational learning
- The importance of the scope and focus of the terms of reference if learning is to be prioritised and a necessary open, inquisitorial orientation to the proceedings adopted by all. The inevitable desire to seek to blame and get retribution in such situations of terrible personal suffering and loss can easily overwhelm the need for and possibility for learning. What would a learning tribunal look like?
- In the face of an adversarial dynamic to need to consider a dedicated post tribunal learning review, extracted from the highly emotional environment of a tribunal.

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