SCOTTISH HOSPITALS INQUIRY

# Bundle of Documents for the Oral Hearing Commencing 12 June 2023

# Bundle 5 – Communications Documents

# Table of Contents

**From:** Armstrong, Jennifer
**Sent:** 07 July 2015 10:01
**To:** Edwards, Emma; Dick, Lorraine
**Subject:** FW:
**Attachments:** Response_to_Environmental_Quailty[2].docx

**From:** Parker, Anne
**Sent:** 06 July 2015 10:32
**To:** Armstrong, Jennifer; Dunlop, David; Stewart, David
**Cc:** Mcquaker, Ian (NHSmail); Irvine, David; Irvine, David (NHSmail); Morrison, Anne; Loudon, Gail; Hart, Alistair; Macdonald, Iain; Clark, Andrew (NHSmail); Clark, Andrew; Jones, Brian; Jones, Brian; Jones, Brian (NHSmail); Jenkins, Gary; Campbell, Myra
**Subject:**

We are sure you are aware of the current concerns with regard to environmental quality on Ward 4B1. We attach our analysis of the situation and recommendations to help resolve this. We would like to thank the consultant microbiologists Dr theresa Inkster and Dr Christine Peters, present at several meeting,s for their analysis of the situation and work to provide data, which has enabled us to reach these conclusions and the Regional Services management team for their prompt recognition of the potential consequences and their handling of the situation. We are keen to ensure that the move back to the Beatson is for as limited a time as possible.

regards

Anne Parker, Consultant haematologist
Grant McQuaker, Consultant haematologist
Andrew Clark, Consultant haematologist
David Irvine, Consultant haematologist
Alistair Hart, Consultant haematologist
Gail Loudon, Consultant haematologist
Ian Macdonald, Consultant haematologist
Brian Jones, Consultant Microbiologist responsible for BMT

**Situation**

The South Glasgow clinical haematology and Scottish adult allogeneic transplant in patient service have moved into potentially unsafe accommodation, for this particular patient group, in the new facilities at the Queen Elizabeth University Hospital, Glasgow. This is following on from advice given by Consultant Microbiologists Dr Theresa Inkster and Dr Christine Peters, that the safety of the environment for immune-compromised patients in terms of water and air quality cannot be guaranteed in the new accommodation on Ward 4B1, QEUH.

**Background**

All haemato-oncology patients are potentially at risk because of a poor quality environment, but the patients at highest risk are those undergoing allogeneic transplant, closely followed by those receiving high dose chemotherapy with stem cell rescue and acute leukaemia induction. There are a number of standards set for these patient groups and the following are pertinent to the current situation.

The CDC guidelines for management of the immunocompromised are the most detailed setting out pressure requirements, air exchanges etc..

The NICE guidelines for Improving Outcomes for haematological cancer (2003) states that acute leukaemia patients should have access to

- In-patient unit that minimises airborne microbial contamination.
- For isolation: a number of single rooms with en-suite facilities. All patients receiving induction therapy or other high-dose chemotherapy should be housed in single rooms with en-suite facilities.
- Full haematology and blood transfusion laboratories on site. Rapid availability of blood counts and blood products including products such as CMV seronegative and gamma-irradiated blood components

The Bone Marrow Transplant standards are set by JACIE in the 6th edition standards

- *B2.1 There shall be a designated inpatient unit of appropriate location and adequate space and design that minimizes airborne microbial contamination.*
- *B2.6 There shall be written guidelines for communication, patient monitoring, and prompt transfer of patients to an intensive care unit or equivalent when appropriate.*
- *B2.13 There shall be an intensive care unit or equivalent coverage available.*
  Explanation: The Clinical Program must have documentation that there is ready access to an ICU or equivalent coverage in an immediate fashion for its patients when appropriate. This requires the ability to provide multisystem support including assisted respiration. Ordinarily, this would be within the institution but contractual arrangements with another institution may be considered if transfer procedures are in place to ensure prompt service and patient safety.

The SGH team moved at the end of April from old suboptimal accommodation with 14 beds on ward 24 to purpose built single rooms with en suite facilities.

The transplant team moved on June 6 from the Beatson, which had a long track record of excellent accommodation in terms of patient support, air and water quality. The team knew that following the move there would be some compromise in environmental quality, due to lack of negatively pressured anterooms. However, the transplant team were assured that the quality of environmental care provided would be sufficient for their populations needs and met regulatory standards. After consideration, the BMT team felt that the move provided a significant gain in quality of care for transplant patient's due to co-location with acute specialties and critical care support. In addition, the award of national service designation for allogeneic transplantation meant that the transplant team required additional bed spaces which were not available in the Beatson facility. It was understood that, prior to the move of the 2 services, the accommodation had the appropriate specifications for the allogeneic BMT patient population and during commissioning validation had had been carried out to ensure that these specifications had been met,. There was no indication at any time prior to the move, to either team or Regional Services management, that there were any problems with the specification or post commissioning validation. The team were reassured during a visit to the ward that the air handling system had central monitoring and was fit for purpose.

The first indication of possible problems was in the week of June 8th when an email was received by Dr Anne Parker, indicating that the 2 rooms with ante-rooms in the renal unit were not functioning to the expected level of air quality. On review, neither room was being used appropriately with doors shut, but the BMT team were not intending to use the rooms and no concerns about other areas were raised. However, this was not the case after the meeting on Wednesday July 1st, when it became clear that none of the rooms on ward 4B1 came close to the standards required to provide a safe environment for highly immuno-compromised patients. It was agreed that remedial action would be taken and the meeting reconvened on Friday July 3rd at 4pm. At this meeting it became clear that neither water nor air quality of an appropriate standard could be guaranteed, and that major works would be required to achieve this.
As part of the move all allogeneic in-patients had an increase in the intensity of their antifungal prophylaxis and were switched from itraconazole to posaconazole to cover the move maximise prophylaxis cover during the transition. Following information about overall air quality the high dose chemotherapy with stem cell rescue patients were changed from fluconazole to itraconazole to give aspergillus cover.

**Analysis**

- The current accommodation at QUEH is not fit for high risk haemato-oncology patients to remain in safely, and would not pass the JACIE inspection planned for the Autumn 2015.
- There are no immediate measures available to promptly remedy the faults at the QUEH.
- Suitable accommodation, which meets environmental standards, is available at the Beatson, West of Scotland Cancer Centre, however, there are only 20 beds rather than the 24 available in the QEUH.
- The current provision of critical care support at the Beatson, WOSCC, is inadequate to meet the needs of this vulnerable population and the lack of co-location of other acute specialties and laboratory support is a cause for concern
- Antifungal prophylaxis measures had been taken for some patients prior to the concerns being raised and for other subsequently increased once the problem was identified.

**Recommendations**

1) Move all high risk patients, currently in ward 4B1, to the Beatson, West of Scotland Cancer Centre, wards B8 and B9 where water and air quality are compliant with requirements. This would include all allogeneic transplant recipients, patients receiving high dose chemotherapy with stem cell rescue, very severe aplastic anaemia and all acute leukaemias undergoing induction chemotherapy.
2) Refine protocols already in place to provide immediate access to critical care assessment at the Beatson, West of Scotland Cancer Centre site with rapid transfer to the Queen Elizabeth University Hospital, Glasgow for critical care monitoring as required.
3) Discuss as soon as possible with patients, relatives and friends the implications of the above for them and explain the remedial action already taken and plans for the move.
4) Put in place a plan to remedy the faults in the accommodation at QEUH to allow a speedy return.
5) Review GG&C haemato-oncology in patient and day case practise as the move will reduce the number of in-patient beds available for GG&C
6) Work in close partnership with colleagues from other disciplines and all management teams to ensure the resolution of this situation promptly and safely to ensure best patient care.

7th July 2015

**BONE MARROW TRANSPLANT SERVICE TEMPORARY RELOCATION**

Routine air quality monitoring has identified a higher particle count than is desirable in the Bone Marrow Transplant unit.

As a precautionary measure, while we explore remedial measures, we have decided to return this service to the Beatson West of Scotland Cancer Centre from the Queen Elizabeth University Hospital together with the intensively treated acute leukaemia patients.

18 patients are being transferred back to the Beatson temporarily, and we have already been in direct contact with the patients affected and their families to explain the situation and apologise for any inconvenience this may cause.

This is temporary measure to enable us to identify and implement what may be necessary to ensure air quality purification levels are optimal for this group of patients.

Dr Anne Parker, Lead Consultant for Haemato-Oncology, said: “In consultation with colleagues from various disciplines, it has been agreed that 18 patients will move to the Beatson West of Scotland Cancer Centre for an interim period. This will enable remedial work to take place without disrupting patient care. This is purely a precautionary step and we have no evidence that any patient has been adversely affected as a result of the environment issues. We are fortunate that the Beatson is available to us and we are working with our critical care colleagues in the new High Acuity Unit which has been established there.”

The return to the new hospital will take place as soon as possible.

This issue relates only to the adult hospital. Bone Marrow Transplant services at the Royal Hospital for Children Glasgow are separate and unaffected.

**ENDS**

For further information either telephone [redacted] or email [redacted]

## BMT Q&A FOR POSSIBLE SUPPLEMENTARY QUESTIONS FOR DISCUSSION

**1 - Why was this not picked up sooner? The unit has been operational for over a month?**

As soon as our routine monitoring arrangements identified a higher air particle count we took swift action to address the situation together with expert clinical haemato-oncology consultant colleagues.

**Why were these issues not picked up during the commissioning process?**

There is a process for validating that facilities are in line with specifications and we are currently in the process of reviewing the processes in this instance to understand why this was not identified. However, our robust routine monitoring arrangements have worked and identified the issue so that early action could be taken.

**3 - How many patients have been treated in the unit so far and can you guarantee that they will not have been adversely affected?**

The 39 patients that have been treated in the unit so far have all been reviewed by expert clinicians and the lead clinician for haemato-oncology has confirmed that she is confident no patients have been adversely affected by this higher air particle count.

**4 - How much will the work cost?**

We are currently identifying what may be necessary to ensure air quality purification levels are optimal and as such as cost is yet to be confirmed.

**5 - What exactly is the work that is required to make the unit fit for these patients?**

We are currently identifying what may be necessary to ensure air quality purification levels are optimal

**7 - Is the anaesthetic cover on the Beatson site adequate for these patients?**

The haemato –oncology clinicians have confirmed that they are content that the BOC will provide a safe environment for this group of patients in the interim given that the unit has only recently transferred for this location and that the out of hours anaesthetic cover arrangements on the site are appropriate.

**8 - In view of these issues only being discovered now what reassurance can you provide that all other areas of the hospital are safe for patients?**

We are not aware of any other issues.

**9 - Is this a fault by the builder?**

There is a process for validating that facilities are in line with specifications and we are currently in the process of reviewing the processes in this instance to understand why this was not identified. However, our routine monitoring arrangements have worked and identified the issue so that early action could be taken.

**7.7.2015 - LD briefing to Scottish Government**

**1. Why did BMT move.**

The Bone Marrow Transplant service was relocated to the new Queen Elizabeth University Hospital because of the benefits from co-locating the service with a range of other specialist services which would deliver enhanced benefit to these patients. This decision was fully supported by haemato-oncology clinicians who provide this service

**2. Is there an detriment to patients being relocated back to the Beatson.**

The Bone Marrow Transplant service was based at the Beatson for five years and operated very successfully. The facilities at the Beatson provide an appropriate environment for these patients and the clinical team will work closely with critical care colleagues in the new high acuity unit . Once the remedial work is complete, it is our intention to move the service back to the new Queen Elizabeth University Hospital.

NHS Greater Glasgow and Clyde

# Core brief

Tuesday, 07 July 2015

**Introduction**

This issue of Core Brief is an NHSGGC press release on the bone marrow transplant service temporary relocation.

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**BONE MARROW TRANSPLANT SERVICE TEMPORARY RELOCATION**

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The return to the new hospital will take place as soon as possible.

This issue relates only to the adult hospital. Bone Marrow Transplant services at the Royal Hospital for Children Glasgow are separate and unaffected.

**Are your contact details up-to-date? Click here to check**

**From:** McLaws, Ally
**Sent:** 08 July 2015 16:36
**To:** Edwards, Emma; Dick, Lorraine
**Subject:** FW: BBC
**Attachments:** BBC statement.htm

**Importance:** High

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**From:** McLaws, Ally
**Sent:** 08 July 2015 16:26
**To:** 'Suzanne.Hart[redacted]
**Cc:** Alan.Hunter[redacted]; Calderwood, Robert; Armstrong, Jennifer; 'catherine.calderwood[redacted]
**Subject:** BBC
**Importance:** High

Dear Suzanne,

There has been no on going coverage of the BMT transfer back to the Beatson following last night broadcast and this morning's print media coverage.
The only outstanding inquiry is from the BBC and they have already run with our reassuring statement of last night. They have asked a few supplementary questions and we have sent them the attached statement. They have asked if they can film outside the new hospital to describe the flit and we have agreed.

Our media handling has resulted in very clean straight reporting of a safe transfer of patients as a precaution to where the service was based before the move. To put up one of our seniors to camera invites questions about "design fault" or construction issues and are investigations ongoing into how this could have happened etc.... the problem lies there in that we would have to confirm ongoing investigations and that in turn drags contract issues and compensation issues to the questions likely to be asked. We must avoid this area at the moment.

I have given my strong advice to our senior management team that we should not put anyone up for the BBC so that we do not invite questions live on camera that could lead to this story picking up new and ongoing media coverage and drag us into delicate/difficult and potential litigious areas that we really should avoid.

I understand that our Medical Director has outlined these risks to the CMO this afternoon. The BBC already has the reassuring lines and they are not even running them this afternoon – and haven't run anything all day.

**Just a few moments ago Suzanne and I discussed these risks. I strongly advice that the risks far outweigh any benefit from confirming what we have already stated last night and has already been covered widely today. I do not believe the BBC will not probe extensively given the chance of an interview.**

**Suzanne has confirmed that she also agrees that these risks are significant and that it would be almost impossible to "bat off" difficult questions by simply insisting to stick to the reassuring message.**

Suzanne has also now confirmed that she will advise Alan Hunter of her professional opinion that our option of offering a statement of reassurance to the BBC and the answers to their supplementary questions is the safest way forward.

Ally

Ally McLaws |Director of Communications |NHS Greater Glasgow and Clyde
[redacted] web: www.nhsggc.org.uk
**Follow us on Twitter @nhsggc**

Wednesday, July 8, 2015

# NHS GREATER GLASGOW ANC LYDE ADDITIONAL STATEMENT ON TEMPORARY RELOCATION OF BMT SERVICE

The patients are in the process of transferring to the Beatson West of Scotland Cancer Centre (BWOSCC) today.

There is a new High Acuity Unit in place at the BWoSCC with enhanced monitoring, dedicated critical care nursing staff, and 24 hour anaesthetic support on site. This additional supporting infrastructure for the Beatson was implemented to ensure ongoing patient safety at the BWoSCC.

The haemato–oncology clinicians have confirmed that they are content that the BWoSCC will provide a safe environment for this group of patients in the interim. The BMT unit has only recently transferred from this location therefore staff are extremely familiar with the environment. Haemato-oncology and Critical Care Consultant representatives have discussed the temporary relocation of services and have agreed the clinical model.

The patients in the BMT unit are extremely susceptible to infection and the ventilation system has special filters which purify the air quality. As the patients require optimal air quality purification we routinely monitor the air particles (these particles are naturally occurring in the atmosphere) and during this testing found that whilst the levels were within the acceptable range for other patients, they were unacceptable to the BMT Unit.

No other patients in the hospital are affected.

Dr Anne Parker, Lead Consultant for Haemato-Oncology, said: “The Bone Marrow Transplant service was successfully located in the BWoSCC for five years.

“However, returning the service back to the new Queen Elizabeth University Hospital when the remedial work is complete will deliver enhanced benefits for these patients with the range of other specialist services on site.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

Friday, July 10, 2015

## NHS GREATER GLASGOW AND CLYDE RESPONSE TO QUESTIONS

**Has the problem with the air quality at the new Glasgow hospital been sorted out, and is there a timescale for sorting it**?
The issue with the air quality is only confined to the Bone Marrow Transplant Unit not the whole hospital. We are assessing what needs to be undertaken in this unit to resolve the issue and move patients back as quickly as possible. We expect this assessment to be complete over the weekend.

**Is there a timescale for returning cancer patients back to the new Glasgow hospital from Beatson**?
The timescale will be clearer after the assessment of the work needed is complete early next week.

**A patient has told us she was aware of the importance of HEPA (High Efficiency Particulate Arresting) to help with resistance to infection was zero. One of the first thing she noticed about her room at the new hospital was the absence of the HEPA filter. Has the hospital got HEPA filters, if not what have they been replaced by**?
HEPA filters are standard in such units. HEPA filters were fitted throughout this area – that was not the issue.

**NHS has said it is a temporary issue. If HEPA is not the issue, what could have caused the problem that would make it seem to be a temporary issue**?
As we have said above the issue is being identified and an assessment of the work needed being carried out.

**A patient group says there needs to be an investigation to ensure something like this never happens again. Is that happening, if so, what is being done in a general sense to ensure that issues with the hospital are not found out after the fact**?
As we have stated this transfer was made as a precaution. There has been no detrimental effect to any of our patients. We monitor all such systems regularly and due to this monitoring process we are able to detect any issues promptly and take appropriate action.

**ENDS**

14 July 2015

# NHSGGC comment regarding Bone Marrow Transplant Unit

A significant amount of work has been undertaken over the past week in order to assess the work necessary within the unit. A range of mock-up alternatives have been developed and are currently being examined by experts in order to determine the best solution. We expect to have agreed the work necessary to consistently achieve the air pressure required to ensure continued air quality by the end of this week. Once this is agreed a final timescale for the work will be known.

**ENDS**

For further information either telephone [redacted] or email [redacted]

July, 2015

## BONE MARROW TRANSPLANT PATIENTS EXPECTED TO RETURN TO NEW QEUH IN THREE MONTHS TIME

Following the relocation of the Bone Marrow Transplant Service Unit from the Queen Elizabeth University Hospital (QEUH) to the Beatson West of Scotland Cancer Centre (BWoSCC) a significant amount of work has been undertaken over the two weeks to assess the work necessary to return the unit back to QEUH.

Working with the building contractors a range of mock-up alternatives has been developed to identify the best option for the unit. These alternatives are being examined by external experts in order to determine the best solution.

We expect to have agreed the work necessary to consistently achieve the air pressure required to ensure continued air quality by the end of this week. Once this is agreed a final timescale for the work will be known.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Wednesday, October 28, 2015

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON BONE MARROW TRANSPLANT UNIT

The contractor is expected to hand the unit back to us at the end of next week.

Over the following three to four weeks there will a number of tests undertaken on the unit and on completion of these tests the service will return to the Queen Elizabeth University Hospital.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**From:** [redacted]
**Sent:** 08 March 2019 12:36
**To:** Office, Press
**Subject:** LD fwd Jennifer Armstrong 08/03/19 QEUH Questions

Hello,

I am working on a story regarding the QEUH and have some points to put to you, if you would like to comment/respond to questions. I will need something by 12pm tomorrow at the latest.

- The cost to repair problems at the QEUH has been estimated at £50m.
- Tom Walsh has been moved to a project management job following the bird poo incident. Why has this happened? And will Mr Walsh be involved in project managing the internal review?
- Images were sent in December by GGC to the cabinet secretary showing the area of contamination where the bird poo was. Can you please supply a copy of these images?
- Healthcare Facilities Scotland have already identified issues with the ventilation and filtration system within the hospital, and that it is not adequate to cope with a facility of this size. Electronic alarm systems within controlled pressure rooms supposed to pick up ventilation failures did not work. Ducting is not the right size, HEPA filters needed cannot fit the ducting which is there currently.
- Mucorales infection – do you know the source of this yet?
- Concerns were raised about the ventilation and the water system problems in 2015 by staff and in 2017, but these were not acted upon (some of this is in the HIS report).
- The BMA contacted NHSGGC in December/ Jan regarding the treatment of a member of staff who raised concerns about the bird poo initially, as they felt the person was being treated unfairly/concerns of bullying. This was looked at by Jennifer Armstrong –Is this still being looked at or has it concluded? If it has concluded, what was the outcome?

Thanks,

[redacted]

[redacted]

[redacted]
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Friday, March 8, 2019 (LD)

[redacted] **Herald on Sunday**

## NHS GREATER GLASGOW AND CLYDE RESPONSE

**Q. The cost to repair problems at the QEUH has been estimated at £50m.**

A. The costs for the upgrade to the ventilation system and the water treatment system have already been confirmed in the public domain and together will cost approximately £2.75 million. The figure of £50 million is therefore wildly inaccurate.

**Q. Tom Walsh has been moved to a project management job following the bird poo incident. Why has this happened? And will Mr Walsh be involved in project managing the internal review?**

A. Tom Walsh, Infection Control Manager, has been appointed to the role of Project Manager for the internal and external review processes for the QEUH/RHC campus. Tom will be supporting the Chief Executive to coordinate the internal reviews and act as the point of liaison for the External Review.

**Q. Images were sent in December by GGC to the cabinet secretary showing the area of contamination where the bird poo was. Can you please supply a copy of these images?**

A. We are not aware of the images you are referring to or of any images being sent to the Cabinet Secretary.

**Q. Healthcare Facilities Scotland have already identified issues with the ventilation and filtration system within the hospital, and that it is not adequate to cope with a facility of this size. Electronic alarm systems within controlled pressure rooms supposed to pick up ventilation failures did not work. Ducting is not the right size, HEPA filters needed cannot fit the ducting which is there currently.**

A. HEPA filters are not generally required throughout hospitals, but only in Bone Marrow Transplant units.

The Bone Marrow Transplant units have been fitted with HEPA filters. There are no current issues with the ventilation system and the ducting for the general wards

within in adult hospital and the children's hospital. There is however work currently underway to upgrade the haemato-oncology ward in the Royal Hospital for Children to the latest specification while patients are temporarily relocated to another ward in the QEUH. We have previously announced that this work is being carried out.

**Q. Mucorales infection – do you know the source of this yet?**

A. No.

**Q. Concerns were raised about the ventilation and the water system problems in 2015 by staff and in 2017, but these were not acted upon (some of this is in the HIS report).**

A. We believe that all concerns have been addressed however we would ask you to tell us what concerns you think have not been addressed so that we can investigate this.

**Q. The BMA contacted NHSGGC in December/ Jan regarding the treatment of a member of staff who raised concerns about the bird poo initially, as they felt the person was being treated unfairly/concerns of bullying. This was looked at by Jennifer Armstrong –Is this still being looked at or has it concluded? If it has concluded, what was the outcome?**

A. We are not aware of any BMA contact with us regarding this claim.

**ENDS**

For further information either telephone [redacted] or email [redacted]

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

# £50m repairs bill for flagship city hospital

## NHS chiefs hear shock cost for work across QEUH campus

**Exclusive**

By Hannah Rodger

NHS chiefs are facing a £50m repair bill to upgrade and fix problems at the site of Glasgow's super hospital.

It comes as the Herald on Sunday can exclusively reveal the first images of bird dropping contamination at the hospital which sparked a major public inquiry and caused the death of a [redacted].

Health inspectors have identified a number of flaws at the site including ventilation ducts being the wrong size, alarm system failures and isolation room issues.

Chronic infighting between two key departments has also caused hold-ups with infection control procedures, which are vital to keep patients and staff safe.

Tomorrow bosses are due to hold their annual meeting, where cabinet secretary Jeane Freeman and members of the public will get the chance to scrutinise the performance of Scotland's largest health board.

**Turn to Page 6**

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

The huge cost of repairing the four-year-old facility and associated buildings was raised earlier this year

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

# £50m repair bill for troubled city hospital

**Exclusive**

by Hannah Rodger

THE catalogue of problems at the Queen Elizabeth University Hospital site could cost as much as £50 million to repair, the Herald on Sunday can reveal.

The staggering cost of repairing the four-year-old facility and associated buildings was raised earlier this year among senior staff at NHS Greater Glasgow and Clyde (NHSGGC), following a number of high-profile infections at the the £842m super hospital.

Today, we can also reveal a number of other issues at the scandal-hit site including ventilation systems not of the correct size, safety alarm failures, chronic infighting among staff and a lack of input from infection control teams on the project before it even opened.

NHSGGC has already admitted it will cost £2.75m to sort out problems with the water system and ventilation at the new hospital, however a report released on Friday by Healthcare Improvement Scotland revealed there are more than 300 outstanding repairs to be done – without any plan to complete them.

It is understood the health board's estates and facilities manager told the corporate management team in January that it could cost as much as £50m to rectify the issues at the site.

NHSGGC refused to officially give a figure for the repairs, but admitted problems with older buildings on the campus do require a "significant investment".

A source close to NHS senior management told the Herald on Sunday: " Early figures quoted to bring the critical areas up to speed are £50m, plus the disruption of closing down areas. The corporate management team were told this earlier in the year, when the issues across the estate were brought up."

Two other senior sources also said they were informed of the staggering costs involved. Problems already identified by auditors at Health Facilities Scotland are believed to include the size of the ventilation ducts, which may not be large enough to fit certain air filters needed for a hospital the size of the QEUH, and alarm systems supposed to detect failures with ventilation and contamination which did not function at all.

Special isolation rooms which are essential to stop the spread of infections are also missing from the facility – an issue now being probed by the Health and Safety Executive.

Infighting between infection control teams and the health board's facilities and estates team is rife, according to various senior NHS sources, who say that staff who previously raised concerns about the state of the new hospital were ignored.

One senior health source told the Herald on Sunday: "Concerns about the ventilation and water were raised as far

The Herald
Date 10 March 2019
Page 1,6,7
Precise.

back as 2015, and these weren't listened to. It was as if they didn't want to know.

"In 2017 various microbiologists also raised concerns in a report and they were ignored too. People are being bullied and right now it is clear that the board and directors at NHSGGC are trying desperately to find someone to blame."

Healthcare Improvement Scotland inspectors picked up on the problems in their report last week, citing "challenges in the working relationships between senior staff" which they say must be resolved.

Trade union BMA Scotland also raised concerns about treatment of an employee who reported the bird droppings issue in December, although no official complaint was made. It has also emerged that the board's infection control manager has been shifted to a project manager job following the bird faeces discovery, and will now be involved in the independent inquiry and internal investigations into the outbreak – a move critics say will stop an impartial investigation taking place.

One source close to the investigation said: "It is ludicrous that someone linked so closely to infection control would now be managing the investigation into infection problems. How can it be independent and balanced if this is the case?"

Hugh Pennington, professor of bacteriology at Aberdeen University, said the fault lies with the health board management and warned there will be further outbreaks if issues are not resolved quickly. He said: "Clearly the management is not on top of these issues. There are communication problems between infection control and other areas. These are all management issues.

"While the infection rate is no higher than anybody else's the problem really is that if the issues carry on – some of them seem to have been there for two or three years – sooner or later they will have a higher number of outbreaks and infections.

"Prevention is the name of the game here. It was very disappointing to see this in a hospital that has only been running for a short period.

"If it was an old building that was going to be pulled down, you might say 'that explains it'. This is a new hospital with problems with routine maintenance, routine cleaning, people raising problems and nothing being done."

Dr Lewis Morrison, Chair of BMA Scotland, said: "While it would be wrong to jump to conclusions around individual infection outbreaks, there now seems little doubt that there are serious issues to address at the QEUH hospital site. The report from Healthcare Improvement Scotland makes that absolutely clear.

"For a report to find that parts of the site are in such a poor state of repair that they therefore cannot be effectively cleaned would seem completely unacceptable in a modern NHS. That there are at least 300 outstanding maintenance jobs without evidence of a plan to complete these, suggest the scale of the challenge of rectifying the situation.

"A further theme that comes through is shortages of staff – including infection control doctors, who play a crucial role with the assessment and mitigation of infection risks presented by the built environment. Without the right staff in place, it is hard to see how real improvements can be made. Equally, there would also appear to be issues with senior management acting on concerns of the clinical staff who are in place – for example in estates meetings. The board must act urgently, as they have set out in their action plan in response to the report, to deal with these critical issues and make improvements across the board.

"But it would also be wrong to suggest these are isolated problems. Our NHS is under resourced and understaffed as we have been warning for some time. Therefore it is no surprise that building maintenance is suffering, with a resulting negative effect on cleanliness. And if this is the case at one of the most modern facilities in Scotland, then it is hard to believe that there are not similar issues at some of the more dated buildings in use.

"Finally, it is welcome that there is a review into the design and building of the QEUH, and we hope there may be lessons for the NHS as a result. For example, and without pre-empting results of the review, an increased and more effective role for infection control experts in the design and building of NHS facilities is an area where real improvements can potentially be made."

A report into water contamination issues at the hospital site revealed there was "no documented evidence of

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

NHSGGC Infection Prevention and Control Team involvement in the commissioning or handover process of the project" although infection control and prevention nurses had been seconded to work on the project team.

The lack of involvement by infection control in new medical projects was raised by BMA Scotland in submissions to the Scottish Government earlier this year, where they said: "It is an uncommon event for an infection control team to oversee a major build – although they are often consulted as the project progresses. However, there may not always be enough time and experience to optimally deliver this input despite expert knowledge clearly being needed. Added to this, the NHS experts and the builder's experts often don't agree on points of design and how this may relate to infection risk."

NHS Greater Glasgow and Clyde didn't respond to specific enquiries regarding safety alarm failures or ducting being the wrong size.

A spokeswoman said that the special HEPA filters required in some areas of the hospital were "not generally required throughout hospitals, but only in Bone Marrow Transplant units" and added: "The Bone Marrow Transplant unit in the QEUH has been fitted with HEPA filters. There are no current issues with the ventilation system and the ducting for the general wards within the adult hospital and the children's hospital.

"There is however work currently underway to upgrade the haemato-oncology ward in the Royal Hospital for Children to the latest specification while patients are temporarily relocated to another ward in the QEUH. We have previously announced that this work is being carried out."

On staff concerns about the site problems being ignored, the spokeswoman said: "We believe that all concerns have been addressed", and added they were "unaware" of any concerns discussed about staff treatment by BMA Scotland.

On the upgrade costing £50m, she said: "We do not know where you have obtained the £50m figure but can confirm that some of the older buildings on the QEUH campus do require significant capital investment but not the two new hospitals. There will always be significant numbers of repair requests ongoing at any one time in any hospital, but a campus as large as the QEUH will have proportionately more. To clarify, the 300 outstanding repair requests are routine repairs like a broken blind, broken door handle, broken hinge etc and do not represent a significant investment."

The Health and Safety Executive said: "HSE is currently investigating the circumstances surrounding the outbreak of Cryptococcus infection at Queen Elizabeth University Hospital. Initial enquiries commenced on 24 January 2019 but it is not possible at this stage to provide a date for completion of the investigation.

"Our investigation will examine the range of control measures in place to reduce and mitigate the risks of such infections. This will, as a matter of course, include the adequacy of ventilation systems but we cannot comment further on the detail of this ongoing investigation."

Health Facilities Scotland did not respond to our request for comment.

The Scottish Government refused to address specific issues highlighted by the Herald on Sunday, but re-iterated the statement made by Cabinet Secretary Jeane Freeman following the HIS report released on Friday.

Ms Freeman said: "Patients and the public deserve to have complete confidence in the cleanliness of Scottish hospitals and the quality of NHS services. I am clear that Scotland's hospitals should be clean and safe, and that we have a strong record on infection control and prevention. However, this report highlights a number of areas where immediate action is required, and we will work with the board to ensure these are addressed as soon as possible.

"The findings of this report will of course feed into the independent review into the design, commissioning, construction, handover and maintenance of Glasgow's Queen Elizabeth Hospital."

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Concerns about the ventilation and water were raised as far back as 2015, and these weren't listened to. It was as if they didn't want to know

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

Hugh Pennington, professor of bacteriology at Aberdeen University

Outstanding repairs and the discovery of bird droppings have heightened infection fears at QEUH

The Herald

Date 10 March 2019
Page 47

Precise.

**In our opinion**

# Safety at city hospital must take priority

IT is concerning to see that up to £50m may have to be spent upgrading and repairing the site of Glasgow's newest flagship hospital.

What is also troubling is the apparent catalogue of errors, safety concerns and problems at the Queen Elizabeth University Hospital itself, despite it being just four years old.

Staff have told watchdogs that their concerns have been ignored, and inspectors just this week found more evidence of dust, dirt and improper practices at the £842m facility.

Clinicians who raised concerns in 2017 say their worries were not dealt with, and more than 300 jobs are still awaiting repair at the new building.

If a [redacted] dying at the site and numerous others becoming ill with strange and rare infections isn't enough to prompt instant and permanent change, what is?

Hospital staff themselves are hard-working, dedicated and care deeply about what they do, as would be expected from our National Health Service.

NHS senior management, Scottish Government staff and the health minister must now do all they can to resolve the problems.

Difficulties between leading staff in key departments must be put aside in order to protect the lives of those most in need of care.

When the NHS works, it is the country's greatest asset and we must not allow this fantastic service or the reputation of its incredibly dedicated staff to be eroded.


Sunday, March 10, 2019 (LD)

**NHS GREATER GLASGOW AND CLYDE RESPONSE**

**TO HERALD ON SUNDAY ARTICLE**

Today's Herald on Sunday claims that there is a £50m repair bill at the Queen Elizabeth University Hospital (QEUH). This is completely inaccurate and we made clear to the paper that we do not recognise the £50m quoted in the article.

We confirmed that we are upgrading the ventilation and the water treatment system at the Royal Hospital for Children (RHC) which will cost approximately £2.75m and this is already in the public domain.

We made it very clear to the Herald on Sunday that no such figure (£50m) applies to the QEUH.

We also confirmed that the campus is large and has other older buildings which require capital investment, which is already in the public domain, and is unrelated to the QEUH or the Royal Hospital for Children.

Our statement to the paper confirmed that there will always be significant numbers of repair requests ongoing at any one time in any hospital, but a campus as large as the QEUH will have proportionately more.

To clarify the 300 outstanding repair requests referred to in the HIS report are routine repairs like a broken blind, broken door handle, broken hinge etc and do not represent a significant investment.

We have today complained to Herald on Sunday about their inaccurate reporting.

**ENDS**

For further information either telephone [redacted] or email [redacted]


13 September, 2019 (MD)

[redacted] **HoS** - I have obtained documents relating the Queen Elizabeth University Hospital and Royal Hospital for Children which show evident problems in the hospital's ventilation system which warrant further investigation. They also detail problems with record keeping on the builds themselves, concerns about thermal wheel devices which are fitted onto ventilation throughout the hospital not being suitable for hospital due to the risk of contamination, and indications that the air handling units selected, potentially throughout the entire site, have not been sized correctly relating to the problem with obtaining the required number of air changes needed for the various wards.

They also contain a suggestion that the children's cancer ward (2A) was not originally designed or intended to be used for immunocompromised patients, the BMT wards for adults were also not built for purpose, the suggestions made by NHSGGC to fix the problems with the adults BMT wards not meeting the guidance nor resolving all the problems they have, and issues with the children's BMT wards. Six of the eight suites for child BMT patients were in need of retrofitting air handling unit changes, as they were not up to standard, but only four in the end were completed. Patients continued to use these eight suites until (correct me if I'm wrong) they were moved from RHC to QEUH along with the other child cancer patients in September 2018.

The other issues identified from these documents involve the inaccurate or missing records from the Zutec system for the builds. In one of the reports, from a company called Innovated Design Solutions, they point out various anomalies in the records system for the build compared to what has actually been implemented.

The documents I have are: Innovated Design Solutions Feasibility study regarding increasing ventilation air change rates in Ward 2A – October 2018

Minutes of meeting to discuss BMT Unit RHC, Monday September 7, 2015 at 4.45pm

Health Protection Scotland and NSS situational report on the SBAR raised about QEUH Bone Marrow Transplant Unit. Completed by Annette Rankin for HPS/HFS on October 2017.

Please let me know what your comment will be in regards to the information contained within these reports, on the points I have highlighted.

## NHS GREATER GLASGOW AND CLYDE RESPONSE.

These documents relate to issues which have been widely covered in the media over the course of the past three years including a number which we ourselves proactively issued to the media.

An upgrade was carried out in four paediatric Bone Marrow Transplant (BMT) isolation rooms in 2015 in line with projected demand. Testing confirmed full compliance with the appropriate technical building requirements. A multidisciplinary team of clinical, estates and infection control experts all agreed that the paediatric BMT facilities were suitable for use. Over the years, the unit has successfully treated a number of patients with cancer related illnesses with good UK bench-marked outcomes.

We have previously openly and publicly stated in 2017 that work was carried out on the adult BMT unit to ensure optimal air quality purification levels for this group of patients. The resulted in a significantly improved environment for BMT adults and again we have successfully treated many patients in this unit.

We have also previously reported that we are proactively investing £2 million to upgrade the ventilation system in Ward 2A and B to provide optimal, state of the art facilities for all our young haemato-oncology patients.

Infection rates within the Royal Hospital for Children are low. The most recent national survey of all hospital infections was carried out in 2016 and this showed the Royal Hospital for Children to be below the national average – with rates of 3.6%.

The next annual Scotland-wide survey is not due to take place until 2020. In the meantime, ongoing monitoring shows that our rates of bloodstream infections are significantly better than many other units – including the old Yorkhill hospital – and are comparable with world leading hospitals such as Great Ormond Street.

**Ends.**

<u>Background</u>

If reporting again, please note that the majority of the 13 cases reported to the Board between March- August had an infection on admission. It is therefore incorrect to report that all 13 ‘contracted’ an infection in hospital.

The management tool that we use to monitor infection rates is through a calculation of the number of bloodstream infection per 1000 days for patients who have a central venous line inserted. Currently we are recording 2.1 infections per 1,000 days.

**ENDS**

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde Health Board
**Page:** 4
**Reach:** 27655
**Size:** 1277
**Value:** 8211.11

# 'How much more evidence do we need to see there are major problems with this hospital?'

## Parents and politicians call for public inquiry as reports reveal extent of crisis at superhospital

**Special report**

By Hannah Rodger

FAMILIES of sick children have criticised Government and health chiefs after a series of leaked reports reveal flaws at the heart of two of Scotland's flagship hospitals.

Documents passed to The Herald on Sunday detail the extent of the issues which have affected the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) since opening.

Families, politicians and experts have now joined in calls for a full-scale inquiry, as records reveal issues with ventilation not being the right size, missing or inaccurate building records, and energy-saving devices not fit for hospitals.

One parent said our revelations confirmed parents' suspicions about safety, and added: "This is a cover-up ... You have to wonder how this all got signed off in the first place."

It comes just days after the Health Secretary Jeane Freeman announced that the Royal Hospital for Children and Young People in Edinburgh will not open for another year, and is to cost upwards of £16 million to fix.

Nicola Sturgeon was grilled by MSPs about the issues, saying she "deeply regrets" the delay at the Edinburgh hospital, and apologised to families of children in Glasgow who had contracted infections while being treated at the QEUH.

Problems identified by investigators into the Edinburgh facility included issues with ventilation not meeting national standards and record-keeping at the build – startlingly similar to some of the issues revealed today about Glasgow's flagship sites.

The cache of reports obtained by The Herald on Sunday include a study into increasing the air circulation within ward 2A of the children's hospital – a cancer ward – which is currently out of use after dozens of children contracted infections last year.

However, the study by a private contractor also states there may be wider problems with the ventilation across both hospitals, and records about building work had been wrong or in some cases had parts missing, making it difficult to investigate further.

Ventilation systems are essential in hospitals as, when working correctly, they help protect patients from external pathogens and ensure the air they are breathing is clean and free of bacteria.

The report also reveals that ceilings would need to be torn down and fixtures taken out of the children's cancer ward and the ventilation system replaced entirely.

Assessors estimated it would cost £2.8m and take at least a year to fix the one ward.

We have also obtained a health watchdog report from October 2017 warning NHS Greater Glasgow and

Client: NHS Greater Glasgow and Clyde Media Coverage
Source: The Herald
Date: 15/09/2019

Keyword: NHS Greater Glasgow and Clyde Health Board
Page: 4
Reach: 27655
Size: 1277
Value: 8211.11

Clyde (NHSGGC) that its plans to fix adult bone marrow transplant suites in the QEUH did not "meet guidance" or "seek to address all the recommendations".

Adults with cancer were moved initially to the QEUH when it opened in April 2015, but were moved back to the Beatson cancer unit three months later due to air quality in the new wards.

By September 2015, NHSGGC management were discussing issues with the children's bone marrow transplant units, which had also been found to have flaws. Out of the eight suites, six needed upgrading to make them suitable for bone marrow patients.

The health board said that two were upgraded "in line with projected demand" and added: "Testing confirmed full compliance with the appropriate technical building requirements. A team of clinical, estates and infection control experts all agreed that the facilities were suitable for use."

NHSGGC say cancer patients who did not require bone marrow transplants were accommodated in the other four.

Children were moved out of the bone marrow transplant suites, as well as ward 2A, three years later in September 2018 after more than 20 young cancer patients contracted infections.

We revealed last week that 13 young patients in the QEUH had infections between April and September.

Families have today hit out at the revelations, calling for the hospital to be closed until a full-scale inquiry takes place.

Politicians have also questioned the Government's previous statements that the hospital site was safe, and said Health Minister Jeane Freeman can no longer blame health board chiefs.

Annemarie Kirkpatrick, whose teenage daughter was receiving treatment for leukaemia when she became infected with a rare bug at the QEUH, said: "I am absolutely disgusted. The ventilation report is highlighting really serious issues, which would have been there at the time children were being treated in that ward. They were at risk for three years.

"They have kids going through some of the hardest things they will ever go through in their lives ... They have chosen to put these children in that hospital, knowing there were problems and knowing that it was unfit. They have risked children's lives. I speak for all the parents when I say this, we feel as though they have tried to mislead us.

"When we asked questions, they would say that the hospital is safe and then move on to something else, instead of being up front.

"It was like that with everything. They would say 'the ward is fine, the hospital is fine' and clearly it is not.

"The whole place needs fixed, and patients shouldn't be in there if they cannot guarantee that it is safe. Parents are not stupid, and this proves what we thought was right – the hospital is not safe. Someone needs to start standing up and admitting what is going on, and getting these children out of that hospital.

"They need to go into another unit or another hospital, they need to come out right now. There needs to be a public inquiry, what they are doing is not good enough. It cannot wait for years until the investigation is finished."

Ms Kirkpatrick was joined by Alfie Rawson whose [redacted] daughter [redacted] is currently receiving treatment for cancer.

He said: "Having read these reports, it proves exactly what we have previously said – this is merely a cover-up from hospital management and the Government, who were all aware of the issues. You have to wonder how this all got signed off in the first place.

"Parents have been made to feel like we were over-protective, paranoid and over-reacting when asking questions and then given letters from the hospital, trying to say infections are normal and common. It's a new hospital – should infection rates not be lower?

"Now they really have nowhere to go on this given ward 2A is closed and ward 6A is closed for admissions.

"They must come clean or a public inquiry must be held to find out who is responsible. Our children and all the parents deserve answers."

Critics say the Government has not taken responsibility for the problems with the new Edinburgh hospital, instead blaming NHS Lothian.

With the addition of the reports into Glasgow today, politicians say Freeman and her SNP colleagues must take responsibility for the failures which have happened under their watch.

Miles Briggs, the Scottish Conservatives' health spokesman, said: "These are deeply concerning reports."

Reflecting on the similar concerns detailed in this week's report about the Edinburgh hospital, he added: "Clearly there needs to be an urgent investigation into whether the ventilation systems in Glasgow do not meet the recommendations and whether it will need a total refit. If that is the case then it will have severe impacts on the operational future of the hospital.

"This week SNP ministers have blamed 'human error and confusion' for the ventilation system at the Sick Kids hospital not meeting standards. It would now seem from the reports that the ventilation system in Glasgow has identical issues – mistakes have been made in the ventilation systems at two major projects commissioned by two separate health boards.

"SNP ministers are simply not in control of our NHS. [They] are quick to blame NHS management but the buck stops with them."

Monica Lennon, Labour's shadow health secretary, said a public inquiry was "no longer optional" and added: "How much more evidence do we need to see that there are major problems with this hospital?

"There are similarities between the problems at QEUH and Edinburgh Sick Kids. Jeane Freeman can no longer blame health board management.

"How can it be a coincidence that both hospitals have problems with ventilation, water, and record keeping for their construction?

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde Health Board
**Page:** 4
**Reach:** 27655
**Size:** 1277
**Value:** 8211.11

"SNP ministers have used a huge amount of taxpayers' money on these facilities and they must be held accountable. Passing the buck on to individual health boards is not good enough. Patient safety and the reputation of our NHS is at stake.

"Nicola Sturgeon took the credit for these hospitals but if she blocks a public inquiry she will be known as the First Minister who tried to cover up incompetence and chaos. She must agree to an independent public inquiry and open her Government up to scrutiny."

Alex Cole-Hamilton, the LibDems' health spokesman, added: "That decisions were taken to move specialist units into facilities that were unfit to receive them is a shocking revelation.

"Nothing should ever compromise the safety of either patients or staff and that means ensuring all new buildings are compliant with all standards for the kind of treatment and care offered by those units.

"If someone has been playing fast and loose with the rules around patent safety so that they could keep the build on track, then that demands the full glare of public scrutiny."

> Parents have been made to feel like we were over-protective, paranoid and over-reacting. Our children and all the parents deserve answers

**The reports in detail**
**Pages 6-7**

| | | | |
|---|---|---|---|
| **Client:** | NHS Greater Glasgow and Clyde Media Coverage | **Keyword:** | NHS Greater Glasgow and Clyde Health Board |
| **Source:** | The Herald | **Page:** | 4 |
| **Date:** | 15/09/2019 | **Reach:** | 27655 |
| | | **Size:** | 1277 |
| | | **Value:** | 8211.11 |

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde Health Board
**Page:** 4
**Reach:** 27655
**Size:** 1277
**Value:** 8211.11

The leaked papers reveal a catalogue of issues and concerns dating back a number of years. Left, from top: Health Minister Jeane Freeman; Alex Cole-Hamilton of the LibDems; Annemarie Kirkpatrick, whose daughter has been treated for cancer at the hospital

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde
**Page:** 6
**Reach:** 27655
**Size:** 1066
**Value:** 6854.38

# Hospital crisis: what the leaked reports said

IN a series of leaked reports passed to The Herald on Sunday, startling new details about the problems at Glasgow's flagship hospital campus have been revealed.

Ventilation reports, minutes of meetings about bone marrow transplant facilities and health watchdog documents detail a catalogue of issues across both the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), dating back to 2015.

The cache of documents includes a report by independent consultants Innovated Design Solutions that looks at how to improve the ventilation and air quality in the RHC. The report suggests problems in the ventilation system in other parts of the hospitals.

A report by Health Protection Scotland was also passed to The Herald on Sunday, expressing concerns about plans to address problems with bone marrow transplant units, and minutes of a meeting with health chiefs about issues with the children's bone marrow units just months after they opened.

Today we can reveal the contents of the documents for the first time.

## Wards

BOTH the cancer ward in the RHC and the adult bone marrow transplant ward at the QEUH are described as having not been built for their purpose.

Private contractor Innovated Design Solutions concluded in its investigation into ward 2A: "We anticipate the original accommodation design was not intended for use by patients with immune response impairment/deficiency. On the contrary, the existing ventilation strategy would appear only likely to promote the risks associated with uncontrolled ingress of infectious aerosols into patient areas."

On the adult bone marrow unit, Health Protection Scotland reports from October 2017 state: "The decision to transfer the care of bone marrow transplant patients from the Beatson oncology unit to the QEUH was made in June 2013. Construction of the QEUH was well established at this point and therefore the new unit was not purpose built."

## Ventilation

THE size of the device which takes air in and out of the hospital was selected incorrectly, according to the Innovated Design Solutions report. The document explains that the devices are only able to take in 100% of the air needed when filters inside the ventilation system are clean. As soon as filters start to get dirty, the amount of air the system can take in falls, reducing the number of times air can be circulated through the hospital. The report indicates the devices would need to be able to take in 125% of the air required to account for dirty filters.

The report explains: "Air handling units [AHUs] fans were not sized or selected to afford a spare 25% capacity, as suggested by record documentation.

"Whilst technical literature would suggest there is 125% capacity available in AHUs, the manufacturer has advised that fans/motors were selected based on 100% duty with clean air filters (ie all AHUs).

"We would emphasise the probability of these issues/inadequacies being applicable to other air handling equipment installed within the A&C [adult and children's] hospital."

The number of times air is circulated around wards is vital to patient safety. Patients with severely restricted immune systems should be in rooms with 10 air changes per hour, while people with more robust immune systems should have six air changes per hour. The ventilation report reveals that there were only three air changes per hour in the children's cancer ward, describing this as "significantly lower than would normally be expected".

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde
**Page:** 6
**Reach:** 27655
**Size:** 1066
**Value:** 6854.38

The report states: "It should also be noted that current air change rates are not in accordance with recommendations defined within either [Scottish or UK guidelines on hospital ventilation].

"Whilst we were unable to locate documentation defining system design criteria, [UK guidelines on hospital ventilation] were available in 2007. If there was an agreed deviation from recommendations defined within guidance documents, available at the time of design, we would expect this to be clarified within the Health and Safety File documentation."

## Energy-saving devices

THERMAL wheels, which help to capture heat and save energy from ventilation systems, are common in large buildings but scientists have begun questioning their use in hospitals as they carry a risk of contamination. The devices are widely used in both the QEUH and RHC, as well as in the nearby Imaging Centre for Excellence and the learning and teaching facility on the campus.

Investigators said they "Consider this to identify a potential risk associated with cross-contamination" and added: "We recommend this be further investigated and level of associated risk considered against the use of facilities. We anticipate the majority of AHUs installed within the building are also equipped with thermal wheels ie Critical Care, General Theatres, Theatre Recovery, Endoscopy, Ultra CT Suite, Nuclear Medicine. Again, we recommend this be further investigated."

## Record keeping

SEVERAL anomalies were picked up by investigators at the private consultancy firm in terms of the records held for the RHC. During their investigations into ward 2A, they found "evident anomalies" with records such as those for the size of air handling units which did not match those installed.

They said there was no record about why the number of air changes in the bedrooms was lower than the required amount and added: "We were unable to locate any details ... pertaining to an agreed deviation from recommended guidance."

The device which supplies air into bedrooms was also noted as being incorrect in the records, with investigators finding the devices were "incorrectly identified within record documentation, albeit functionality is very similar". The sizes of pipes which carry air into the hospital were recorded differently on two separate drawings – one stated they were 7550x600mm and another said they were 600x500mm.

Drawings of ventilation systems on other floors were also found to be inaccurate.

## Bone marrow units

NHS Greater Glasgow and Clyde medical director Jennifer Armstrong, Grant Archibald, the then-head of acute services, and Billy Hunter, head of facilities, as well as five other senior colleagues held a meeting in September 2015 to discuss apparent problems with the children's bone marrow transplant suites.

The minutes of this meeting state they "acknowledged clinical frustration about progress and the need to plan for patients currently waiting transplant".

They also state that "two suites have been sealed (which should safely last one year) to avoid air penetration from a source outwith the air handling unit" and add "Brookfield [contractor] could retrofit air handling unit modifications ... at an approximate cost of £35k per room".

NHSGGC confirmed that upgrades were made to four of the suites, which had been used for bone marrow transplant patients, while four of the other suites were used to accommodate other children with cancer.

Health Protection Scotland documents raise concerns about plans to fix the adult bone marrow transplant suites in the QEUH, which had been emptied of patients several months

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde
**Page:** 6
**Reach:** 27655
**Size:** 1066
**Value:** 6854.38

after the hospital opened.

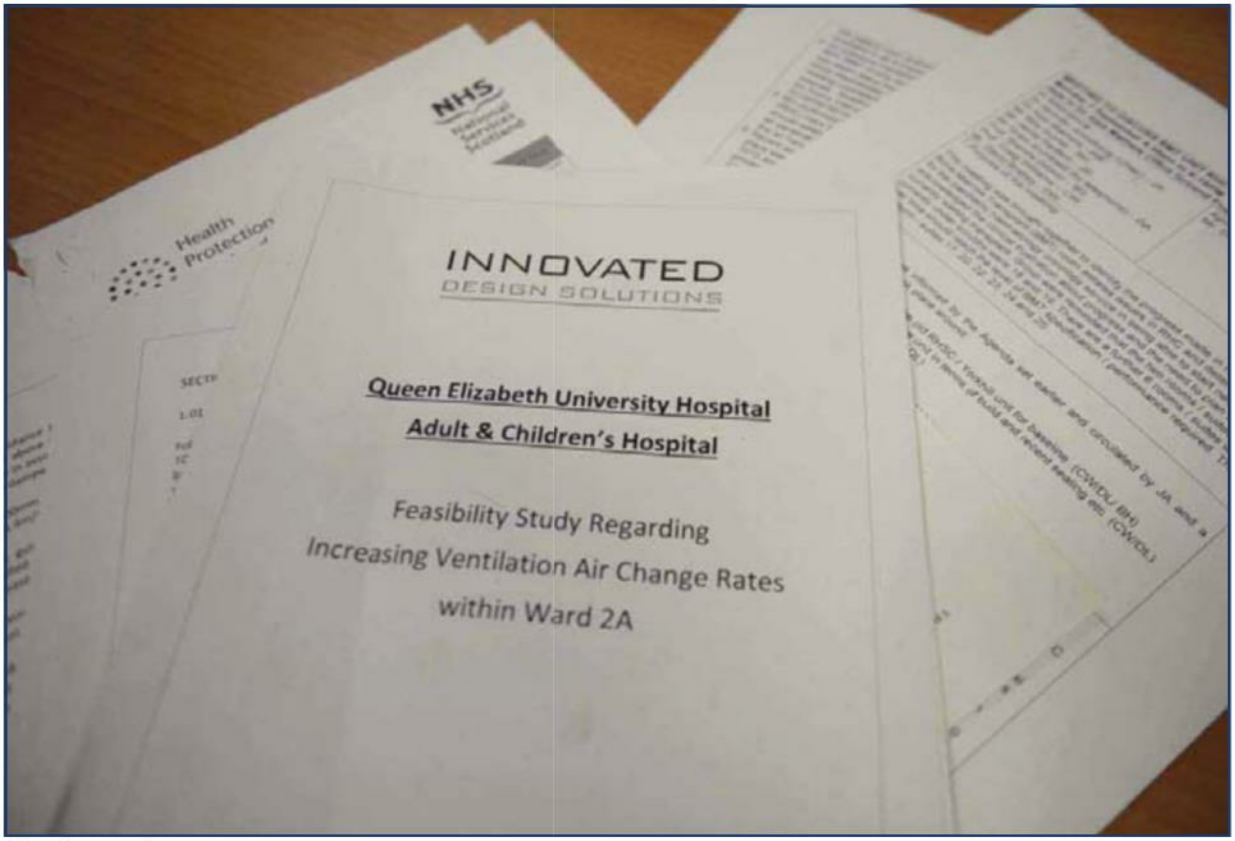
The document states: "The decision to transfer the care of bone marrow transplant patients from the Beatson oncology unit to the QEUH was made in June 2013. Construction of the QEUH was well established at this point and therefore the new unit was not purpose built.

"Whilst NHSGGC has continued to work towards recommendations, it is noted that the solution proposed does not meet guidance, nor does it seek to address all the recommendations ... As a result, HFS cannot comment on the effectiveness of the measures intended to be put in place."

Bone marrow transplant patients have now returned to the QEUH, following work undertaken in 2017, according to NHSGGC.

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 15/09/2019

**Keyword:** NHS Greater Glasgow and Clyde
**Page:** 6
**Reach:** 27655
**Size:** 1066
**Value:** 6854.38




**The documents leaked to The Herald on Sunday amounted to dozens of pages**

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|---|---|---|---|
| **Client:** | NHS Greater Glasgow and Clyde Media Coverage | **Keyword:** | NHS Greater Glasgow and Clyde Health Board |
| **Source:** | The Herald | **Page:** | 5 |
| **Date:** | 15/09/2019 | **Reach:** | 27655 |
| | | **Size:** | 134 |
| | | **Value:** | 861.62 |

**Right of reply**

# What the health board and Government say

**NHS Greater Glasgow and Clyde:**
"THESE documents relate to issues which have been widely covered in the media over the course of the past three years including a number which we ourselves proactively issued to the media.

"We have previously openly and publicly stated in 2017 that work was carried out on the adult BMT unit to ensure optimal air quality purification levels for this group of patients.

"We have also previously reported that we are proactively investing £2 million to upgrade the ventilation system in ward 2A and B to provide optimal, state-of-the-art facilities for all our young haemato-oncology patients.

"Infection rates within the Royal Hospital for Children are low.

"The most recent national survey of all hospital infections was carried out in 2016 and this showed the Royal Hospital for Children to be below the national average – with rates of 3.6%."

**Scottish Government:**
"WE expect NHSGGC to ensure the necessary control measures are in place and are continually reviewed to ensure patients, families and visitors are safe – and the Health Secretary has communicated this directly to the board's chair.

"Patient safety is paramount, which is why the Health Secretary has commissioned a review which is already looking at the design, build, commissioning and maintenance of the QEUH.

"We understand that NHS Greater Glasgow and Clyde are currently undertaking work to improve the ventilation system in the cancer wards 2A and 2B, so that they meet the current ventilation guidance."

■ To read the full responses, go to heraldscotland.com

Today's Herald on Sunday has a report on a selective number of historical documents shared with the newspaper relating to discussions about ventilation held at various times going back to 2015. Our response to the newspaper was not printed in full (although we note that the newspaper advised readers that they could go to heraldscotland.com to read it). We have therefore shared the full statement with you now.

**Statement:**

These documents relate to issues which have been widely covered in the media over the course of the past three years including a number which we ourselves proactively issued to the media.

An upgrade was carried out in four paediatric Bone Marrow Transplant (BMT) isolation rooms in 2015 in line with projected demand. Testing confirmed full compliance with the appropriate technical building requirements. A multidisciplinary team of clinical, estates and infection control experts all agreed that the paediatric BMT facilities were suitable for use. Over the years, the unit has successfully treated a number of patients with cancer related illnesses with good UK bench-marked outcomes.

We have previously openly and publicly stated in 2017 that work was carried out on the adult BMT unit to ensure optimal air quality purification levels for this group of patients. The resulted in a significantly improved environment for BMT adults and again we have successfully treated many patients in this unit.

We have also previously reported that we are proactively investing £2 million to upgrade the ventilation system in Ward 2A and B to provide optimal, state of the art facilities for all our young haemato-oncology patients.

Infection rates within the Royal Hospital for Children are low. The most recent national survey of all hospital infections was carried out in 2016 and this showed the Royal Hospital for Children to be below the national average – with rates of 3.6%.

The next annual Scotland-wide survey is not due to take place until 2020. In the meantime, ongoing monitoring shows that our rates of bloodstream infections are significantly better than many other units – including the old Yorkhill hospital – and are comparable with world leading hospitals such as Great Ormond Street.

**Ends.**

It is also important to note that the majority of the 13 cases that are highlighted in the report, which covered a period of six months, had an infection on admission. This was confirmed to the Herald on Sunday.


19 September, 2019 (MD)

[redacted] The Times - I know now that when the Glasgow hospitals opened the ventilation systems did not all meet with the standards stipulated in the Scottish Health Technical Memoranda.

The same problem caught ahead of opening at the sick kids.

Please can you comment.

If possible, please provide further details on the wards where the systems did not meet these standards

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Derogations to the national guidance were agreed at the time the ventilation design strategy was developed.

Patient safety is of paramount importance to the Board. Infection rates at both hospitals are low and the hospitals are clinically safe.

The general air filtration system is of a high industry standard. This was designed in line with the national guidance including the application of derogations. This is a recognised and standard process for managing complex construction projects.

An upgrade was carried out in four paediatric Bone Marrow Transplant (BMT) isolation rooms in 2015. Testing confirmed full compliance with the appropriate technical building requirements. Over the years, the unit has successfully treated a number of patients with cancer related illnesses with good UK bench-marked outcomes.

Work was carried out on the adult BMT unit to ensure optimal air quality purification levels for this group of patients. The resulted in a significantly improved environment for BMT adults and again we have successfully treated many patients in this unit.

We are proactively investing £2 million to upgrade the ventilation system in Ward 2A and B to provide optimal, state of the art facilities for all our young haemato-oncology

patients.

**ENDS**

For further information either telephone [redacted] or email [redacted]


19 September, 2019 (MD)

[redacted] **BBC** - What I am trying to ascertain whether the ventilation system had failed t meet safety standards when the hospital opened?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Ventilation systems are primarily designed to ensure a flow of air through a hospital building and the general ventilation filtration system for QEUH and RHC is of a high specification. The Scottish health technical memoranda referred to in today's article are design standards - not safety standards.

In terms of safety, from an infection prevention and control perspective, data has shown that there is sound evidence our hospitals are safe – airborne infection rates are low indicating that our systems are providing good levels of protection against infection.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**From:** [redacted]
**Sent:** 21 February 2020 11:20
**To:** Office, Press
**Subject:** LD dealing 21/02/20 Sunday Post query re QEUH

Hi there
I'm looking for a response to a story about the day the Queen officially opened the QEUH (July 3 2015).
The story is about the fact that during the Queen's visit, adult cancer patients at the hospital were being transported to the Beatson due to concerns doctors had raised about the air quality (bacterial levels in the air) at the QEUH. It was adult patients not children.
This is a colleague's story, but hopefully that'll be enough detail to get a response. If not, then please let me know.
Cheers
[redacted]



[redacted]


Friday, February 21, 2020

## NHS GREATER GLASGOW AND CLYDE STATEMENT

In July 2015 routine air quality monitoring identified a higher particle count than was desirable in the adult Bone Marrow Transplant unit at the QEUH.

As a precautionary measure, we took the decision to return the service to the Beatson West of Scotland Cancer Centre (BWOSCC) to enable us to identify and implement the work required to ensure air quality purification levels were optimal for this group of patients.

Work was carried out to improve the air quality and provide HEPA filtration in all patient rooms and the service was returned to the QEUH.

We continue to monitor the air quality in this unit.

This was well documented by the media in 2015 when we proactively made the public aware of this temporary move.

**ENDS**

For further information either telephone [redacted] or email [redacted]

24 June, 2017

[redacted] **Sunday Express** – SG has put out release saying it is asking all boards to check their facilities for cladding used at Grenfell. Been told QEUH has similar aluminium cladding panels.

What is being done?

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON CLADDING

We proactively started reviewing our facilities last week.

No concerns have been identified.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Tuesday, July 11, 2017 (LD)

**Daily Record** - insulation at the QEUH same as Grenfell Tower.
**Herald**
**BBC Sun**
**Radio Clyde**
**Telegraph**
**STV**
**The Times**
**Scotsman**

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The Queen Elizabeth University Hospital is one of the safest buildings in the UK in terms of fire engineering.

Multiplex, the main contractor for the hospital construction, have assured NHSGGC that the Kingspan Kooltherm K15 Insulation Boards were properly installed to meet Scotland's stringent building and fire safety regulations.

The hospital itself is designed and equipped to the highest standards for fire safety.

It has heat/smoke detection and early warning fire alarm systems combined with automatic fire suppression sprinkler systems fitted in all areas. The hospital patients, staff and visitors are further protected by designated fire fighting and fire evacuation lifts, as well as multiple fire escape stairwells.

**ENDS**

For further information either telephone [redacted] or email [redacted]

NHS Greater Glasgow and Clyde

# Core brief

Wednesday 12 July 2017

**Introduction**

This issue of Core Brief is a message from Jane Grant, Chief Executive, on insulation panels at the QEUH.

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**Message from Jane Grant, Chief Executive**

Staff will be aware of the recent media coverage about some insulation panels found on the Grenfell Tower block, which are also used on the Queen Elizabeth University Hospital (QEUH) building.

We would like to reassure staff that the Queen Elizabeth University Hospital is one of the safest buildings in the UK in terms of fire engineering.

Multiplex, the main contractor for the hospital construction, have assured us that the insulation boards (Kingspan Kooltherm K15 Insulation Boards), used on the QEUH, were properly installed to meet Scotland's stringent building and fire safety regulations.

The hospital itself is designed and equipped to the highest standards for fire safety.

It has heat/smoke detection and early warning fire alarm systems combined with automatic fire suppression sprinkler systems fitted in all areas. The hospital is further protected by designated fire fighting and fire evacuation lifts, as well as multiple fire escape stairwells.

**Are your contact details up-to-date? Click here to check**

04 August, 2017 (CC)

[redacted] Daily Record - Hello,

Jane Grant has apparently sent this letter to a campaigner worried about fire safety at the new hospital. I'm hoping you can confirm that this letter is genuine (it seems to be) and also expand on the information in the last paragraph about "further external expert advice" being sought.

Hoping you can tell me whether or not this advice has been delivered, and if so what it was.

Cheers
[redacted]

**NHS GREATER GLASGOW AND CLYDE STATEMENT ON QEUH CLADDING**

The hospitals were passed as compliant with Scottish fire safety and building standards by Glasgow City Council who issued the formal building warrant approval.

Health Facilities Scotland and their National Fire Advisor endorsed the fire strategy for the QEUH development.

Multiplex, the main contractor for the hospital design and construction, have assured us that the hospitals meet Scotland's stringent building and fire safety standards.

- to give additional reassurance, NHSGGC appointed Currie & Brown, one of the world's leading construction consultancy firms, to check and verify the construction and certification process throughout. This work is underway.

ENDS

For further information either telephone [redacted] or email [redacted]

04 August, 2017 (MD)

[redacted] **The Herald -** I've been contacted by a retired architect called Robert Menzies – he was the senior architect at BMG who drew up the exemplar design for the new Royal Hospital for Children. He was also involved in reviewing the subsequent bids to design and build the children's hospital/QEUH complex.

However, he said he was concerned by a number of fire safety failures in the winning Brookfield Multiplex's design.

Namely – there were only two stairways in the adult tower of the QEUH but he said there should have been three in order to comply with building regulations because there were more than 100 patients per floor.
- at least one fire compartment in the QEUH design exceeded the safe maximum allowed under Scottish building regulations (2000sq m, as opposed to 1500 sq m)
- the hose-reel fitted for firefighter exceeded the maximum length of 60 metres stipulated under building regulations
- some fire doors opened in the wrong direction
- he said that the presence of a sprinkler system throughout the facility was used to justify not complying 100% with some of the Scottish building regulations.

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON QEUH FIRE ENGINEERING DESIGN REASSURANCE

The Queen Elizabeth University Hospital and the Royal Hospital for Children are designed and equipped to the highest standards for fire safety.

The fire strategy for the buildings was approved by Glasgow City Council Building Control and endorsed by Health Facilities Scotland during the design stage.

- The hospitals were passed as compliant with Scottish fire safety and building standards by Glasgow City Council who issued the formal building warrant approval.

- Health Facilities Scotland and their National Fire Advisor endorsed the fire strategy for the QEUH development.

- Multiplex, the main contractor for the hospital design and construction, have assured us that the hospitals meet Scotland's stringent building and fire safety standards.

- To give additional reassurance, NHSGGC have appointed Currie & Brown, one of the world's leading construction consultancy firms, to check and verify the construction and certification process throughout.

It is important that everyone working in and coming to these world class facilities for healthcare know that we take fire safety extremely seriously and that there are heat/smoke detection and early warning fire alarm systems combined with automatic fire suppression sprinkler systems fitted in all areas.

The hospitals are further protected by designated fire fighting and fire evacuation lifts, as well as multiple fire escape stairwells.

NHSGGC would like to reassure patients, the public and our staff that both the Queen Elizabeth University Hospital and The Royal Hospital for Children are amongst the safest buildings in the UK in terms of fire engineering design.

**ENDS**

For further information either telephone [redacted] or email [redacted]


10 August, 2017

# NHSGGC MOVES TO REASSURE PUBLIC CONFIDENCE IN QEUH

The Queen Elizabeth University Hospital is one of the most fire safe buildings in the country having been designed and engineered to meet building and fire safety regulations.

Last month we brought in external technical advisers to give the Board further assurance on fire safety following concerns arising about external cladding as a result of the Grenfell Tower fire.

As part of these further forensic checks we have identified a type of Aluminium Composite Material on parts of the Queen Elizabeth University Hospital of a similar type to, but not the same as, Grenfell.

Health Facilities Scotland and their National Fire Advisor have given us renewed assurances that the hospital is an extremely safe building.

The Scottish Fire and Rescue Service have also provided further reassurance that as part of its regular risk based audit programme, it had carried out fire safety audits within the Queen Elizabeth University Hospital, which were found to be satisfactory.

Assistant Chief Officer David McGown, Scottish Fire and Rescue Service said: "The Scottish Fire and Rescue Service have reassured NHS Greater Glasgow and Clyde, and Scottish Ministers that as part of its regular risk based audit programme, it had carried out fire safety audits within the Queen Elizabeth University Hospital, which were found to be satisfactory."

However, as a purely precautionary measure, and to make sure the public, our patients and our staff have full confidence in the safety of the hospital we have taken the decision to remove the panels from the areas of the hospital where these panels are.

The panels that will be removed are present in three external sections of the building and we are currently working with contractors and technical advisers to assess how this work can proceed at the earliest possible opportunity.

Our hospital management teams are working on plans to minimise the impact on patient care.

**Ends**

For more information contact the press office, tel: [redacted] or email: [redacted]

NHS Greater Glasgow and Clyde

# Core brief

Thursday 10 August 2017

**Introduction**

This issue of Core Brief details an update about the QEUH.

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## NHSGGC moves to reassure staff and public confidence in QEUH

The Queen Elizabeth University Hospital is one of the most fire safe buildings in the country having been designed and engineered to meet building and fire safety regulations.

Last month we brought in external technical advisers to give the Board further assurance on fire safety following concerns arising about external cladding as a result of the Grenfell Tower fire.

As part of these further forensic checks we have identified a type of Aluminium Composite Material on parts of the Queen Elizabeth University Hospital of a similar type to, but not the same as, Grenfell.

Health Facilities Scotland and their National Fire Advisor have given us renewed assurances that the hospital is an extremely safe building.

The Scottish Fire and Rescue Service have also provided further reassurance that as part of its regular risk based audit programme, it had carried out fire safety audits within the Queen Elizabeth University Hospital, which were found to be satisfactory.

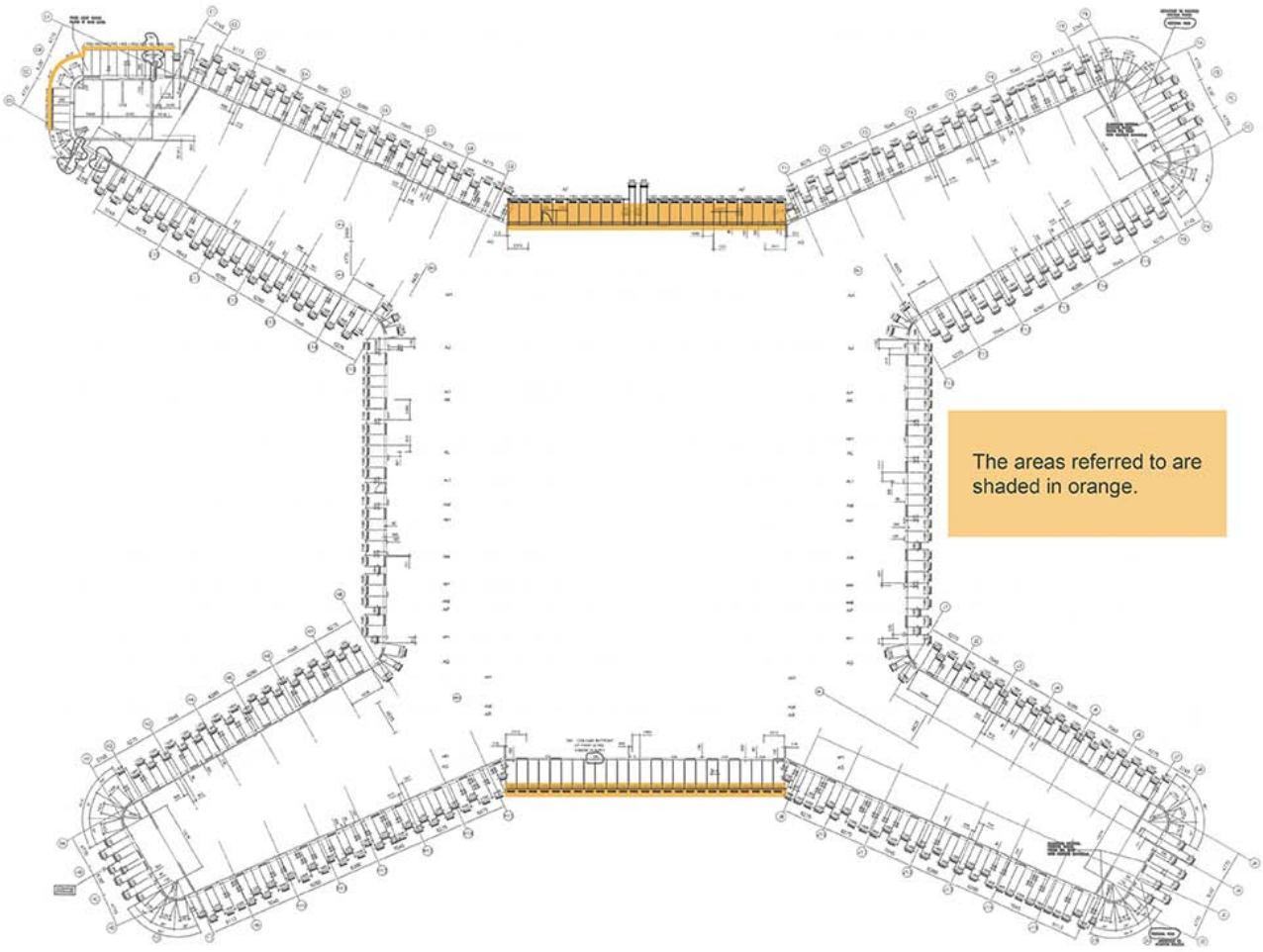
Assistant Chief Officer David McGown, Scottish Fire and Rescue Service said: "The Scottish Fire and Rescue Service have reassured NHS Greater Glasgow and Clyde, and Scottish Ministers that as part of its regular risk based audit programme, it had carried out fire safety audits within the Queen Elizabeth University Hospital, which were found to be satisfactory."

However, as a purely precautionary measure, and to make sure the public, our patients and our staff have full confidence in the safety of the hospital we have taken the decision to remove the panels from the areas of the hospital where these panels are.

The panels that will be removed are present in three external sections of the building and we are currently working with contractors and technical advisers to assess how this work can proceed at the earliest possible opportunity.

Our hospital management teams are working on plans to minimise the impact on patient care.

Diagram of affected areas below.



**What exactly has been found?**
As part of the further forensic checks across all our buildings we have identified a type of Aluminium Composite Material on parts of the Queen Elizabeth University Hospital of a similar type to, but not the same as used at Grenfell. To ensure full public confidence in the hospital we have decided to remove these panels as a precautionary measure.

**Where is the location?**
See diagram. These panels (Alucobond PE) are present in limited areas of the adult hospital – the parts coloured yellow on the diagram. It is also present levels four and above of the stairwell leading up to the helicopter pad.

**What about the rest of the hospital?**
Further investigations continue with our external advisers and with Health Facilities Scotland along with the main hospital contractor however at present there is no indication of other cladding issues.

**Why has it taken so long to identify this?**
This has been a forensic examination covering a large and complex site. Technical teams have had to assess all types of materials used in cladding across the entire estate and have followed a rigorous process. The Scottish Fire and Rescue Service have also provided further reassurance that as part of its regular risk based audit programme, it had carried out fire safety audits within the Queen Elizabeth University Hospital, which were found to be satisfactory. The decision to take action to remove these panels to to ensure renewed public confidence following Grenfell.

**When did you first know about this?**
Our comprehensive review with our contractors and technical advisers included a wide-ranging review of cladding materials has been on-going since the Grenfell Tower fire. This was part of an iterative process which was an element of a national risk assessment led by the SG Ministerial Working Group. Our professional advisers continue to advise us that the presence of ACMs in the QEUH is compliant and presents low risk. However, at a site meeting on Tuesday, a perceived risk was made known to us SG were alerted.

**Is patient safety at risk?**
The Scottish Fire and Rescue Service have given their reassurances that given the other fire stopping measures and fire safety management in place at the hospital, they are confident the building remains fire-safe. Health Facilities Scotland and their National Fire Adviser have also given us their view that the QEUH is an extremely well-engineered building and is designed and equipped to a high standard for fire safety.

**Is this material compliant with regulations?**
We have firm assurances from the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed in full.

The appropriate Building Standards completion certificates are in place.

Regardless of this and in order to ensure public confidence, as precautionary measure, the Board has decided to remove the material.

**Who is liable?**
Ongoing investigations are required to establish a comprehensive understanding of the position and associated responsibilities.

**What about the wider NHS estate?**
We are not aware of any other sites but are continuing with our investigations.

**Will there be impact on patient care?**
Detailed technical work is on-going to establish the best way to remove and replace these ACMs. Given the range of facilities across Scotland's largest health Board it is expected that the impact on patient activity will be minimal. Our hospital management teams are preparing contingencies while they await details of how the work will need to be taken forward.

**What size of area is covered by the panels that are to be removed?**
Core G, East & West elevations approx  total 3500m2

Core G app 1800
West & East 1700

NHS Greater Glasgow and Clyde

# Core brief

Friday, 15 September 2017

**Introduction**

This issue reminds staff of the importance of having and wearing their ID badge, QEUH campus cladding update and RAH HEI inspection report.

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**ID Badges**

Following a recent resilience meeting it has again been raised that a number of staff still don't have the correct ID badges - staff are reminded of the importance of wearing their ID badges.

Wearing your official ID badge is essential. If you do not have one then you must take urgent action to get one.

Many NHSGGC staff also wear the yellow “Hello my name is” badge… this is not a security ID badge and you are also required to wear the official photo ID identity card.

Many of our hospitals and community facilities have security doors. They are there to ensure only those authorised or escorted by an authorised person can enter these areas.

To arrange for an up-to-date ID badge please contact your line manager or facilities team.

**Queen Elizabeth campus cladding update**

In August we informed staff of our decision to remove a type of aluminium composite material panelling on the QEUH as a precautionary measure as it was similar to, but not the same as, that found on Grenfell Tower.

Since then we have been working with our external advisers and Multiplex, the main contractor for the hospital design and construction, to establish how and when the panels will be removed and what they will be replaced with.

The update from the technical experts is that the panels can be removed by external clips and that the work will cause minimal, if any, internal disruption to any wards or other clinical or corridor areas. Work continues to plan for when this work will proceed.

As part of our on-going work with technical advisers an area on the front elevation of the Royal Hospital for Children has been identified as having panels that we have also decided to remove.

Health Facilities Scotland and their National Fire Officer have reiterated their assurance that both the adult and children’s hospitals are extremely fire safe buildings.

We continue to work diligently with our technical advisers and Multiplex to make sure that our hospitals are as safe as they can be.

**NHGGC statement on unannounced inspection report care of older people in acute at RAH**
A Healthcare Improvement Scotland inspection report highlights a number of positive findings about the quality of care for patients, patient dignity and respect and staff interaction with patients at the Royal Alexandra Hospital (RAH). Click here to read our response.

**Are your contact details up-to-date? Click here to check**

Thursday, 28 September, 2017 (CC)

[redacted] Sunday Post

Ah, yeah. Sorry for not getting questions over more quickly. It's about the following response I received from the Scottish Government when looking into issues around ACM cladding last week: "7. What progress has been made on assessing the information and determining the next steps with regards to an ACM product found on a section of the cladding system of the Queen Elizabeth Hospital in Glasgow as per the minutes of the building and fire safety working group minutes on August 9?
"A. NHS Greater Glasgow and Clyde (NHS GC&C) is taking this matter very seriously and has been in close dialogue with Multiplex (the building contractor) and its appointed consultants since the safety concerns first arose regarding Aluminium Composite Materials (ACMs).
"Last week NHS GG&C received a feasibility study from Multiplex which identified options, a potential works programme and a suggested technical solution as to how the work would actually be carried out. Allowing for a lead in period for material and statutory consents, their indicative programme indicates that works will take 26 weeks to complete and discussions are on-going as to when the work will start. The Board is exploring whether the programme could be completed in a shorter timeframe."

Could you please provide more detail on the nature of the suggested technical solution, an estimated cost and any expected start date (if one exists)?

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON CLADDING

The cladding will be replaced and we are continuing to work with our technical advisers and Multiplex (the main hospital contractor) on the details of what replacement material will be used and when work can get under way. They have advised us that the panels can be removed with minimal disruption as they can be "unclipped" externally.

Work is on-going to agree what replacement material will be used and therefore the final cost is at this stage unknown.

Health Facilities Scotland and their National Fire Officer have reiterated their assurance that the hospital is an extremely safe building having been "fire engineered" to an exceptionally high standard.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Friday, 13 October, 2017

Hello

Is it the case that replacing the cladding on the Queen Elizabeth University Hospital will cost up to £8m?
Who will be liable for this sum?

[redacted]
Herald/Sunday Herald

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The cost of removing and replacing the sections of panels on parts of the hospital won't be known until the detailed technical work on how best to remove them, and what they will be replaced with, is established.

We remain in discussion with various stakeholders including the Scottish Government and our contractors regarding the funding of this work.

Health Facilities Scotland and their National Fire Officer have reiterated their assurance that the hospital is an extremely safe building having been "fire engineered" to an exceptionally high standard.

**ENDS**

For further information either telephone [redacted] or email [redacted]

05 December, 2017 (MD)

[redacted] **STV –** been told it will cost circa £50 Million to replace cladding. Was this mentioned in the draft report by Multiplex that was due to go to the board?

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON QEUH CLADDING

We have received an interim paper, which we are discussing to identify the most appropriate way forward.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Friday, January 19, 2018 (LD)

# QEUH CAMPUS CLADDING UPDATE

Replacement products for cladding panels on sections of the Queen Elizabeth University Hospital and on a section of the Royal Hospital for Children have now been identified and the process of preparing to remove and replace is now getting underway

Our senior management team, with the support of Health Facilities Scotland and the Fire Service, have been studying the best options to remove and replace the sections following the Grenfell tower block blaze in London.

The Board has been given assurances from the National Fire Officer that the hospitals are amongst the safest buildings in the UK in terms of fire engineering, however the decision was taken replace panels to give extra reassurance to the public, our patients and our staff

The replacement materials will not change the outward appearance of the hospitals and the engineering process to remove and replace them will not require alterations to the buildings. To ensure minimal disruption the works will be spread over several months - everything scheduled to be completed within 12 months of the building warrant approval being granted.

The total cost of replacing the cladding panels will be in the region of £6m with the works being funded by the Scottish Government

**ENDS**

For further information either telephone [redacted] or email [redacted]

# NHS Greater Glasgow and Clyde Core brief

Friday, 19 January 2018

**Introduction**

This issue brings you information on service reforms in NHSGGC and cladding in the QEUH.

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**Scottish Government have today issued the following release:**

**NHS Greater Glasgow and Clyde service reforms**
Ministerial decision on services at Royal Alexandra Hospital and Lightburn Hospital

Health Secretary Shona Robison has agreed to NHS Greater Glasgow & Clyde's proposals to transfer inpatient and day case paediatrics from Ward 15 at the Royal Alexandra Hospital to the Royal Hospital for Children in Glasgow

The Scottish Government has agreed on the strict condition that local community paediatric care provision is maintained and continually improved. This will ensure that communities continue to access the majority of paediatric services locally, with more serious conditions treated at the state of the art Royal Hospital for Children, in line with the national clinical guidelines. Click here to read the full release.

**Decision on children's ward welcomed**
NHS Greater Glasgow and Clyde has welcomed today's (19 January 2018) decision by the Cabinet Secretary for Health, Sport and Wellbeing to approve the transfer of inpatient paediatric services from the Royal Alexandra Hospital to the Royal Hospital for Children.

The Board remains very focussed on ensuring that our local community services to children in Clyde are maintained and improved, with care provided by expert clinical staff.

However when children require inpatient care, Clyde children will now benefit from the same state-of the-art hospital facilities as other children from across the west of Scotland. Click here to read more.

**NHS Greater Glasgow and Clyde statement on Lightburn**
A spokesperson for NHS Greater Glasgow and Clyde said: "We are committed to working with the Glasgow Health and Social Care Partnership to deliver a new health and social care hub for the east end of Glasgow, bringing an investment of approximately £40 million in new facilities to the area.

"The Board re-iterated its support today (19 January 2018) to invest in the area following the announcement by the Cabinet Secretary on the board's proposals for rehabilitation services for older people whilst further work is done to develop proposals for the new facility.

“We remain committed to developing a new model of rehabilitation for older people which results in better outcomes for patients.

“Proposals for a new health and social care hub continue to be developed, in collaboration with local east end communities, and we look forward to bringing these plans to fruition.”

**QEUH campus cladding update**
Replacement products for cladding panels on sections of the Queen Elizabeth University Hospital and on a section of the Royal Hospital for Children have now been identified and the process of preparing to remove and replace is now getting underway.

Our senior management team, with the support of Health Facilities Scotland and the Fire Service, have been studying the best options to remove and replace the sections following the Grenfell tower block blaze in London.

Despite receiving assurances from the National Fire Officer that both hospital buildings are extremely safe, The decision was taken to replace panels to give extra reassurance to the public, our patients and our staff although the Board has been given assurances from the National Fire Officer that the hospitals are amongst the safest buildings in the UK in terms of fire engineering.

The replacement materials will not change the outward appearance of the hospitals and the engineering process to remove and replace them will not require alterations to the buildings. To ensure minimal disruption the works will be spread over several months - everything scheduled to be completed within 12 months of the building warrant approval being granted.

The total cost of replacing the cladding panels will be in the region of £6m with the works being funded by the Scottish Government.

**Are your contact details up-to-date? Click here to check**

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

Monday, February 12, 2018 (LD/MD)

[redacted] BBC Scotland - The Times article on replacing of cladding at QEUH
[redacted] Global Radio
[redacted] Radio Clyde
[redacted]

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON QEUH CAMPUS CLADDING UPDATE

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The total cost of replacing the cladding panels will be in the region of £6m with the works being funded by the Scottish Government

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

**26/6/18 – Email exchange on need for HAISCRIBE for cladding work at QEUH/RHC**

**Lynn Pritchard to TI**
Subject: hai scribe

Hi Teresa
I have had a call from Estates re the cladding work on the new hospital building. Colin has asked if a scribe is required. I have said no scribe is required as

- The work does not involve drilling but screwing onto the fixing strips
- The windows of the hospital do not open
- The vents on the roof etc are filtered.

Would you be happy with this.
Thanks
Lynn

**From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)** [redacted]
**Sent: 26 June 2018 11:04**
**To: Pritchard, Lynn**
**Subject: [ExternaltoGGC]Re: hai scribe**

Agree we dont need a scribe . Do we know how much dust generation there will be? If there is significant amounts then we might need to use a patient entrance on other side for BMT patients
T

From: Pritchard, Lynn [redacted]
Sent: 26 June 2018 14:43
To: Purdon Colin (NHS GREATER GLASGOW & CLYDE)
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: FW: hai scribe

Hi Colin
I tried calling you earlier but thought it may be easier to email. Please see below response from Teresa and are you able to answer her question re dust.
Thanks
Lynn

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
**Sent: 26 June 2018 14:45**
To: Pritchard, Lynn; Purdon, Colin
Subject: [ExternaltoGGC]Re: hai scribe

Hi Lynn - I spoke to Colin re this earlier when we were looking at sinks. Happy that there will not be dust generated

From: Purdon, Colin [redacted]
Sent: **26 June 2018** 16:57
To: 'Stevie McLachlan' [redacted]; 'Holmes, Keith' [redacted]
Subject: FW: hai scribe

Gents

Please see below response confirming there will be no requirement to complete a HAISCRIBE.

Regards
Colin

Colin Purdon | BSc (Hons)
Site Manager Operational Estates (Retained Estate)


Hospital access
this way

**Additional closures signage**

**Potential design for 2x1m foamex board, similar to Phase 1**

16 August 2018 From: Kathleen.Harvey-Wood to TI

***QEUH cladding*** - infection control

Re the replacement of sections of the cladding to QEUH and RHC, has it been assessed if there is an increased risk of fungal infections to the immunocompromised patients while the work is being carried out ?

There is currently a skip, old removed cladding panels and Rookwool outside the entrance to RHC.

16 August 2018 TI to Karen Connelly

HI Karen - see email below from my colleague, Im not sure who to contact about this but this represents a risk to patients as this material will contain fungal spores.

Is it possible to move this away from the main entrances to the buildings? If you could let me know what is possible as I might need to look at alternate entrances for some patients and masks etc

16 August 2018 – KC to TI

Hi Theresa, The skip/container is in the current location to reduce the travel distance for the transfer of waste, minimise any debris and to reduce moving and handling of materials .

I can speak to Multiplex about ensuring the doors are kept closed except when waste is being put in, would that help? Happy to discuss further if you are in the office?

om: Redfern, Jamie

Sent: 17 August 2018 14:07

To: Hill, Kevin; Jenkins, Gary; Harkness, Anne

Subject: FW: ***QEUH cladding*** - infection control

fYI

17 August 2018 email from Teresa Inkster to Gibson, Brenda; Gibson, Brenda (NHSmail); Ronghe, Milind; McQuaker, Grant; Hart, Alistair , Cc: Redfern, Jamie; Pritchard, Lynn; Dodd, Susie; Johnson, Angela

Subject: [ExternaltoGGC]Fw: ***QEUH cladding*** - infection control

Hi all ,

The issue below with cladding has been brought to my attention. There are old building materials from the cladding work being stored in an open skip in proximity to the front entrances of both hospitals. This represents a risk to immunocompromised patients as the material will contain fungal spores and the wind tunnel at the front will enhance dispersal of dust and spores.

The standard infection control advice for these situations is;

- ask patients to enter via an alternate route - safest option is via the discharge lounge entrance to QEUH
- antifungal prophylaxis
- surgical masks if patients require to be in the vicinity of the main entrances

17 August 2018 - Jamie Redfern to Hutton, Melanie [redacted]; Thomson, Kathleen [redacted]

Cc: Rodgers, Jennifer [redacted]

Subject: FW: ***QEUH cladding*** - infection control

Hi Melanie / Kathleen

Can you liaise with the clinical team in RHC for this and how we implement? And note if any concerns raised about what Teresa is suggesting?

Jamie

20 August 2018 – Melanie Hutton To: Inkster, Teresa

Cc: Redfern, Jamie; Rodgers, Jennifer

Subject: Info for Parents 2A/B

Teresa

Will you prepare info with regards to prophylactic antibiotic cover?

Below is a brief statement with regards to access, is this enough information, was also wondering if we could get a site map to give visual aid for parents

Info for Parents – 2A/B

Due to ongoing cladding works on the QEUH site alternative access arrangements are in place.

All Children and parents should utilise Car Park 1.

Entrance and exit to Royal Hospital for Children should be through QEUH side entrance (discharge lounge).

Regards

Melanie

From: Inkster, Teresa

Sent: 20 August 2018 15:18

To: Hutton, Melanie

Cc: Redfern, Jamie; Rodgers, Jennifer

Subject: RE: Info for Parents 2A/B

HI Melanie - added in some info below

Thanks

Teresa

From: Hutton, Melanie

Sent: 20 August 2018 13:57

To: Inkster, Teresa

Cc: Redfern, Jamie; Rodgers, Jennifer

Subject: Info for Parents 2A/B

Teresa

Will you prepare info with regards to prophylactic antibiotic cover?

Below is a brief statement with regards to access, is this enough information, was also wondering if we could get a site map to give visual aid for parents

Info for Parents – 2A/B

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Building materials can contain fungal spores so any child at risk of fungal infection will be commenced on antifungal drugs as a precaution - your patients doctor will decide whether this is required or not

Regards
Melanie

Melanie Hutton
Clinical Service Manager

From: Hutton, Melanie
Sent: 20 August 2018 15:26
To: Inkster, Teresa
Cc: Redfern, Jamie; Rodgers, Jennifer
Subject: RE: Info for Parents 2A/B

I have added in Discharge lounge hours below and alternative arrangements outwith these times.

Jamie

Will you send for Comms approval

Thanks
Melanie

From: Somerville, Emma
Sent: 22 August 2018 14:52
To: Hutton, Melanie
Subject: Update for Parents

Hi Melanie,
Do you know when the communication for the cladding will be ready for our families?

Thanks

Emma

From: Hutton, Melanie

Sent: 22 August 2018 16:41

To: Redfern, Jamie

Cc: Rodgers, Jennifer; Thomson, Kathleen; Somerville, Emma; Inkster, Teresa

Subject: FW: Update for Parents

Jamie

Can you please advice if we got approval from Comms on info I sent earlier in the week.

Thanks

Melanie

From: Redfern, Jamie

Sent: 23 August 2018 10:19

To: Hutton, Melanie

Cc: Rodgers, Jennifer; Thomson, Kathleen; Somerville, Emma; Inkster, Teresa

Subject: RE: Update for Parents

I am just waiting for Jonathan Best to approve.

From: Thomson, Kathleen

Sent: 23 August 2018 13:04

To: Hutton, Melanie; Redfern, Jamie

Cc: Rodgers, Jennifer; Somerville, Emma; Inkster, Teresa

Subject: RE: Update for Parents

Hi Melanie and Jamie, is there something we should be telling parents in meantime, or do you wait until comms?

Kind Regards

Kathleen

Kathleen Thomson | Lead Nurse | Royal Hospital for Children [redacted]

Sent: 23 August 2018 13:29

To: Thomson, Kathleen [redacted]; Redfern, Jamie [redacted]

Cc: Rodgers, Jennifer [redacted]; Somerville, Emma [redacted]; Inkster, Teresa [redacted]

Subject: RE: Update for Parents

Hi Kathleen

We will wait for formal response from comms.

Regards

Melanie

Parent or Guardian

My child is currently being [redacted] had to be put on antibiotics because of the dust from the skip at the front door! Seems ridiculous, I'm sure the skip could be better located elsewhere rather than having to put children on long term antibiotics?? The only other entrance is through a wall of smokers. Please help!

From: Davidson, Linda On Behalf Of Webmaster

Sent: 28 August 2018 08:30

To: Redfern, Jamie

Subject: FW: [ExternaltoGGC]NHSGGC Patient Feedback Form Submission

Jamie please read below as received via the NHSGGC webmaster box. Would you mind tasking somebody to respond [redacted] please.

Many thanks

Linda

Press office investigated this and were given the following response from Karen Connelly:

Dr Inkster raised concerns regarding works associated with the cladding replacement at RHC as she and colleagues felt it represents a risk to patients as this material will contain fungal spores. Multiplex have taken steps to cover the skip and to minimise materials being left uncovered, having the skip as near to the work ensures the materials are put into containment as soon as possible.

Patients who are attending ward 2a and Ward 4b (adults) have been advised by Infection Control to enter the building via the discharge lounge.

TI then commented: Hi Claire - this is standard advice as per national guidance during building works that are in close proximity to patients. The most important measures are to offer high risk patients antifugal prophylaxis and to divert them away from the work. Wards 2A/B RHC and 4B/C QEUH are the highest risk group - haemato-oncology

Kind regards
Terresa

From: Brady, Coral
Sent: **04 September** 2018 09:11
To: Gibson, Brenda; Somerville, Emma; Mather, Karen
Subject: FW: [ExternaltoGGC]NHSGGC Patient Feedback Form Submission
Hi Brenda, Emma,
Do you know what this is about? Which patient this is, or is it multiple patients? Do we know what the issue is?
Karen,

You were kindly going to look at much more prominent notices at the entrances during the refurbishment work – could we please prioritise this – several people have mentioned it in the past week, however, this is the first official complaint / feedback we've had.
Thanks so much
Coral

From: Somerville, Emma
Sent: **04 September** 2018 12:25
To: Brady, Coral; Gibson, Brenda; Mather, Karen

Cc: Hutton, Melanie; Thomson, Kathleen; Rodgers, Jennifer

Subject: RE: [ExternaltoGGC]NHSGGC Patient Feedback Form Submission

Dear Coral,

I am not sure what family it is. I am still waiting on a formal response from comms to update the families in the unit about the cladding work.

Regards

Emma

**From:** Brady, Coral
**Sent: 04 September** 2018 13:06
**To:** Robertson, Gordon; Dick, Lorraine; Killick, Rachel
**Subject:** FW: [ExternaltoGGC]NHSGGC Patient Feedback Form Submission

Hiya,

Do you know who from comms would be providing the communication briefing?

Thanks

C

**From:** Dick, Lorraine
**Sent:** 04 September 2018 13:13
**To:** Brady, Coral [redacted]; Robertson, Gordon [redacted]; Killick, Rachel [redacted]
**Subject:** RE: NHSGGC Patient Feedback Form Submission
**Importance:** High

Hi Coral

You need a briefing from Teresa Inkster, she raised the issue with Facilities (Karen Connelly) and is the one who organised the prophylaxis.

Best wishes.

Lorraine

From: Redfern, Jamie

Sent: 05 September 2018 14:04

To: Hill, Kevin [redacted]

Cc: Rodgers, Jennifer [redacted]

Subject: Info for aprents 2A/B

JB was going to speak to MAK and get back to me but don't think he did.

We have already put some of the selected patients on prophylaxis and as a result one has complained about the alternative approach we propose.

I am being pressurised to put something out to wider patient group as per below.

Before doing so wanted JB to approve and also to make sure not out of step with Adult services (have asked Melanie McCgolgan what they are intending to do)

jamie

From: Inkster, Teresa
**Sent: 05 September 2018 15:33**
To: Dick, Lorraine
Cc: Hutton, Melanie; Redfern, Jamie; Rodgers, Jennifer; Somerville, Emma
Subject: FW: Info for Parents 2A/B

Lorraine - this email trail relates to the Comms around the cladding and the info is below

Info for Parents – 2A/B

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Entrance and exit to Royal Hospital for Children should be through QEUH side entrance (discharge lounge).The Discharge Lounge entrance is opened at 6am and closed at 9pm. This applies Mon to Sun. Outwith these hours access can be obtained via Emergency Department at RHC
Building materials can contain fungal spores so any child at risk of fungal infection will be commenced on antifungal drugs as a precaution - your patients doctor will decide whether this is required or not

Im not sure where this is at - does anyone know if this info has been released to paremts?

Kind regards
Teresa

Monday, August 27, 2018 (LD)

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Dr Teresa Inkster, Consultant Microbiologist said: "This is standard advice as per national guidance during building works that are in close proximity to patients.

"The most important measures are to offer high risk patients antifungal prophylaxis and to divert them away from the work.

"Wards 2A/B RHC and 4B/C QEUH are the highest risk group - haemato-oncology."

**ENDS**

For further information either telephone [redacted] or email [redacted]

07/09/18

Dear Parent/Carer

Due to ongoing cladding works on the QEUH site alternative access arrangements are in place.

All Children and parents should utilise Car Park 2.

Entrance and exit to Royal Hospital for Children should be through QEUH side entrance (discharge lounge).The Discharge Lounge entrance is opened at 6am and closed at 9pm. This applies Mon to Sun. Outwith these hours access can be obtained via Emergency Department at RHC

Building materials can contain fungal spores so any child at risk of fungal infection will be commenced on antifungal drugs as a precaution - your patients doctor will decide whether this is required or not

For information regarding access to car park and discharge lounge please refer to map attached.

# The South Glasgow University Hospital & The Royal Hospital for Sick Children

Directions Guide

NHS Greater Glasgow and Clyde


## Building Entrances

1. South Glasgow University Hospital
2. Royal Hospital for Sick Children
3. Acute Receiving Unit
4. A&E Adult Emergency Department
5. A&E Chidrens Emergency Department
6. GP Out of Hours Service
7. RHSC Ward 4 Entrance
8. Maternity Unit
9. Laboratory Medicine & Facilities Managment
10. Physically Disabled Rehabilitation Unit (PDRU)
11. Langlands Building
12. Neurology Block
13. Institute of Neurological Sciences
14. Queen Elizabeth National Spinal Injuries Unit
15. Teaching & Learning Centre
16. Office Building
17. Central Medical Block
18. Acute Medical Block
19. Westmarc
20. Podiatry
21. Ronald McDonald House
22. Energy Centre
23. Deliveries
24. Mortuary - Visitors

07/09/18

Dear Parent/Carer

Due to ongoing cladding works on the QEUH site alternative access arrangements are in place.

All Children and parents should utilise Car Park 2.

Entrance and exit to Royal Hospital for Children should be through QEUH side entrance (discharge lounge).The Discharge Lounge entrance is opened at 6am and closed at 9pm. This applies Mon to Sun. Out with these hours access can be obtained via Emergency Department at RHC

Building materials can pose a risk of infection. Appropriate measures will be put in place to protect any child at risk as a precaution.

For information regarding access to car park and discharge lounge please refer to map overleaf

# The South Glasgow University Hospital & The Royal Hospital for Sick Children

Directions Guide

NHS Greater Glasgow and Clyde


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17. Central Medical Block
18. Acute Medical Block
19. Westmarc
20. Podiatry
21. Ronald McDonald House
22. Energy Centre
23. Deliveries
24. Mortuary - Visitors

# NHS Greater Glasgow and Clyde Core brief

Friday, 07 September 2018

**Introduction**

This issue brings you information on the cladding at RHC, winter resilience monies, the Hamish Allan Centre is closed and moving and handling.

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**RHC cladding replacement programme**

Staff should note that from Monday 10 September at approximately 10pm, the RHC Main Entrance will be closed until March 2019.

All access will be via the side door opposite the Play Garden.

The bus stop directly outside the Main Entrance area will also be closed and buses that use the stop will utilise the alternative bays outside QEUH Entrance.

A pedestrian route will be provided to facilitate external access from RHC to QEUH and bus stops.

External and internal signage will be in place, and staff will be on site during the initial period to assist with way finding.

**Funding for winter resilience**
**Health boards receive additional £10m**

A further £10 million will be allocated to NHS boards to help cope with added pressures over the winter months.

Provided earlier than ever before, the funding, which comes on top of the £9 million already allocated to support unscheduled care all year round, will allow health boards to put robust plans in place quickly.

The investment will support health and social care services to increase weekend discharges where patients are fit to go home. Traditionally, the weekend discharge rate is lower than during the week, leading to a backlog of delay going into a Monday morning. Click here to read more.

**Hamish Allan Centre**

From 4 September 2018, the Hamish Allan Centre will be closed. **All** services based in this building are re-located as follows:

**Out of Hours Homelessness Services –** if anyone is homeless and needs a service then:

Between the hours of 4.45pm and 11pm

- single males/females should attend [redacted]

- families with children should phone [redacted]

After 11pm and at weekends, you should call: [redacted] . During working hours, anyone who requires a homeless service should contact their local casework team at:
https://www.yoursupportglasgow.org/directory/providerlist/455

**Asylum and Refugee Team** will now be based at:
[redacted]

**Moving and handling**

Are you one of the many NHSGGC staff who are involved in the moving and handling of patients? If so, this is a must-read article for you on what we are doing to ensure the safety of you and your patients. To find out more click here.

**Are your contact details up-to-date? Click here to check**


26 June, 2019 (MD)

[redacted] **BBC Radio** - I work for BBC radio current affairs. I am seeking an update regarding the ACM style cladding on the Queen Elizabeth University Hospital and the Royal Hospital for Children. Has work started to replace the cladding? If work has started, when will it be finished?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The work to replace the area of cladding on the Royal Hospital for Children was completed last year. We expect the work to be concluded on the areas of cladding identified on the Queen Elizabeth University Hospital by the end of July.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**Information for Parents and Staff below;**

Water testing has revealed the presence of bacteria in the water supply

This bacteria is not harmful to a health individual but can cause infections in the immunocompromised

Immediate chemical treatment of the water supply is being undertaken

Taps and showerheads will be replaced

After chemical treatment the water will be safe to use

In the meantime we have supplied bottled water for patients for washing and brushing teeth

Sterile water will be supplied for patients to drink

**16/3/2018**

NHSGGC are investigating the presence of bacteria in the water supply to wards in the Royal Hospital for Children.

These bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

Three children are currently receiving treatment for infections that may be linked to these bacteria found in the water supply.

It's not unusual for children in this type of ward to suffer infections but we are carrying out tests to determine whether these bacteria are linked to any of the three patients.

However, we can confirm none of the three patients are giving any cause for concern as a consequence of their infection.

The source of the bacteria is as yet unknown but we are taking advice from Health Protection Scotland, Health Facilities Scotland and Scottish Water.

In the meantime alternatives to tap-water supplies to paediatric patients in wards 2A, 2B, 3C and the hospital's intensive care unit have put in place. Given the low immune system of patients in these wards we have also given them oral antibiotics.

Sterilised water is being supplied for drinking and bottled water for brushing teeth.

In addition, portable sinks stocked with bottled water have been supplied to all patient rooms in the affected wards.

Staff and others in these wards are able to use the tap water safely although we have taken an extra precaution of fitting taps and showers with filters to ensure no cross transmission from staff and visitors to patients.


March 2018

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

**ON WATER ISSUE AT RHC**

Bacteria has been found inside the taps of patient rooms in ward 2A of the Royal Hospital for Children where some of the patients in the ward are immuno-compromised.

The water supply from the main tanks to the hospital have tested clear and our infection control experts have now identified the taps as a likely source.

Given the low immune system of patients in this ward Dr Teresa Inkster, NHSGGC Consultant Microbiologist has discontinued the use of these taps to allow for their removal and chemical disinfection.

Our infection control experts also found traces of bacteria in existing shower heads and these have also now been replaced.

As a contingency while this matter is being sorted bottled water is available for washing and brushing teeth. Baby wipes are also being used. Sterile water is also available to the patients for drinking.

Patients and their parents/carers have been kept fully informed of the situation which we aim to have fully resolved in the next couple of days complete with full all-clear test results.

Dr Inkster added: "It's not unusual for children in this type of ward to suffer infections but it is impossible to know for sure if any patient with an infection is connected or not to what we have found in the taps, however, we can confirm that no patients are giving any cause for concern for any bacterial infections associated with anything that has been found in the taps."

**ENDS**

For further information either telephone [redacted] or email [redacted]

**Information for Parents and Staff below;**

Water testing has revealed the presence of bacteria in the water supply

This bacteria is not harmful to a health individual but can cause infections in the immunocompromised

Immediate chemical treatment of the water supply is being undertaken

Taps and showerheads will be replaced

After chemical treatment the water will be safe to use

In the meantime we have supplied bottled water for patients for washing and brushing teeth

Sterile water will be supplied for patients to drink


Friday, March 16, 2018

**STATEMENT ON WATER SYSTEM**

NHSGGC are investigating the presence of bacteria in the water supply to wards in the Royal Hospital for Children in Glasgow.

These bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

Three children are currently receiving treatment for infections that may be linked to these bacteria found in the water supply. Tests are ongoing to confirm if they are indeed linked.

Dr Teresa Inkster, infection control doctor, said: “It’s not unusual for children in this type of ward to suffer infections but we are carrying out tests to determine whether these bacteria are linked to any of the three patients.

“However, we can confirm none of the three patients are giving any cause for concern as a consequence of their infection.”

The source of the bacteria is as yet unknown but we are taking advice from Health Protection Scotland, Health Facilities Scotland and Scottish Water.

In the meantime alternatives to tap-water supplies to paediatric patients in wards 2A, 2B, 3C and the hospital’s intensive care unit have put in place. Given the low immune system of patients in these wards we have also given them oral antibiotics.

Sterilised water is being supplied for drinking and bottled water for brushing teeth.

In addition, portable sinks stocked with bottled water have been supplied to all patient rooms in the affected wards.

Staff and others in these wards are able to use the tap water safely although we have taken an extra precaution of fitting taps and showers with filters to ensure no cross transmission from staff and visitors to patients.

**ENDS**

For further information either telephone [redacted] or email [redacted]

16.3.18 – briefing note to parents/carers Ward 2A/2B

Water testing has revealed the presence of bacteria in some hospital wards and we are working with experts to locate the source of the contamination.

These bacteria are not harmful to healthy individuals but can cause infections in people who have a low immune system

In the meantime we have a number of enhanced infection control measures in place as a precaution. These include some patients using wet wipes for hygiene purposes rather than showers and use of portable sinks. Wash hand basins can still be used but we are asking that parents apply alcohol gel after washing their hands.

NHS Greater Glasgow and Clyde

# Core brief

Friday, 16 March 2018

**Introduction**

This issue provides a media statement on the water system at RHC.

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**NHS GREATER GLASGOW AND CLYDE STATEMENT ON WATER SYSTEM**

NHSGGC are investigating the presence of bacteria in the water supply to wards in the Royal Hospital for Children in Glasgow.

These bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

Three children are currently receiving treatment for infections that may be linked to these bacteria found in the water supply. Tests are ongoing to confirm if they are indeed linked.

Dr Teresa Inkster, infection control doctor, said: “It’s not unusual for children in this type of ward to suffer infections but we are carrying out tests to determine whether these bacteria are linked to any of the three patients.

“However, we can confirm none of the three patients are giving any cause for concern as a consequence of their infection.”

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In the meantime alternatives to tap-water supplies to paediatric patients in wards 2A, 2B, 3C and the hospital’s intensive care unit have put in place. Given the low immune system of patients in these wards we have also given them oral antibiotics.

Sterilised water is being supplied for drinking and bottled water for brushing teeth.

In addition, portable sinks stocked with bottled water have been supplied to all patient rooms in the affected wards.

Staff and others in these wards are able to use the tap water safely although we have taken an extra precaution of fitting taps and showers with filters to ensure no cross transmission from staff and visitors to patients.

**NHSGGC STATEMENT REGARDING WATER PROVISION
ON ROYAL HOSPITAL FOR CHILDREN WARD 2A**

It's not unusual for children in this type of ward to suffer infections and we are carrying out tests to determine whether the bacteria detected in the water are linked to any of the three patients. As a result, staff are aware that patient safety is always our paramount concern and are acting accordingly.

Patients on the Ward have access to portable sinks in their rooms. These sinks have a heating element enabling bottled water to be heated for use by patients. Wet wipes are also being provided for for use in cleaning patients. This is standard practice in paediatric intensive care and is entirely appropriate for patients whose immune systems are compromised.

Hot water has been available for use by staff and parents during this time apart from three occasions where the water was being treated, which meant it was unavailable for 4-6 hours. This was explained to parents at the time as was the reason for treating the water.

**From:** Armstrong, Jennifer
**Sent:** 18 March 2018 16:51
**To:** Armstrong, Jennifer; Inkster, Teresa (NHSmail); Grant, Jane [Chief Exec]; Redfern, Jamie; Mathers, Alan; Kane, Mary Anne; Powrie, Ian; Dell, Mark; Scott, Sonya
**Subject:** 18/03/18: midday call for update on RHC water incident:

All
Here are a few brief notes and actions from today's teleconference which involved GGC/HPS/HFS and Public Health England

1. Update regarding RHC
    a. All areas have correct communications in place and IC nurses have visited them with IC precautions in place.
    b. All areas have contingency plans in place and in control: no patients at present have been re-directed.
    c. Ward 2A had reported a few patients spiked temperatures with blood cultures sent to the lab.
    d. 3 cases with BC positive are **not** giving cause for concern at present.
    **e.** Patient due to be admitted this week [redacted] – **JR will link with BG to ascertain patient status and links with** [redacted] **if required.**
2. Update on control measure (with reference to HPS/NHS GGC/HFS and NHS E note sent out yesterday )
    **a.** The email from NHS E regarding bottled water and mobile sinks was discussed; it was confirmed that all BMT patients on sterile water; After some debate, it was accepted by all that a risk base assessment had been carried out by the IMT and it was agreed to retain the current arrangements.
    **b.** The filters are due to be fitted today and tomorrow; it was agreed that so long as these were fitted correctly, they should remove the bacteria; Although it was stressed this was a short term measure.
    **c.** There was discussion about further tests over the next 24 hours to give confidence that the negative results were consistent; the IMT would discuss the results further tomorrow. It was agreed that it would be better to wait an extra day or so, to be confident that the filters were working and that results were negative before resuming normal water use.
    **d.** There was much debate about the need to make longer term changes in terms of filters, shower heads, taps, water treatment and water testing and they would be discussed during this week to enable a clear plan to be developed.
    **e.** It is likely that the bacteria (aerobic) are near the end point of the distribution (outlets) rather than further back in the water supply with large air/water interfaces at risk,
3. **Communication**
    a. Staff and families have had adequate communication at present; it was updated at the huddle. It was felt this was sufficient for today but would have to be updated tomorrow following the IMT.
    b. Press reporting had been widespread using GGC statement with few further calls. However it was recognised that a further update maybe required tomorrow.
    c. It was suggested that the IMT could be brought forward to 12 midday if water tests were in to enable timely decisions to be made and clear messages for families and ward staff as well as press.

As always, if I have missed anything or got anything wrong, please correct.
Kind regards
Jennifer

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**From:** Armstrong, Jennifer
**Sent:** 18 March 2018 11:47
**To:** Inkster, Teresa (NHSmail); Grant, Jane [Chief Exec]; Redfern, Jamie; Mathers, Alan; Kane, Mary Anne; Powrie, Ian; Dell, Mark; Scott, Sonya
**Subject:** Re: [BlockedURL][ExternaltoGGC]Fw: cupriavidus pauculus URGENT

All
Here is a structure for today's call.

1. Update from Jamie regarding RHC situation and status of children
2. Update from Sonya regarding HPS note
3. Theresa will update on control measures
4. Estates issues Mary Anne
5. Communications issue both internal and press.

J

Sent from my BlackBerry 10 smartphone on the EE network.

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**From:** INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
**Sent:** Sunday, March 18, 2018 11:14 AM
**To:** Armstrong, Jennifer; Grant, Jane [Chief Exec]; Redfern, Jamie; Mathers, Alan; Kane, Mary Anne; Powrie, Ian; Dell, Mark; Scott, Sonya
**Subject:** [BlockedURL][ExternaltoGGC]Fw: cupriavidus pauculus URGENT

Ahead of the TC, please see email thread below which contains expert opinion from Suzanne Lee ( water expert, former HPA).

Kind regards
Teresa

Dr Teresa Inkster
Lead Infection Control Doctor NHSGGC
[redacted]

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**From:** RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND)
**Sent:** 18 March 2018 10:52
**To:** INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
**Subject:** FW: cupriavidus pauculus URGENT

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**From:** STORRAR, Ian (NHS NATIONAL SERVICES SCOTLAND)
**Sent:** 18 March 2018 10:42
**To:** STEELE, Tom (NHS NATIONAL SERVICES SCOTLAND); MCLAUGHLAN, Edward (NHS NATIONAL SERVICES SCOTLAND); RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND)
**Subject:** FW: cupriavidus pauculus URGENT

FYI
Copy of email from Phil Ashcroft and Susanne Lee ( Independent Public Health Microbiology Consultancy & Advisory Service)

Regards

Ian

**Ian Storrar**
Principal Engineer - Health Facilities Scotland
Procurement, Commissioning and Facilities
[redacted]

www.hfs.scot.nhs.uk



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**From:** ASHCROFT, Philip (NHS IMPROVEMENT - T1520)
**Sent:** 17 March 2018 21:02
**To:** STORRAR, Ian (NHS NATIONAL SERVICES SCOTLAND)
**Cc:** Wilson, David (DoH); Mark Gapper; BELLAS, Michael (NHS IMPROVEMENT - T1520)
**Subject:** FW: cupriavidus pauculus URGENT

Hi Ian
You probably didn't receive this from Susanne as I note the e-mail address was corrupted.

I'm off for a week but please keep me copied in. Also please copy in Michael Bellas in case we get any press calls south of the border
Thanks
Phil

Sent from my Windows 10 phone

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**From:** Susanne Lee
**Sent:** 16 March 2018 22:50
**To:** ASHCROFT, Philip (NHS IMPROVEMENT - T1520)
**Cc:** Ginny.Moore[redacted]; STORRAR[redacted]; [redacted]
**Subject:** Re: cupriavidus pauculus URGENT

Dear Phil
Sorry for the delay I have forwarded to Mike Weinbren . I agree with Ginny it is an uncommon pathogen and it would be good to have more information. I haven't had any personal experience of dealing with this but I suspect it might Be difficult to remove. If the BBC report is correct that bottled water and mobile sinks are being used I would be a little concerned about the use of bottled water with highly immunocompromised patients though , it is not the same as sterile water and and as there have been previous P. aeruginosa outbreaks in ICU associated with bottled water it is important that there has been sufficient quality assurance to ensure its safe for this patient group. I also have concerns with the use of the mobile sink units unless they have been thoroughly disinfected first. Following the Dutch lead and removing water from the highest risk areas and relying on alcohol gel and sterile water only.

Sent from my iPhone

On 16 Mar 2018, at 15:18, ASHCROFT, Philip (NHS IMPROVEMENT - T1520) <[redacted]> wrote:

Hello Ginny, Susanne, Elise and Tom

Have you had any experience with this particular problem and assisted Trusts in addressing it? If so any chance you could share anything you may have with Ian Storrar.

I'm afraid since I left DH I don't have access to my old contacts list or I would have dropped a note to Drs Michael Weinbrein and Michael Kelsey too.

Any help will be much appreciated by Ian.

Kind regards
Phil

**Philip Ashcroft BEng (Hons) CEng CEnv MIMechE MIET | Principal Engineer - Senior Policy and Strategy Lead (Hard FM)**
**NHS Estates and Facilities Efficiency & Productivity Division**
[redacted]
**NHS Improvement**

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We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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**From:** STORRAR, Ian (NHS NATIONAL SERVICES SCOTLAND)
**Sent:** 16 March 2018 14:20
**To:** ASHCROFT, Philip (NHS IMPROVEMENT - T1520); 'Simon.Russel[redacted]'; Wilson, David (DoH)
**Subject:** cupriavidus pauculus URGENT
**Importance:** High

Guys

Do you have any experience in getting rid of cupriavidus pauculus

Regards

Ian
**Ian Storrar**
Principal Engineer - Health Facilities Scotland
Procurement, Commissioning and Facilities
**NHS National Services Scotland**
[redacted]

www.hfs.scot.nhs.uk


20 March, 2018 (MD)

**BBC** - water issue at QEUH

**UPDATE STATEMENT ON BACTERIA CONTROLS**

We are continuing to investigate the presence of bacteria in the water supply to some wards in the Royal Hospital for Children (RHC) with experts from Health Protection Scotland, Health Facilities Scotland and Scottish Water.

These bacteria can pose a risk to patients whose immunity is compromised, however we have put in place robust infection control measures to protect our patients.

We have now extended this testing and infection control measures to four wards treating the most immunity compromised patients in the Queen Elizabeth University Hospital (QEUH) to ensure that we take every precaution.

Three children continue to receive treatments for infections that may be linked to bacteria found in the water supply. Tests are ongoing to confirm if they are indeed linked. A fourth patient has shown symptoms and has been readmitted to the RHC. There are no reports of any patients being infected by bacteria from water in the adult wards.

A series of infection control measures were introduced to the affected RHC wards at the weekend and water filters are set to be installed. As a result, it is hoped that the full water supply will return to normal within 48 hours after appropriate testing has been carried out and it is anticipated this will be mirrored at the QEUH.

We would like to thank the patients and families in the wards affected in the RHC for their continuing patience and support while the testing was carried out and fitting of filters is being undertaken.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Tuesday, March 20, 2018

**STATEMENT ON WATER SYSTEM**

We are continuing to investigate the presence of bacteria in the water supply to some wards in the Royal Hospital for Children in Glasgow with experts from Health Protection Scotland, Health Facilities Scotland and Scottish Water.

These bacteria can pose a risk to patients whose immunity is compromised but we have put in place robust infection control measures to protect our patients.

Three children continue to receive treatment for infections that may be linked to bacteria found in the water supply. Tests are ongoing to confirm if they are indeed linked. A fourth patient who has shown symptoms has been readmitted to the hospital.

Patients who have a low immunity have been given oral antibiotics.

Other measures, including the fitting of filters and extending infection control precautions to other patients whose immunity is compromised, are progressing and it is hoped that the full water supply will return to normal within 48 hours after further appropriate testing has been carried out.

Dr Teresa Inkster, infection control doctor, said: “Testing continues to identify whether the bacteria present has any link to the four patients

“All the appropriate infection control measures are in place and we would like to thank the patients and families in the wards affected for their patience and support while the testing and fitting of the filters is taking place.

"The infections the patients have are not giving us cause for concern.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

# NHS Greater Glasgow and Clyde Core brief

Tuesday 20 March 2018

**Introduction**

This issue of Core Brief updates on bacteria controls; fire safety training; and we share another NHS 70th heroes story.

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**Update statement on bacteria controls**

We are continuing to investigate the presence of bacteria in the water supply to some wards in the Royal Hospital for Children (RHC) with experts from Health Protection Scotland, Health Facilities Scotland and Scottish Water.

These bacteria can pose a risk to patients whose immunity is compromised, however we have put in place robust infection control measures to protect our patients.

We have now extended this testing and infection control measures to four wards treating the most immunity compromised patients in the Queen Elizabeth University Hospital (QEUH) to ensure that we take every precaution.

Three children continue to receive treatments for infections that may be linked to bacteria found in the water supply. Tests are ongoing to confirm if they are indeed linked. A fourth patient has shown symptoms and has been readmitted to the RHC. There are no reports of any patients being infected by bacteria from water in the adult wards.

A series of infection control measures were introduced to the affected RHC wards at the weekend and water filters are set to be installed. As a result, it is hoped that the full water supply will return to normal within 48 hours after appropriate testing has been carried out and it is anticipated this will be mirrored at the QEUH.

We would like to thank the patients and families in the wards affected in the RHC for their continuing patience and support while the testing was carried out and fitting of filters is being undertaken.

**Fire safety training**

All staff are reminded of the importance of fire safety training. Fire can happen anywhere and at any time and it is vital that all NHSGGC staff regularly carry out their fire safety training.

Fire safety training is **statutory** and can give you the skills needed to deal with fire safely. Staff should note in the event of a Fire activation you **must** call 2222 as stated in the fire protocol. Visit our online LearnPro module to find out more: https://nhs.learnprouk.com/lms (you will need your payroll number to log in).

**SN - NHS heroes**

In this, the 70th year of the NHS, we want to celebrate our NHS heroes, the men and women in our service who have touched our patients' lives and shown overwhelming dedication and professionalism. Over the coming months, we will share with you some examples of the messages and support we receive about you, our staff, on a daily basis. You are all our heroes!

To read the first three feature in this month's Staff Newsletter, click here

We plan to run these articles throughout the year. If you know of a hero in your workplace please let us know – simply go to: www.nhsggc.org.uk/patientfeedback

**Are your contact details up-to-date? Click here to check**

20.03.18 – Email responses from Senior Communications Officer Lorrain Dick to telephone questions from [redacted] Daily Record.

Hi [redacted]

Following our conversation this morning I want to reiterate that these bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised and we have put in place robust infection control measures to protect our patients.

We have now extended this testing and infection control measures to four wards treating the most immunity compromised patients in the Queen Elizabeth University Hospital (QEUH) to ensure that we take every precaution.

Best wishes.
Lorraine


20 March, 2018

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

**ON WATER ISSUE AT RHC**

We responded to a single patient case and – without a waiting for any potential second case to occur - we started investigating at that point for a potential water source.

When we found water tests were positive on 01 March we implemented enhanced infection control measures.

The parents of all affected patients were immediately spoken to by their consultant following receipt of lab test results being made available.

Our only concern throughout this period has been the safety of these immunity compromised patients.

The robust infection control measures we immediately put in place included shutting off the taps and showers to these patients. Appropriate measures tailored to each patient were put in place including the provision of sterile wipes for cleaning skin and sterile or bottled water for drinking and brushing teeth.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Wednesday, March 21, 2018

**NHS GREATER GLASGOW AND CLYDE UPDATE**

**ON BACTERIA CONCERNS**

Patients in the affected wards at the Royal Hospital for Children (RHC) are expected to be able to resume using showers and tap water for bathing tomorrow (Thursday, 22 March).

Filters have now been fitted to the affected wards. Bottled and sterile water will continue to be provided for drinking and brushing teeth while investigations continue.

Four children remain stable as a result of their infections and continue to receive treatments for infections which may be linked to bacteria found in the water supply at the RHC.

The parents of all affected patients were immediately spoken to by their consultant following receipt of lab test results being made available and have been kept fully informed throughout.

There are no reports of any patients being infected by bacteria from water in Queen Elizabeth University Hospital (QEUH) wards treating the most immunity compromised patients.

Appropriate infection control measures tailored to each patient in the affected QEUH wards are in place, including the provision of sterile wipes for cleaning skin and bottled water for drinking and brushing teeth.

We continue to investigate the presence of bacteria in the water supply to some wards in the RHC with input from experts at Health Protection Scotland, Health Facilities Scotland and Scottish Water.

All of the actions we took including the switching off of showers and taps during the investigation were taken with the safety of our patients on these wards in mind.

**ENDS**

For further information either telephone [redacted] or email [redacted]

NHS Greater Glasgow and Clyde

# Core brief

Wednesday 21 March 2018

**Introduction**

This issue of Core Brief details information on the update on bacteria concerns.

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## Update on bacteria concerns

Patients in the affected wards at the Royal Hospital for Children (RHC) are expected to be able to resume using showers and tap water for bathing tomorrow (Thursday, 22 March).

Filters have now been fitted to the affected wards. Bottled and sterile water will continue to be provided for drinking and brushing teeth while investigations continue.

Four children remain stable as a result of their infections and continue to receive treatments for infections which may be linked to bacteria found in the water supply at the RHC.

The parents of all affected patients were immediately spoken to by their consultant following receipt of lab test results being made available and have been kept fully informed throughout.

There are no reports of any patients being infected by bacteria from water in Queen Elizabeth University Hospital (QEUH) wards treating the most immunity compromised patients.

Appropriate infection control measures tailored to each patient in the affected QEUH wards are in place, including the provision of sterile wipes for cleaning skin and bottled water for drinking and brushing teeth.

We continue to investigate the presence of bacteria in the water supply to some wards in the RHC with input from experts at Health Protection Scotland, Health Facilities Scotland and Scottish Water.

All of the actions we took including the switching off of showers and taps during the investigation were taken with the safety of our patients on these wards in mind.

**Are your contact details up-to-date? Click here to check**


Thursday, March 22, 2018

**NHS GREATER GLASGOW AND CLYDE UPDATE**

**ON BACTERIA CONCERNS**

Patients in the affected wards at the Royal Hospital for Children (RHC) are now able to access the regular water flow from the taps and showers.

Filters fitted have been quality checked and the water can now be used for washing. Bottled and sterile water will continue to be provided for drinking and brushing teeth while investigations continue.

Four children remain stable as a result of their infections and continue to receive treatments for infections which may be linked to bacteria found in the water supply at the RHC.

The parents of all affected patients were immediately spoken to by their consultant following receipt of lab test results being made available and have been kept fully informed throughout.

There are no reports of any patients being infected by bacteria from water in Queen Elizabeth University Hospital (QEUH) wards treating the most immunity compromised patients.

Appropriate infection control measures tailored to each patient in the affected QEUH wards are in place, including the provision of sterile wipes for cleaning skin and bottled water for drinking and brushing teeth.

We continue to investigate the presence of bacteria in the water supply to some wards in the RHC with input from experts at Health Protection Scotland, Health Facilities Scotland and Scottish Water.

All of the actions we took including the switching off of showers and taps during the investigation were taken with the safety of our patients on these wards in mind.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Friday, March 23, 2018

**NHS GREATER GLASGOW AND CLYDE UPDATE**

**ON BACTERIA CONCERNS**

The water supply is now available in the four affected wards at the Royal Hospital for Children (RHC).

Filters fitted have been quality checked and the water can now be used for washing. Bottled and sterile water will continue to be provided for drinking and brushing teeth while investigations continue.

Four children remain stable as a result of their infections and continue to receive treatments for infections which may be linked to bacteria found in the water supply at the RHC.

Filters are also being fitted to wards in the adult hospital that treat immuno comprised patients.

**ENDS**

For further information either telephone [redacted] or email [redacted]

# Media Statement

NHS Greater Glasgow and Clyde

Friday, March 23, 2018

**NHS GREATER GLASGOW AND CLYDE UPDATE**

**ON BACTERIA CONCERNS**

The water supply is now available in the four affected wards at the Royal Hospital for Children (RHC).

Filters fitted have been quality checked and the water can now be used for washing. Bottled and sterile water will continue to be provided for drinking and brushing teeth while investigations continue.

Four children remain stable as a result of their infections and continue to receive treatments for infections which may be linked to bacteria found in the water supply at the RHC.

Filters are also being fitted to wards in the adult hospital that treat immuno comprised patients.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**From:** Rodgers, Jennifer
**Sent:** 04 July 2022 17:16
**To:** Bustillo, Sandra
**Subject:** FW: Water Incident update 28.3.18
**Attachments:** General IPC Precautions V3 Updated guidance 28.03.18.docx; BMT IPC Precautions V3 Updated guidance 28.03.18.docx

**From:** Johnson, Angela
**Sent:** 28 March 2018 10:12
**To:** Dodd, Susie [redacted]; Hackett, Janice [redacted]; Armstrong, Allison [redacted]; Begley, Aileen [redacted]; Bell, Fiona [redacted]; Bell, Louise [redacted]; Boyce, Gwyneth [redacted]; Brady, Coral [redacted]; Brindley, Nicola [redacted]; Brown, Sharon [redacted]; Bruce, David [redacted]; Carlton, Sharon [redacted]; Clark, Marjorie [redacted]; Clark, Marjorie [redacted]; Crawford, Belinda [redacted]; Crookes, Cathy [redacted]; Cruikshank, Lynda Anne [redacted]; Cupchunas, Helen [redacted]; Davies, Philip [redacted]; Dawes, Heather [redacted]; Dixon, Melville [redacted]; Drummond, Elaine [redacted]; Fallon, Joanne [redacted]; Fiona Scott [redacted]; Fraser, Dougie [redacted]; Friel, Liz [redacted]; Friel, Patricia [redacted]; Gallacher, Alana [redacted]; Gracie, Edith; Hamilton, Pauline [redacted]; Hanratty, Julie [redacted]; Harper, Lorraine [redacted]; Harrigan, Jim [redacted]; Heggie, janice [redacted]; Heron, John [redacted]; Horsburgh, Gillian [redacted]; Howat, Angela [redacted]; Hutton, Melanie [redacted]; Johnson, Elinor [redacted]; Johnston, Elaine [redacted]; Johnstone, Sharon [redacted]; Liddell, Morag [redacted]; Louise McDade [redacted]; Lundy, Wendy [redacted]; Maclean, Anne [redacted]; Madden, William [redacted]; Martin, Karen [redacted]; McGuigan, Mags [redacted]; McNeil, Grainne [redacted]; Meechan, Mandy [redacted]; Millar, Ashley [redacted]; Miller, Susan [redacted]; Mohammed, Kalsoom [redacted]; Monachan, Ursula [redacted]; Montague, Margaret-Ann [redacted]; Morley, Andrew [redacted]; Munro, Kim [redacted]; Parker, Katharine [redacted]; Phyllis MacKenzie [redacted]; Pirie, Mary [redacted]; Prince, Karen [redacted]; Redfern, Jamie [redacted]; Riddell, Catriona [redacted]; Rodgers, Jennifer [redacted]; Rolls, Gael [redacted]; Scott, Fiona [redacted]; Selkirk, Eleanor [redacted]; Sheila Shepherd [redacted]; Shivas, Ailsa [redacted]; Somerville, Emma [redacted]; Stock, Kate [redacted]; Symington, Karen [redacted]; Taylor, Karen [redacted]; Thomson, Kathleen [redacted]; Todd, Lorraine [redacted]; Ward, Danielle [redacted]; Williams, Libby [redacted]; Wilson, Glenda [redacted]; Wilson, Lesley [redacted]; Strachan, Anne [redacted]; MacKenzie, Fiona [redacted]; Whiteside, Jeanette [redacted]

**Cc:** Inkster, Teresa [redacted]; Kane, Mary Anne [redacted]; Connelly, Karen [redacted]; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]; Pritchard, Lynn [redacted]; Devine, Sandra [redacted]; Redfern, Jamie [redacted]
**Subject:** RE: Water Incident update 28.3.18

Good morning,

Over the last 3 weeks a number of control measures have been put in place for our immunocompromised patients around water use. Facilities staff have fitted external filters to taps in high risk areas for care of immunocompromised patients.
The attached advice sheets are updated to inform staff of the control measures agreed at the Incident Management Team (IMT) meeting on 27th March.
There is a separate set of control measures for BMT patients only, attached also.

The key changes are:
Staff no longer need to gel their hands following hand washing with soap and water for **all** patients including Bone Marrow Transplant patients.
The Point of Care (PoC) water filters in the BMT rooms will be changed every 7 days
BMT patients may use water from the PoC filters to shower and wash their hands

Staff should report to Estates if they notice the following

- The PoC filter falls off
- The PoC filter is loose
- Water leaking from around the sides of the PoC filter

Please note that Estates colleagues will be in Ward 2A weekly to obtain water samples and we ask that staff facilitate access to rooms timeously as samples are required to be sent to the lab for processing within a short time frame.

Some good practice points which should be in place regardless of any water incident;

- Please ensure no equipment is ever cleaned in clinical hand wash basins. This includes tracheostomy tubes, gastrostomy tubes, pill crushers etc etc. Trachy and gastrostomy tubes should be rinsed into a disposable macerator bowl and the waste water discarded in the sluice
- Please ensure excess drugs/TPN/ventilator & nebuliser condensate are not discarded into clinical hand wash basins. These should be discarded in the sluice.
- Please ensure trolleys for a clinical procedure are prepared away from any sinks and splash risk.
- Please ensure baby bottles are warmed in waterless bottle warmers. They should not be warmed in jugs of hot water or bottle warmers that require water.

Understandably, there have been a lot of questions and queries from staff around control measures and the IPCT have tried to answer these as quickly and clearly as we can in what has been a complex and frequently changing incident.
Please pass on our thanks to all staff for their patience and cooperation. If you have any further infection control queries please speak with your lead nurse or your local IPCN in person/by email/telephone. IPCNs will continue to visit wards daily to distribute the attached updated guidance and answer any queries staff have. Please feel free to share this email with colleagues who are not included on the distribution list.
Thank-you for your assistance with this.

Kind regards,

*Angela*

Angela Johnson
Senior Infection Prevention and Control Nurse

# Infection Prevention and Control Measures – Water Incident, March 2018

## Updated guidance 28/3/18

The Information below applies to all inpatient areas in RHC with the **exception of ward 2A Bone Marrow Transplant (BMT) patients (separate control measures available)**. NICU and SCBU are not required to carry out the control measures below and can use mains outlets as normal.

- Filters have been fitted to all clinical hand wash basins in rooms of immunocompromised patients. Disposable showerheads have also been fitted in these rooms. The clinical hand wash basins and showers can be used for all patients (including those who are immunocompromised), parents and staff.

- Staff can revert to normal hand hygiene practice. Alcohol based hand rub is not required routinely after every hand wash with soap and water.
- For all line care, aseptic technique and surgical scrub staff should continue to carry out hand washing as normal followed by application of alcohol based hand rub.
- ****For 2A patients only (incl those boarding in other wards)**** CVC lines should be covered when showering. Point of entry should be covered in a water resistant dressing. The lumens should be wrapped in sterile gauze swab and secured with a tegaderm dressing.
- Water coolers will remain out of use for patients in inpatient areas until further notice. Parents, staff and patients attending OPD clinics on the ground floor may use the water coolers throughout the hospital.
- Bottled water will be provided for patients for drinking and brushing teeth.
- Twice daily cleans of patient rooms with Actichlor plus (1000ppm) is for source isolation rooms only as per normal practice.

# Infection Prevention and Control Measures – Water Incident, March 2018

## Updated guidance 28/3/18

The Information below applies to the inpatient **Bone Marrow Transplant (BMT) group only.**

## Patients

- Patients can be washed with water supplied via a Point of Care (PoC) filter fitted to the clinical wash hand basin (CWHB) tap and shower. The PoC filters in the BMT rooms will be changed every 7 days.
- Patients should drink sterile bottled water only.
- Patients should only use sterile bottled water for brushing teeth.

## Parents

- Parents may continue to use the showers.
- Parents may wash hands in the clinical wash hand basins.
- Parents can drink from the water cooler but must not give this water to their child who is an inpatient.
- Ensure rooms are kept tidy and clutter free to assist with staff cleaning.

## Staff

- Staff should wash hands with water supplied via a Point of Care (PoC) filter fitted to the CWHB tap.
- For aseptic procedures staff will wash hands at the (CWHB), then use Sterilium lotion (surgical rub) for 90 seconds (See poster for technique). If not available, staff can use surgical scrub (Betadine or Chlorhexadine) with standard technique followed by rinsing with water supplied via a Point of Care (PoC) filter fitted to the CWHB tap.
- Single patient use nebulisers should be rinsed out in sterile bottled water after each use.
- Where water is required for reconstituting medicines for oral/NG route, sterile water should be used.
- Ensure rooms are kept tidy and clutter free to allow twice daily clean of room and equipment with Actichlor plus (1000ppm).


Thursday, March 29, 2018

**NHS GREATER GLASGOW AND CLYDE UPDATE**

**ON BACTERIA CONCERNS**

The water supply is now available in the four affected wards at the Royal Hospital for Children (RHC).

Filters have been fitted and quality checked in wards at both the RHC and the adult hospital that treat immuno comprised patients.

The water can now be used for washing. Bottled and sterile water will continue to be provided for drinking and brushing teeth while investigations continue.

Four children remain stable as a result of their infections and continue to receive treatments for infections which may be linked to bacteria found in the water supply at the RHC.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Thursday 26 April, 2018 (CC)

[redacted] - update on water issue at RHC

**NHS GREATER GLASGOW AND CLYDE UPDATE**

**ON WATER ISSUES**

We are continuing to investigate the water supply to some wards in the Royal Hospital for Children (RHC) with experts from Health Protection Scotland, Health Facilities Scotland, and Scottish Water.

Since a series of infection control measures were introduced to the affected RHC wards and water filters were installed, there have been no new cases of infection amongst our patients.

We would like to thank the patients and families in the wards affected in the RHC for their continuing patience and support.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Monday, June 4, 2018

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

Our facilities team is today carrying out treatment on the drains within Wards 2A/B after traces of bacteria were found during testing.

These bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

Patients and their parents/carers are being fully informed of the situation, including the potential to move patients temporarily to another ward within the hospital, if required, to allow the work to be completed.

Our infection control experts believe the bacteria to be linked to an earlier issue with taps which have since been fitted with filters. The water supply is unaffected.

Dr Teresa Inkster, NHSGGC Consultant Microbiologist, said: “As the wards affected treat patients whose immune system is compromised we have taken these immediate steps to apply a chemical disinfection to the drains and to inform the families of the situation.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

# Media Statement

NHS Greater Glasgow and Clyde

Tuesday 5 June 2018

[redacted] **– Evening Times**

I've just been informed there's a bug in the water at the Royal Hospital for Children in the south side. I've been told patients are having to be given precautionary antibiotics with potential sickness and diarrhoea side effects, kids are being moved around from room to room because deep cleaning is having to take place, the ward kitchen is closed, parents are having to use bottled water, kids can't have baths, and any items that can't be deep cleaned will probably have to be thrown out.

We've also been told the hospital has stopped accepting patients.

Can I get confirmation on this? What measures are being put in place to handle the bug? What's the board's advice to parents who were planning to take their children to the RHC? This is the second bug in a matter of months, how are the board planning to combat this issue?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Traces of bacteria have been found during testing in the drains of two wards in the Royal Hospital for Children.

We are carrying out chemical cleaning of these drains in ward 2A and 2B. We are treating the drains in blocks of four rooms at a time and as the work involves chemicals and during this short period our young patients will be temporarily moved to another room until the work is completed.

The drain in the kitchen area serving these wards is also being treated and so will also be temporarily closed until tomorrow night. The same cleaning programme is being carried out in the bathrooms of these wards.

There is no problem with the drinking water supply as it is filtered but due to the kitchen being closed we are supplying bottled water at this time.

The rest of the Royal Hospital for Children is working as normal and the drain cleaning work in ward 2A and 2B will be completed by the weekend.

The traces of bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

Dr Teresa Inkster, NHSGGC Consultant Microbiologist, said: "As the wards affected treat patients whose immune system is compromised we have taken these immediate steps to apply a chemical disinfection to the drains and to inform the families of the situation.

"We have also taken the extra precaution of prescribing antibiotics to a few patients who are at risk of infection and we are sorry for the disruption this has caused to our young patients and their families in wards 2A and 2B at this time."

Patients and their parents/carers have been fully informed of the situation.

Our infection control experts believe the bacteria to be linked to an earlier issue with taps which have since been fitted with filters. The water supply is unaffected.

We acknowledge the inconvenience this temporary move has on our patients and families however it is being undertaken to ensure we maintain safe patient care throughout this time.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**Update Ward 2a/b 7th June 2018**

**Drain and Chilled Beams cleaning**

The cleaning of all drains and chilled beams has commenced as planned and this process will now be built in to the regular cleaning programme.

**Hydrogen Peroxide Vapour (HPV)**

HPV cleaning is in progress and will continue until completion which is expected to be Sunday 11th June.

**Antibiotics**

If your child has received antibiotic prophylaxis this will be discontinued after cleaning has been completed.

**Cleanliness**

Hand washing sinks are restricted to hand washing practice only. Please do not pour anything e.g. milk, coffee or any other liquid down the hand washing sinks.

Please do not sit anything on top of or within the hand washing sink.

Please speak to the Nurse in Charge if you have any other questions.

Thank you for your patience and understanding.

# This basin is for hand wash only

## Nothing should ever be poured down or washed/rinsed in this hand wash basin



Information for parents about cleaning in ward 2a

The week beginning 12th June we will be using a new cleaning method in ward 2A. Your childs room will be cleaned as normal by the ward domestic. After this we will be using a mist to spray each room - this is called Hydrogen peroxide vapour (HPV).

This is a fairly new cleaning technology which we have used elsewhere in the childrens' hospital and also in the adult hospital. It works by coating every surface evenly with HPV and is therefore more reliable and effective than the human eye for cleaning.

To clean your childs room you will need to move into another room whilst the process is undertaken for approximately three hours . Most things can stay in your childs room but any item made of fabric or paper such as bedding ,soft toys and books will need to be removed. Nursing and domestic staff will remove these items for you.

You will notice a technician and two machines on the ward for the whole week. The technology is very safe. The hydrogen peroxide quickly dissolves into oxygen and water. Your child can go back into the room once it is finished.

We will also be taking the opportunity to clean ceiling areas and sink drains which ordinarily can be difficult to access, so you may notice this also.

Because this technology is very effective it may be used as a cleaning method 2-3 times a year in ward 2A

13 June 2018

# NHS GREATER GLASGOW AND CLYDE STATEMENT

As a result of traces of bacteria being found during testing in the drains of wards 2A and 2B in the Royal Hospital for Children, a chemical cleaning has now been completed.

As a further precaution, all metal spigots in sinks are being replaced with a plastic equivalent on these wards and are being followed by a further deep clean.

The drains in the kitchen area and bathrooms serving these wards have also been treated.

The traces of bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

Dr Teresa Inkster, NHSGGC Consultant Microbiologist, said: “As the wards affected treat patients whose immune system is compromised we took immediate steps to apply a chemical disinfection to the drains and to inform the families of the situation.

“We have also taken the extra precaution of prescribing antibiotics to a few patients who are at risk of infection and we are sorry for the disruption this has caused to our young patients and their families in wards 2A and 2B at this time.”

Patients and their parents/carers have been fully informed of the situation.

Our infection control experts believe the bacteria to be linked to an earlier issue with taps which have since been fitted with filters. The water supply is unaffected.

We acknowledge the inconvenience this temporary move has on our patients and families however it is being undertaken to ensure we maintain safe patient care throughout this time.

**ENDS**

For further information either telephone [redacted] or email [redacted]


04 July, 2018

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

Ward 2A and 2B returned to full operational arrangements in the middle of June with patient admissions scheduled as planned.

We have had no new cases of infection amongst our patients since infection control measures were carried out.

**ENDS**

For further information either telephone [redacted] or email [redacted]


# ***Helping to keep your child safe from Infection***

## Hand Hygiene:

- Clean your hands and your child's hands with soap and water, alcohol hand gel or where applicable, with the hand wipes provided:
  - On entering and leaving the ward and your child's room
  - Before and after meals
  - After using the toilet/changing a nappy
- Please note that the sinks in your child's room are strictly for hand hygiene only
- Please do not pour or discard any used liquids/water from drinking containers such as cups, bottles, washbowls or baby baths into the sinks or shower drain in your child's room

## Your Child's Room:

- Store personal items in drawers and cupboards (not on sinks or floor)
- Keep your child's room tidy and clutter free – take any unused toys home
- Please fold up your bed during daytime (if staying overnight)
- Regularly clean your child's toys – please ask staff for appropriate cleaning materials
- If you are concerned about the cleaning standards in your child's room, please report your concerns to the Nurse in Charge

## General Ward Areas:

- Do not enter other patient's rooms, nursing treatment areas or preparation rooms

## Lines:

- Do not tuck your child's line into nappy or underwear or allow your child's line to trail along the floor

## Visitors

- Parents and visitors who are symptomatic of diarrhoea and/or vomiting should not visit until at least 48 hours free of symptoms. Discourage family and friends from visiting if they feel unwell

## If your child is in isolation

- Your child must stay in their own room to prevent the spread of infection
- Your child should not use communal areas of the ward such as the playroom
- If you wish more information about the isolation of your child you can speak to a member of staff or ask to speak to an Infection Prevention and Control Nurse (IPCN)

## If your child has diarrhoea and vomiting

- Parents should not use the communal areas of the ward such as the kitchen
- Parents and visitors must clean their hands with soap and water rather than alcohol gel
- The room and equipment will be cleaned twice daily with a chlorine based product
- The door to the room should be kept closed when not in use and a sign placed on the door
- Staff will wear and apron and may also wear gloves when entering the room

# Media Statement

NHS Greater Glasgow and Clyde

Monday, September 17, 2018

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

Following further testing of the drains in ward 2a and 2b in the Royal Hospital for Children, a decision has been reached to temporarily move patients to allow remedial work to take place.

Ward 2a is a **haemato-oncology inpatient ward and ward 2b haemato-oncology day ward. Both treat children with cancer and blood diseases. A date has not been set for the decant.**

Despite carrying out chemical cleaning of the drains, further bacteria has been found in the drains meaning further work now needs to take place.

To allow this to happen patients will be temporarily moved from 2A and 2b to other wards on the same site. Bone morrow paediatric patients will be moved to an adult bone marrow ward.

Patients and their parents/carers are being fully informed of the situation, including the plan to move patients temporarily to another ward within the hospital to allow the work to be completed.

Dr Teresa Inkster, NHSGGC's Lead Infection Control Doctor said: "While we appreciate this will cause disruption patient safety needs to be our priority.

"These bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised.

"There is no problem with the drinking water supply as it is filtered and patients and their parents/carers have been fully informed of the situation.

"Experts from various fields are working together to develop a plan for the decant which will minimise any disruption."

**ENDS**

For further information either telephone [redacted] or email [redacted]

18 September 2018

**WARD 2A AND 2B UPDATE**

We appreciate that you have been experiencing disruption whilst we have introduced an enhanced cleaning programme.

As you may be aware we initially experienced a build-up of material (known as biofilm) in the sink drains in Ward 2A and 2B. This is the same sort of biofilm we get in domestic sink drains but as the patients in these wards are being treated for cancer their immune system is compromised and they are more susceptible to infection.

Today we have introduced a new cleaning product called Hysan to clean the drains. Hysan is a hard surface disinfectant effective against bacteria.

Whilst this will work in the short term; longer term we require a permanent solution. This will require us to temporarily transfer ward 2A and 2B to another ward in QEUH adult hospital.

This will provide opportunity for drainage and technical experts to undertake a comprehensive investigation and complete any remedial works required.

We are working to make this happen as soon as possible and will keep everyone in the two wards fully updated on our plans as they develop.

As this only affects immuno-compromised patients and no other patients at the Royal Hospital for Children are affected.

Thank you for your cooperation and assistance to ensure the highest standards of care and treatment continue to be provided for your child.

18 September 2018

**BRIEFING FOR OTHER PATIENTS AND PARENTS**

You may be aware that two of our wards have been experiencing disruption whilst we have introduced an enhanced cleaning programme.

This is the result of a build-up of material (known as biofilm) in the sink drains in Ward 2A and 2B. This is the same sort of biofilm we get in domestic sink drains but as the patients in these wards are being treated for cancer their immune system is compromised and they are more susceptible to infection.

Today we have introduced a new cleaning product called Hysan to clean the drains. Hysan is a hard surface disinfectant effective against bacteria.

Whilst this will work in the short term; longer term we require a permanent solution. This will require us to temporarily transfer ward 2A and 2B to another ward in QEUH adult hospital.

This will provide opportunity for drainage and technical experts to undertake a comprehensive investigation and complete any remedial works required.

We are working to make this happen as soon as possible and will keep everyone in the two wards fully updated on our plans as they develop.

This only affects immuno-compromised patients and no other patients at the Royal Hospital for Children are affected.

NHS Greater Glasgow and Clyde

# Core brief

Tuesday 18 September 2018

**Introduction**

This issue of Core Brief details information on a statement issued today on drains at the RHC.

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**NHS Greater Glasgow and Clyde statement on drains at the Royal Hospital for Children**

From January until June this year we experienced issues with the water supply in wards 2A and 2B of the Royal Hospital for Children when a number of patients were affected by bacteraemia.

Our technical experts advised the metal parts inside taps were replaced with plastic ones, filters attached to the taps and the drains cleaned with a chlorine based detergent. In addition the ward environment was cleaned with Hydrogen Peroxide Vapour (HPV).

After this work was completed there had been no new cases of bacteraemia for several weeks.

But more recently there have been six new cases and although all the children have recovered and been discharged or are continuing with their normal treatments we instigated an Incident Management Team to further investigate and manage the situation.

What we are seeing is a build-up of biofilm in the drains which is the same sort of biofilm we get in domestic sink drains. This build up has happened only seven weeks after they were cleaned by HPV.

We have worked with national experts in Scotland and sought advice from UK experts on the issue as we seek to find a permanent solution and understand why this has happened.

These wards treat children with cancer who have very low immunity to infections so to let our experts in and put cameras down the drains we need to move the patients.

Ward 2A has a combination of haemato-oncology patients and other cancer patients. Four bone marrow patients will move to the bone marrow adult ward (4b) in the adjoining Queen Elizabeth University Hospital (QEUH).

The remainder of the 22 patients from ward 2A and the outpatients who attend ward 2B (this is a day case ward with no inpatients) will move to another ward in the QEUH.

Patient safety is the one key overriding issue and this temporary move will enable our technical experts to make thorough investigations.

No other services at the Royal Hospital for Children are affected.

**PATIENTS IN TWO WARDS AT THE ROYAL HOSPITAL FOR CHILDREN TO MOVE TO ENABLE DRAIN CLEANING INVESTIGATIONS**

From January until June this year we experienced issues with the water supply in wards 2A and 2B of the Royal Hospital for Children when a number of patients were affected by bacteraemia.

Our technical experts advised the metal parts inside taps were replaced with plastic ones, filters attached to the taps and the drains cleaned with a chlorine based detergent. In addition the ward environment was cleaned with Hydrogen Peroxide Vapour (HPV).

After this work was completed there had been no new cases of bacteraemia for several weeks.

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These wards treat children with cancer who have very low immunity to infections so to let our experts in and put cameras down the drains we need to move the patients.

Ward 2A has a combination of haemato-oncology patients and other cancer patients. Four bone marrow patients will move to the bone marrow adult ward (4b) in the adjoining Queen Elizabeth University Hospital (QEUH).

The remainder of the 22 patients from ward 2A and the outpatients who attend ward 2B (this is a day case ward with no inpatients) will move to another ward in the QEUH.



Patient safety is the one key overriding issue and this temporary move will enable our technical experts to make thorough investigations.

No other services at the Royal Hospital for Children are affected.

# Media Statement

NHS Greater Glasgow and Clyde

Tuesday, September 18, 2018

**PATIENTS IN TWO WARDS AT THE RHC TO MOVE**

**TO ENABLE DRAIN CLEANING INVESTIGATIONS**

From January until June this year we experienced issues with the water supply in wards 2A and 2B of the Royal Hospital for Children when a number of patients were affected by bacteraemia.

Our technical experts advised the metal parts inside taps were replaced with plastic ones, filters attached to the taps and the drains cleaned with a chlorine based detergent. In addition the ward environment was cleaned with Hydrogen Peroxide Vapour (HPV).

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But more recently there have been six new cases and although all the children have recovered and been discharged or are continuing with their normal treatments we instigated an Incident Management Team to further investigate and manage the situation.

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We have worked with national experts in Scotland and sought advice from UK experts on the issue as we seek to find a permanent solution and understand why this has happened.

These wards treat children with cancer who have very low immunity to infections so to let our experts in and put cameras down the drains we need to move the patients.

Ward 2A has a combination of haemato-oncology patients and other cancer patients. Four bone marrow patients will move to the bone marrow adult ward (4b) in the adjoining Queen Elizabeth University Hospital (QEUH).

The remainder of the 22 patients from ward 2A and the outpatients who attend ward 2B (this is a day case ward with no inpatients) will move to another ward in the QEUH.

Patient safety is the one key overriding issue and this temporary move will enable our technical experts to make thorough investigations.

No other services at the Royal Hospital for Children are affected.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**25 September 2018 – Letter to parents**

Dear Parent, 25/09/18

Re: Relocation of Wards 2A & 2B.

You are aware that ward 2A & 2B has an issue with bacteria in the drains and it is now the opinion of experts that resolving the problems requires access to rooms which cannot happen whilst patients are on the ward. For this reason wards 2A & 2B are being relocated to ward 6A in the adult hospital (QEUH) on Wednesday 26th September 2018. Bone marrow transplant patients will move to ward 4B which is the adult bone marrow transplant unit. This is a temporary arrangement, however in the interim the following changes will be necessary:

**1. Leukaemia Out Patient Clinic**

There will be no change for most patients. The only exception is to patients with central lines who receive vincristine.

1. Patients who receive vincistine via a peripheral cannulae will receive vincristine in a room in the clinic area as already happens .
2. Patients who receive vincristine via a cental line will also receive vincristine in a room in in the clinic area. These patients should not come to ward 6A. This is the only change in arrangements for this clinic.

**2. Leukaemia and Oncology patients attending Day Care.**

Patients should attend Clinic 3 area for a FBC and then make their way to ward 6A, QEUH. This is best done by taking the link corridor to the adult hospital and taking the Arran lift (on the right at the end of the corridor going from the clinic area) to the 6th floor.

**3. Transplant Patients.**

Transplant patients who attend for review, blood products or immunoglobulins will attend the Day Care Unit on ward 6A. The transplant clinic will run as normal in the outpatient department.

**4. Telephone numbers to contact staff on ward 6 A will remain unchanged. The telepone number for ward 4B is [redacted].**

I apologise for this inconvenience and thank you for your patience and understanding.

Yours sincerely

Professor B E Gibson

MB ChB, FRC Path, FRCP, FRCPCH


01 October, 2018

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

Patient safety is always the number one priority for NHS Greater Glasgow and Clyde.

The patients have been temporarily moved to allow our experts to get free and open access to the drains to seek a permanent solution and understand why there is a biofilm build up in the drains.

Prior to the move and as a precaution, a small number of chemotherapy treatments had to be delayed for a few days. Each consultant reviewed their patients and made safe, clinical decisions on a case by case basis.

The figure of 16 patients relates to the first nine months of this year. All treatments have now taken place and Wards 2A and 2B are operating as normal from their temporary base.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Tuesday, 20 November 2018

**Statement**

The Royal Hospital for Children will be without running water for a short period of around four hours on Thursday 22 and Thursday 29 November. This has been scheduled to take place during the night (12 midnight until 4am) to minimise any disruption.

This is to allow the planned chlorine dioxide dosing to be carried out. This treatment will enable us to remove the temporary filters that were previously installed in certain wards at the Royal Hospital for Children.

Clinicians have confirmed that there are no safety concerns and a mixture of cleaning wipes, hand gel, bottled water, portable sinks, commodes and portable toilets will be used during these short periods.

**END**

For further information either telephone [redacted] or email [redacted]


Thursday, December 6, 2018

**UPDATE ON PAEDIATRIC CANCER WARD**

Our engineering experts have now completed work to resolve the water and drainage issues in the two paediatric cancer wards at the Royal Hospital for Children.

This work has included chemical treatment and the replacement of drains, taps and sinks in wards 2A (inpatient) and 2B (outpatient).

The patients were transferred to ward 6A of the neighbouring Queen Elizabeth University Hospital during this work which allowed our technical staff to carry out a more detailed examination of the overall environment of the two wards.

Following this work we have decided to upgrade the ventilation system in this area.

This will cost £1.25m and will deliver the highest standards of ventilation for our young patients. During the 12 month programme to design and install the upgraded system, our young patients will continue to receive their expert care from our paediatric clinical teams in the adult hospital.

Kevin Hill, RHC hospital director, said: “As our patients and staff had already relocated to another ward, this provided a good opportunity to carry out this upgrading of the system. We have informed patients, their families and our staff about the plans for the ward and I am grateful for their understanding.

“While the BMT unit has already had a ventilation upgrade its proximity to ward 2A means that the best option is for those patients also to remain in the adult hospital until all work is completed.”

**ENDS**

**Background note**

In March of this year bacteria was found inside the taps of patient rooms in ward 2A of the Royal Hospital for Children.

The water supply from the main tanks to the hospital tested clear and we identified the taps and shower heads as potential sources - all have been replaced.

The drains were also tested and in September we took the decision to move the patients out of wards 2A, 2B and the adjoining Bone Marrow Transplant unit into wards in the adult hospital next door. This allowed our technical staff to carry out remedial works and to make investigations into the whole ward environment. It was during this period that our teams identified the opportunity to upgrade the ventilation system and this work is now being progressed.

**Q&A**

**Q: Who is going to pay for this?**

A: NHSGGC are paying for this upgrade.

**Q: Has the current ventilation system been causing risk to patients since the hospital opened.**

A: We regularly monitor infection rates and the trigger for the work that has taken place over recent months on the water supply and drainage system was a rise in the presence of bacteria and a number of infections above the rate we would normally expect in this cohort of patients. The ventilation work is not linked to infections but is an opportunity to install the very highest standards currently achievable.

**Q: You have already carried out work on the BMT unit. Are you having to replace the ventilation system in this unit for a second time in three years?**

A: No, the ventilation system for the BMT unit is not being replaced. The work carried out in 2015 ensured that the BMT unit has optimal air quality purification. The redesign of the ventilation system within wards 2A and b will ensure that these areas too have the highest air quality purification.

**Q:Is the rest of the hospital affected?**

A: Wards 2A and B are haemato-oncology wards which treat patients who are immune-compromised. There is no evidence that the issues affecting wards 2 A and B have wider implications.

For further information either telephone [redacted] or email [redacted]

**NHS Greater Glasgow and Clyde (NHS GGC)**
[redacted]

**Minutes of the meeting with [redacted] 4th January 2019 at the Royal Hospital for Children (RHC)**

**Attendance**
Professor Brenda Gibson , Paediatric Haematology Consultant (BG)
Dr Teresa Inkster, Board Lead for Infection Control (TI)
Ms Jennifer Rodgers, Chief Nurse Hospital Paediatrics and Neonatology (JRo)
Mr Jamie Redfern ,General Manager Hospital Paediatrics and Neonatology (JR)
[redacted]

**Apologies**
Dr Shahyza Chaudhury , Paediatric Haematology Consultant (SC)

**Opening Comments**

BG opened the meeting by asking everyone to introduce themselves which they duly did. She explained the purpose of the meeting, which was to update the parents on information on [redacted].

BG told [redacted] that they could ask for a break at any time, if they required this and that if [redacted] was unsure of what was being said that they should be comfortable asking for clarification.

TI, JR and JRo summarised their role and why they were present at the meeting.

[redacted]

**Clinical Update**

BG confirmed that [redacted] was not her patient [redacted].

[redacted] She offered to obtain the answer to any questions that they might have that she could not answer.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

TI explained that it was impossible to confirm the exact date when [redacted] Cryptococcus and indeed on which ward. However, it was likely that this was on [redacted] or [redacted].

[redacted]

It was agreed that when Cryptococcus is detected in blood cultures/the blood stream, deterioration is rapid and the outcome poor.

[redacted]

**Cryptococcus**

TI gave a brief description of Cryptococcus. This included how it could be contracted by a patient in a hospital setting.

She also confirmed that clinical samples [redacted] had been taken and sent to the UK laboratory in Bristol which is the laboratory routinely used by NHS GGC to analyse samples and report results.

TI noted results [redacted] specimens would take a number of weeks.

These results would then be compared with air and environmental samples reported by our local laboratory team.

**Significant Clinical Incident Review (SCIR)**

JR and JRo confirmed that there would be a SCIR conducted, which was standard procedure for this type of event.

JR confirmed that the SCIR would be chaired by a Consultant out with the Haematology Oncology team.

A multidisciplinary review team would be established.

The review would be supported by risk experts from the NHS Board's Clinical Governance team.

JR noted that the review would take a number of weeks to complete.

It would involve a number of statements taken from staff involved [redacted].

He confirmed that the final report would be jointly signed off by JR, JRo and Alan Mathers (Chief of Medicine).

He also noted that the report would be shared with [redacted].

[redacted] would be offered a meeting with the review team; this would be an opportunity for [redacted] to go over the outcomes and recommendations from the review.

The meeting would [redacted] to ask questions on how recommendations had been reached, what was expected following their implementation how any recommendations would be progressed and the timescales for this .

**Conclusions**

BG concluded the meeting by thanking [redacted] for attending.

[redacted].

JR noted that the minute should be available in 5 working days.

TI confirmed that the results from the Bristol laboratory would be shared with [redacted] .

JR and JRo both confirmed that [redacted] would be kept up to date with the SCI progress .

[redacted]

*Footnotes*

1. Minutes were delayed because TI was on holiday. [redacted] will have the opportunity to comment on them before approval.

2. On the 18h January 2019 BG and TI telephoned [redacted] and spoke with [redacted]. [redacted] was told that there had been a second case of Cryptococcus at QEUH which had lead to an investigation of the source and potential sites of acquiring the infection. [redacted] was told that air sampling on ward 6A had detected Cryptococcus in the air. [redacted] was offered an opportunity to discuss this further .

**Wednesday, 9th of January: Level 3: RHC Room @ 2.30pm**

Present: Jennifer Armstrong, Sandra Devine, Kevin Hill, Ian Kennedy, Alan Mathers, Alek Marek, Jamie Redfern, Jen Rodgers, Tom Steele and Pepi Valyraki

On phone: Mags Mcguire

**Introduction**

JLA thanked everyone for attending the meeting which had been called urgently at short notice in response to:

- The IMT minutes of Monday 7th of January (sent out Tuesday 8th of January) which described a range of significant issues and results;
- The email from Brenda Gibson sent to Dr Armstrong on Tuesday 8th of January requesting meeting to discuss a range of concerns and progress.

JLA set out that she was keen to hear from everyone in the room on progress on the investigation into Cryptococcus infection and determine what actions required to be taken urgently. She had asked Tom Steele to urgently source hepa filtration units this morning and would like to discuss this measure as well as other actions which may be required;

**The key issues which were raised included:**

1. The vulnerable patients had been started on prophylaxis following the lab reports of 2 cases of Cryptococcus. There was concern from the BG's email about the requirement for [redacted].
2. Patients were currently attending the day unit for OP chemotherapy and there was a need to determine whether they required prophylaxis given that they were not restricted to the ward.
3. JRe reported that there had been a review of prophylaxis requested with a microbiologist, a clinical pharmacist and a clinical oncologist to review the guidance; He would chase up where that had got to. **(Action 1: JRe to chase up where this work has got to)**
4. AM reported that the ward air sampling results (6A, 4C and PICU) which has been carried out in December 2018 had been incubated too long and was therefore not reliable. PV/AM reported that plates had been repeated last night (Tuesday 8th of January) and would be ready in about a week.
5. The portable hepa filter units had been discussed at the IMT on Monday 7th of January and there was a comment that they were noisy and indeed there were some on the ward which were not in use.
6. However JenR and AM said that they were no louder than a fan heater and it was agreed by all, that given the risks, the filters should be deployed without

delay while the repeat samples were awaited. (This was also what was recommended in the IMT on Monday)

7. JA had asked TS early this am to urgently source hepafilter units which could be deployed without delay pending this meeting.
8. TS reported that we had 30 hepafilter units on the QUEH site which were ready to use and required to be plugged in; they had been purchased as a 'back up' for ward 4B (the adult BMT unit) . There was a need for advice from IC colleagues on the spacing of the units in the ward and the cleaning required. It was agreed that Dr A Marek and one of the Lead IPCN would visit the ward and advise on the placement of these units.
9. All agreed that there was an urgent need to deploy them to ward 6A in the first instance with further filters to 4C and repeat the air testing post filters
10. **JRo/AM and SD agreed to visit the ward tonight and agree cleaning schedule and placing of the machines with estates colleagues which would take place within 24 hours. In addition, it may be helpful to resample following their deployment (Action 2)**
11. There were also 2 rooms which were situated on ward 6A and were closed off pending estates colleagues and IC to agree a scribe. TS reported that the work could go ahead and PV agreed to sign off the scribe either this evening or tomorrow. It was important that these rooms were at negative pressure to ensure no detriment to the ward. **(Action 3: PVi would agree the scribe to enable work to commence)**
12. TS also queried some of the issues raised in the IMT minutes with the following:
    a. there were reports that some boxes were seen to have 'white marks' on them but as no sample was taken, it was difficult to know what this was and he encouraged samples to be taken
    b. There has been smoke tests done of the plant rooms and there was no leakage into the ventilation room detected;
    c. The building was triple glazed with no obvious leakage for ingress to get in. They would carry out thermal imaging cameras to detect any drafts.
13. TS reported that there had been a lot of very positive progress with the water samples which showed that the chlorine dioxide treatment installed was having a great impact with very good results in the water samples.
14. There was discussion about the need to supply information to staff and parents so they were alerted to why the filters would be deployed on the unit. It was agreed that Jen R would work with colleagues to set out a note which would either be handed out or given as an aid memoir to the staff as there was a need for discussion with each patient and their family tonight. **Action 4: Jen Ro to set out note for review and also JRe/JenR with IC visit the ward to discuss with families and staff the current situation**.
15. JLA raised the issue that there required to be an operational group set up, led by Director for W&C with input from clinical teams, infection control, estates,

other directorates as appropriate, comms and W&C directorate to review the risk assessment given the fact that Ward 2A/2B would be out of commission longer than anticipated and therefore there required to be a medium term plan put in place as well as a weekly/ daily review of actions and safety to ensure sustainable service. This would report to chief operating officer and MD weekly in the first instance. **Action 5 KH to set up operational exec group**

16. It was also agreed that there was a need to meet directly with the consultants and senior nursing staff on Friday 11th of January to hear their views and also address the points set out in BG's email and address some of the issues which require further work:
    a. The further work on prophylaxis
    b. The signed off work to correct the 2 rooms currently out of action
    c. The information on progress on ward 2A/2B
    d. The implementation of an overarching operational group as described
    e. Confirmation of the filtration plan
17. It was agreed that the note would be shared with staff and discussions with families tonight and units placed on the ward tomorrow with further units ordered **(action 6: Jro to set out note for advising families)**
18. The group including IC, Public Health, directorate team and estates would meet with consultants, senior nursing staff and Dr Armstrong on Friday to discuss any issues and agree next steps.

**From:** Rodgers, Jennifer
**Sent:** 11 August 2022 11:57
**To:** Bustillo, Sandra
**Subject:** FW: Statement on Ward 6A Hepa Filters V3

**From:** Rodgers, Jennifer
**Sent:** 09 January 2019 19:09
**To:** Armstrong, Jennifer [redacted]; Hill, Kevin [redacted]; Best, Jonathan [redacted]; Marek, Aleksandra [redacted]; Mathers, Alan [redacted]; Redfern, Jamie [redacted]; Dell, Mark [redacted]
**Subject:** RE: Statement on Ward 6A Hepa Filters V3

Dear All,

Following discussion with Jennifer, another option is to give the following brief note to the consultants to use as an aid memoir in order to communicate to families in a consistent and open manner.

- As you will know there is an ongoing group chaired by infection control (IMT) in place since December triggered by two unusual fungal infections within the site.
- As a precaution those children most at risk were given prophylactic antifungal medication.
- There have been no further infections.
- The IMT recommended this week, as an additional measure to install portable HEPA filter units, these are machines which filter the air continuously, releasing cleaned air into the surrounding area.
- We will monitor the air quality within the unit and keep patients and families informed.
- If you would like a more detailed discussion please ask a member of staff.

Jennifer Rodgers
Chief Nurse
Children, Neonates and Young People
Royal Hospital for Children
[redacted]


***The best way to reduce harm ... is to embrace wholeheartedly a culture of learning***

**From:** Rodgers, Jennifer
**Sent:** 09 January 2019 18:38
**To:** Armstrong, Jennifer; Hill, Kevin; Best, Jonathan; Marek, Aleksandra (NHSmail); Mathers, Alan; Redfern, Jamie; Dell, Mark
**Subject:** Statement on Ward 6A Hepa Filters V3

Dear All,

As discussed today, please see below draft lines for parents, for comment.

Dear Patients and Parents,

It is our priority to ensure the best possible environment for the children and young people during the period of extended transfer to ward 6A from ward 2A/B. We are investigating two recent cases of an unusual fungal infection on the QEUH site. As a precaution we are giving those children most at risk prophylactic antifungal medications.

We are also installing portable HEPA filter units, these are machines which filter the air continuously, releasing cleaned air into the surrounding area.

We will monitor the air quality within the unit and keep patients and families informed.

If you would like a more detailed discussion please ask a member of staff.

Jennifer Rodgers
Chief Nurse
Children, Neonates and Young People
Royal Hospital for Children
[redacted]


***The best way to reduce harm ... is to embrace wholeheartedly a culture of learning***

# Briefing for Parents and Families

It is our priority to ensure a safe environment for the children and young people during the period of extended transfer to ward 6A from ward 2A/B. There is a review of two isolated cases of an unusual fungal infection within the QUEH site detected in December 2018. Control measures were taken and there have been no further cases reported.

However, as an extra precaution, we have installed portable HEPA filter units to the ward and adjoining areas. These HEPA machines filter the air continuously to give us extra reassurance for this vulnerable group of young patients.

As an additional measure those children most at risk were, and continue to be given prophylactic antifungal medication.

We continue to monitor the air quality regularly within the unit and these results are being analysed by our experts.

It is also important to note that the additional measures to ensure water quality have been put in place for the whole site (QUEH/RHC) and these have been successful. Our rigorous water quality testing is demonstrating good results alongside the ongoing use of water filtration devices.

Although our clinical staff in the ward will have already discussed the measures we have taken to ensure patients are in a safe environment we thought it would be helpful to provide you with an update to reassure you.

Infection rates are monitored carefully and remain within expected levels for this very vulnerable group of patients.

Please be assured of our continued and total commitment to delivering the best medical and nursing care in a safe environment for our patients.

Please let a member of our clinical staff know if you wish to discuss anything further and we will arrange this with a member of senior medical, nursing and infection control teams.

**From:** Rodgers, Jennifer
**Sent:** 11 August 2022 11:20
**To:** Bustillo, Sandra
**Subject:** FW: Briefing for parents and families 6a Jan 13th 2019
**Attachments:** Briefing for parents and families 6a Jan 13th 2019.docx

**From:** Rodgers, Jennifer
**Sent:** 13 January 2019 15:07
**To:** Gibson, Brenda [redacted]; Redfern, Jamie [redacted]; Mathers, Alan [redacted]; Hill, Kevin [redacted]
**Subject:** Briefing for parents and families 6a Jan 13th 2019

Dear Brenda,

This is the final brief for the families as agreed by the exec team. I will come up now to the ward.

Many thanks

Jen

Jennifer Rodgers
Chief Nurse
Children, Neonates and Young People
Royal Hospital for Children
[redacted]

***The best way to reduce harm ... is to embrace wholeheartedly a culture of learning***

**Briefing to parents – Sunday 13 January**

It is our priority to ensure a safe environment for the children and young people during the period of extended transfer to ward 6A from ward 2A/B. There is a review of two isolated cases of an unusual fungal infection within the QUEH site detected in December 2018. Control measures were taken and there have been no further cases reported.

However, as an extra precaution, we have installed portable HEPA filter units to the ward and adjoining areas. These HEPA machines filter the air continuously to give us extra reassurance for this vulnerable group of young patients.

As an additional measure those children most at risk were, and continue to be given prophylactic antifungal medication.

We continue to monitor the air quality regularly within the unit and these results are being analysed by our experts.

It is also important to note that the additional measures to ensure water quality have been put in place for the whole site (QUEH/RHC) and these have been successful. Our rigorous water quality testing is demonstrating good results alongside the ongoing use of water filtration devices.

Although our clinical staff in the ward will have already discussed the measures we have taken to ensure patients are in a safe environment we thought it would be helpful to provide you with an update to reassure you.

Infection rates are monitored carefully and remain within expected levels for this very vulnerable group of patients.

Please be assured of our continued and total commitment to delivering the best medical and nursing care in a safe environment for our patients.

Please let a member of our clinical staff know if you wish to discuss anything further and we will arrange this with a member of senior medical, nursing and infection control teams.

**From:** Cook, Claire
**Sent:** 17 January 2019 19:55
**To:** Bustillo, Sandra
**Subject:** Fwd: [ExternaltoGGC]Re: Statement

Sent from my iPhone

Begin forwarded message:

**From:** [redacted]
**Date:** 17 January 2019 at 19:53:23 GMT
**To:** "Cook, Claire" [redacted]
**Subject: [ExternaltoGGC]Re: Statement**

Thanks Claire. I might be in touch tomorrow

Sent from my iPhone

On 17 Jan 2019, at 19:14, Cook, Claire [redacted] wrote:

Hi [redacted],

Sorry it's late.

Best wishes,

Claire

Statement – The Sun

We are continuing to monitor closely the air quality of the paediatric cancer unit following two isolated cases of an unusual fungal infection within the QEUH site detected in December.

Control measures were taken at the time and there have been no further cases reported.

In the meantime, patients have been receiving prophylaxis treatment and air sampling is continuing.

Parents of the young patients are being kept up-to-date on the situation.

It remains our priority to ensure a safe environment for the children and young people in our care.

We are taking this issue seriously and an Incident Management Team are continuing to review all options for the delivery of the best medical and nursing care in a safe environment for our patients.

ENDS

Claire Cook
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

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<image001.png>

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# Information for Parents and Families

Following the information which we handed out on Sunday, we thought it would be helpful to update you on progress. It remains our priority to ensure a safe environment for the children and young people during the period of extended transfer to ward 6A from ward 2A/B.

We are continuing to monitor closely the air quality of the unit following two isolated cases of an unusual fungal infection within the QEUH site detected in December.

We have completed the installation of portable HEPA filter units to the ward. These HEPA machines filter the air continuously to give us extra reassurance for this vulnerable group of young patients. As a precautionary measure patients continue to receive prophylactic anti fungal medicine to provide protection from fungal infection. These control measures were taken at the time and there have been no further cases identified.

Following the deployment of portable HEPA filter units, we have seen a reduction in air particle counts, however not to the level anticipated. Given this result and following further investigation we identified an issue with sealant coming away from the wall in some of the shower rooms, this can lead to dampness. Our maintenance team are working hard to remedy this issue. In order to complete this remedial work patients will be moved within the ward, we apologise for the disruption this will cause.

As an additional precaution we have identified patients which due to their clinical diagnosis and ongoing treatment will be moved out with the ward.

Please let a member of our clinical staff know if you wish to discuss anything further and we will arrange this with a member of senior medical, nursing and infection control teams.

Jan 17 2019 - Information for patients and families

**Information for Parents and Families**

Following the information which we handed out on Sunday, we thought it would be helpful to update you on progress. It remains our priority to ensure a safe environment for the children and young people during the period of extended transfer to ward 6A from ward 2A/B.

We are continuing to monitor closely the air quality of the unit following two isolated cases of an unusual fungal infection within the QEUH site detected in December.

We have completed the installation of portable HEPA filter units to the ward. These HEPA machines filter the air continuously to give us extra reassurance for this vulnerable group of young patients. As a precautionary measure patients continue to receive prophylactic anti fungal medicine to provide protection from fungal infection. These control measures were taken at the time and there have been no further cases identified.

Following the deployment of portable HEPA filter units, we have seen a reduction in air particle counts, however not to the level anticipated. Given this result and following further investigation we identified an issue with sealant coming away from the wall in some of the shower rooms, this can lead to dampness. Our maintenance team are working hard to remedy this issue. In order to complete this remedial work patients will be moved within the ward, we apologise for the disruption this will cause.

As an additional precaution we have identified patients which due to their clinical diagnosis and ongoing treatment will be moved out with the ward.

Please let a member of our clinical staff know if you wish to discuss anything further and we will arrange this with a member of senior medical, nursing and infection control teams.

**From:** Cook, Claire
**Sent:** 18 January 2019 10:44
**To:** Bustillo, Sandra
**Subject:** sun

**From:** [redacted]
**Sent:** 18 January 2019 10:40
**To:** Cook, Claire
**Subject:** [ExternaltoGGC]Re: Statement

Hi Claire.

I was just wanting to check where the two cases of the fungal infection originated? Or at least to make clear whether they were in the cancer unit, or whether the treatment they are receiving is more a precaution because these kids will have weaker immune systems?

I was also wondering if it was only the cancer unit where people are receiving treatment and air sampling?

I was also wondering if there was more general guidance I could be given about the fungal infection? Does it mean two patients took unwell with fungal infections, and is it clear where it came from? Was also wondering their condition if it was two who took unwell?

Apologies for the 20 questions.

Cheers

On Thu, 17 Jan 2019 at 19:14, Cook, Claire [redacted] wrote:

> Hi [redacted],
>
> Sorry it's late.
>
> Best wishes,
>
> Claire
>
> Statement – The Sun

We are continuing to monitor closely the air quality of the paediatric cancer unit following two isolated cases of an unusual fungal infection within the QEUH site detected in December.

Control measures were taken at the time and there have been no further cases reported.

In the meantime, patients have been receiving prophylaxis treatment and air sampling is continuing.

Parents of the young patients are being kept up-to-date on the situation.

It remains our priority to ensure a safe environment for the children and young people in our care.

We are taking this issue seriously and an Incident Management Team are continuing to review all options for the delivery of the best medical and nursing care in a safe environment for our patients.

ENDS

Claire Cook

Senior Media Relations Officer

NHS Greater Glasgow and Clyde

J B Russell House

Gartnavel Royal Hospital

[redacted]

[redacted]

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**From:** Cook, Claire
**Sent:** 18 January 2019 11:49
**To:** Armstrong, Jennifer; Hill, Kevin; Rodgers, Jennifer; Inkster, Teresa; Inkster, Teresa (NHSmail)
**Cc:** Bustillo, Sandra
**Subject:** Urgent - further questions from the Sun today

**Importance:** High

Good morning,

We have had further questions in from the Sun this morning.

For clarity, here is what we sent last night:

Statement – The Sun

We are continuing to monitor closely the air quality of the paediatric cancer unit following two isolated cases of an unusual fungal infection within the QEUH site detected in December.

Control measures were taken at the time and there have been no further cases reported.

In the meantime, patients have been receiving prophylaxis treatment and air sampling is continuing.

Parents of the young patients are being kept up-to-date on the situation.

It remains our priority to ensure a safe environment for the children and young people in our care.

We are taking this issue seriously and an Incident Management Team are continuing to review all options for the delivery of the best medical and nursing care in a safe environment for our patients.

ENDS

His further questions today are:

I was just wanting to check where the two cases of the fungal infection originated?

Or at least to make clear whether they were in the cancer unit, or whether the treatment they are receiving is more a precaution because these kids will have weaker immune systems?

I was also wondering if it was only the cancer unit where people are receiving treatment and air sampling?

I was also wondering if there was more general guidance I could be given about the fungal infection?

Does it mean two patients took unwell with fungal infections?

Is it clear where it came from?

Was also wondering their condition if it was two who took unwell?

Lastly, here is our proposed statement.

Can you please if possible reply by 1.30pm?

Draft statement
We can confirm that one of the cases in December originated in the [redacted] and the other in a separate ward in the Queen Elizabeth University Hospital. Controlled measures were taken and there have been no further cases reported.

The prophylaxis medication is being given as a precaution to patients in the cancer unit because the children and young people are immuno-compromised. No other patients are being given prophylactics as the fungal infection poses no risk to people with normal immune systems.

In addition to the air sampling being taken from the cancer unit we are also carrying out air sampling of selected other areas in the Queen Elizabeth as part of our response to these two isolated cases.

Due to patient confidentiality and the small numbers involved, we are unable to comment on the condition of the two patients.

If pressed:
Sadly, the two patients, [redacted] have since passed away.

Thanks

Claire

Claire Cook
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

[redacted]

[redacted]
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**From:** Bustillo, Sandra
**Sent:** 18 January 2019 18:41
**To:** Suzanne.Hart[redacted]
**Subject:** Release on two cases of Cryptococcus
**Attachments:** Final release.doc

Suzanne

Please find attached a copy of a press release that will be getting issued to media either later this evening or tomorrow. (We are only going to issue to media once we have spoken to families, hence the question over timing of release). Jane has shared this release also with Shirley. Mark on call this weekend and I am available too.

Please get me back to me or Mark if you have any queries.

Sandra

Investigations into two cases of Cryptococcus

Investigations are continuing into two isolated cases of an unusual fungal infection within the Queen Elizabeth University Hospital.

The organism is a Cryptococcus species, which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus ***Cryptococcus***. These fungi are primarily found in soil and pigeon droppings.

A number of control measures were immediately put in place, and there have been no further cases.

We have found a likely source in a non-public area away from wards and the droppings were removed.

The small number of paediatric and adult patients who are vulnerable to this infection are receiving medication to prevent potential infection. This has proved effective.

As an additional precaution, we have also installed portable HEPA filter units in specific areas. These HEPA machines filter the air continuously to give us reassurance for this vulnerable group of patients.

During the detailed investigation, a separate issue has arisen with the sealant in some of the shower rooms.

Repairs are underway and our maintenance team are working to remedy this issue as quickly as possible with the minimum disruption.

As a further precaution, a specific group of patients are being moved within the hospital due to their clinical diagnosis and ongoing treatment.

Teresa Inkster, Lead Consultant for Infection Control, said: “Cryptococcus lives in the environment throughout the world. It rarely causes infection in humans.

“People can become infected with it after breathing in the microscopic fungi, although most people who are exposed to it never get sick from it.

“There have been no further cases since the control measures were put in place.

“In the meantime we are continuing to monitor the air quality and these results are being analysed.

“It remains our priority to ensure a safe environment for patients and staff.”

Ends.


19 January, 2019 (MD)

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We can confirm an elderly patient has sadly died, but of an unrelated cause.

A second patient has also sadly died and the factors contributing to the death are still being investigated.

Our thoughts are with the families at this distressing time.

Due to patient confidentiality we cannot share further details of the two cases.

The organism is harmless to the vast majority of people and rarely causes disease in humans.

**ENDS**

For further information either telephone [redacted] or email [redacted]


20 January, 2019 (MD)

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The investigation remains ongoing into the cause of two isolated cases of Cryptococcus at the Queen Elizabeth University Hospital.

These two cases of infection were identified in December and an Incident Management Team was formed. A likely source was identified and dealt with immediately. The small number of paediatric and adult patients who are vulnerable to this infection are receiving medication to prevent potential infection and this has proved effective.

Air sampling was carried out and HEPA filters were brought in on 10 January to specific areas before conclusive results were available. Results identifying the organism were obtained on 16 January.

Early indications suggest the filters are having a positive effect.

The organism is harmless to the vast majority of people and rarely causes disease in humans.

We are unable to comment further on the two cases due to patient confidentiality.

**ENDS**

For further information either telephone [redacted] or email [redacted]


20 January, 2019

## NHS GREATER GLASGOW AND CLYDE UPDATE

The investigation remains ongoing into the cause of two isolated cases of Cryptococcus at the Queen Elizabeth University Hospital.

These two cases of infection were identified in December and an Incident Management Team was formed. A likely source was identified and dealt with immediately. The small number of paediatric and adult patients who are vulnerable to this infection are receiving medication to prevent potential infection and this has proved effective.

Air sampling was carried out and HEPA filters were brought in on 10 January to specific areas before conclusive results were available. Results identifying the organism were obtained on 16 January.

Early indications suggest the filters are having a positive effect.

The organism is harmless to the vast majority of people and rarely causes disease in humans.

We are unable to comment further on the two cases due to patient confidentiality.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**From:** Office, Press
**Sent:** 21 January 2019 10:58
**To:** Bustillo, Sandra; Dell, Mark
**Cc:** McLaws, Ally
**Subject:** Go Radio News - latest lines and interview pls

**From:** [redacted]
**Sent:** 21 January 2019 10:37
**To:** Office, Press
**Subject:** [BlockedURL][ExternaltoGGC]Go Radio News inquiry - pigeon issue at Queen Elizabeth University Hospital

Hi Claire

As I was saying please let me know what the latest lines are on the two patients who died on Saturday who had Cryptococcus.

Please let me know what the NHSGGC response is to the issue of pigeons in the building being known about for 24 months.

Please let me know if anyone from NHSGGC is available for interview. Ideally I'd like to include some words of reassurance from NHSGGC in today's coverage.

Best regards
[redacted]

--
[redacted]

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www.twitter.com/GoRadioDab

[redacted]

**From:** Office, Press
**Sent:** 21 January 2019 10:54
**To:** Bustillo, Sandra; Dell, Mark
**Cc:** McLaws, Ally
**Subject:** STV interview request

---

**From:** [redacted]
**Sent:** 21 January 2019 09:29
**To:** Office, Press
**Subject:** [ExternaltoGGC]STV News request

Hi there,

Will anyone be available for an on camera interview today regarding the pigeon dropping infection at the QEU?

Thanks,
[redacted]

[redacted]

*Please consider the environment before printing this email*

**From:** Office, Press
**Sent:** 21 January 2019 10:57
**To:** Bustillo, Sandra; Dell, Mark
**Cc:** McLaws, Ally
**Subject:** [redacted] BBC - interview request and further questions

**From:** [redacted]
**Sent:** 21 January 2019 10:04
**To:** Office, Press
**Cc:** [redacted]
**Subject:** [BlockedURL][ExternaltoGGC]QEUH - deaths Monday

Hi all.

I'm sure you have plenty of requests for an update on the deaths at the QEUH and the Cryptococcus infection. I'll be following it today for the BBC and so would be grateful if you would keep me and [redacted] (copied in) of any updates today.

1. Would it be possible to put a bid in for Teresa Inkster? Or someone else if she is unavailable. We'd be really keen to get somebody to explain what is being done, as much as anything as a reassurance message for worried patients.
2. Is it possible to get into the hospital grounds for filming Ptc and GV's (anonymous of course)?

Also it would be very helpful for background information if you could clarify for us:

1. There is an investigation ongoing into the patient that died. Is that the child patient?
2. Was that patient an inpatient in the main hospital, rather that the Sick Children's hospital?
3. If so, why would that be – and was it because of the ward closures in the Sick Kids hospital?
4. Is there an investigation into the second patient's death given it was of unrelated causes
5. What is currently happening to ensure patients are not exposed to the infection?
6. Can you provide any information on the group of patients who have been moved to other parts of the hospital (what sort of conditions do they have, are the children or adults)
7. Does the responsibility for this fall to Multiplex? Or another contractor?

Sorry for all the questions.

I'd be very grateful if somebody could give me a call, or get back to me asap. Particularly regarding access for filming on hospital grounds and the interview request.

All the best

[redacted]

[redacted]

[redacted]

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**From:** Office Press
**To:** Bustillo Sandra; Dell Mark
**Cc:** McLaws Ally
**Subject:** Radio Clyde - Request for statement /interview
**Date:** 21 January 2019 12:00:48
**Attachments:** image001.jpg
image002.png

---

**From:** [redacted]
**Sent:** 21 January 2019 11:53
**To:** Office, Press
**Subject:** [BlockedURL][ExternaltoGGC]Request for statement /interview

HI, thanks for your time on the phone there – I was calling from Radio Clyde News, looking to see if there was an updated statement following newspaper reports today that former Health Secretary Health Secretary, Shona Robison, received concerns about the volume on pigeons and associated risks last March.

We already have the original statement which we can continue to use, I was just wondering if there would be an update.

Thanks,

[redacted]

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**From:** Office, Press
**Sent:** 21 January 2019 12:16
**To:** Bustillo, Sandra; Dell, Mark
**Cc:** McLaws, Ally
**Subject:** Radio Clyde - was issue raised in March?

**From:** [redacted]
**Sent:** 21 January 2019 12:04
**To:** Office, Press
**Cc:** DiMascio, Lesley; Docherty, Kerri-Ann; Murray, Vicky
**Subject:** [BlockedURL][ExternaltoGGC]QEUH Pigeon statement

Hi,

Could we please ask for a statement – or even better someone to speak to – about the claims concerns about pigeons were first raised in March 2018

Many thanks

[redacted]

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**From:** Office, Press
**Sent:** 21 January 2019 12:29
**To:** Bustillo, Sandra; Dell, Mark
**Cc:** McLaws, Ally
**Subject:** STV - further bid and more questions

**From:** [redacted]
**Sent:** 21 January 2019 12:21
**To:** Office, Press
**Subject:** [ExternaltoGGC]Pigeon droppings

Hi there,

[redacted] STV News.

I just wanted to clarify, if possible, a few things regarding the deaths of two people who contracted an infection linked to pigeon droppings.

When did the patients die?

Was the second patient a child?

How many patients have been moved and which wards have they been moved to?

What type of conditions do they have?

The patients that have been moved, how many are adults and how many are children?

Were any of these patients previously moved as precautionary measure previously?

Do you have any further updates today?

Will someone from the health board be speaking today?

Yours sincerely,
[redacted]

Media Statement

NHS Greater Glasgow and Clyde

21 January, 2019 (MD)

## Update on Cryptococcus cases

The investigation remains ongoing into the cause of two isolated cases of Cryptococcus at the Queen Elizabeth University Hospital.

At present, the clinical, management and infection control teams are focussed on ensuring a safe clinical environment for our patients and are actively managing this incident.

These two cases of infection were identified in December and an Incident Management Team was formed.

A likely source was identified and dealt with immediately.

The small number of paediatric and adult patients who are vulnerable to this infection have been receiving medication to prevent potential infection and this has proved effective.

Air sampling was carried out and HEPA filters were brought in on 10 January to specific areas before conclusive results were available. Early indications suggest the filters are having a positive effect.

Results identifying the organism were obtained on 16 January.

These control measures have been effective as there have been no further cases.

The organism is harmless to the vast majority of people and rarely causes disease in humans.

Dr Jennifer Armstrong, Medical Director, said: “Our thoughts are with the families of the two patients who have sadly died. An elderly patient has died of an unrelated cause while the factors contributing to the death of the second patient are being reviewed.

“We are pursuing rigorously the root causes of this incident to ensure all measures are taken to prevent it happening again.

“Health Protection Scotland are working closely with us in the investigations.

“I must stress again that this organism is harmless for the vast majority of humans and most people who are exposed to the fungus never get sick from it.

“The control measures that we have put in to place for the small number of patients who are vulnerable to the infection have been effective and there have been no further cases since December.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

21 January, 2019

[redacted] **Daily Record** - A patient took a pic, back in October and has just sent to DR. They took the same pic today.

It's at the car park at the back of neuro, described as an alcove area.

The pics show a pigeon poo covered chair. Chair still there today.

The man used to be a concierge in Glasgow and he said when they were cleaning poo years ago they were given masks and protective suits.

The alcove may be used by smokers.

Vivienne said they (Smokers?) will then be bringing it into the hospital and there will be 'spores off it'.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We recognise there are a number of pigeons around the hospital site and we have taken a number of measures including netting, spikes to help reduce this issue. It is a fact that large buildings in cities often attract a lot of birds.

Our Facilities staff will continue to use pest control measures to reduce the presence of pigeons and we are also consulting with pest control experts to seek other methods of control.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

21 January, 2019

[redacted] **SWNS -** I wanted to clarify whether 'two patients died on Saturday' at QEU, or whether 'on Saturday it was confirmed that two patients had died' - have seen both reported.
Seems like a bit of a coincidence that two people would die on the same day.
Is it possible to confirm too that one was an elderly person and the other was a child, please?
Best wishes
Sarah

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We can confirm that we confirmed on Saturday that two patients had died…NOT that they died on Saturday.

We have already confirmed that one was an elderly patient and died of an unrelated cause. An investigation continues into the factors which contributed to the second patients death. Due to patient confidentiality we are unable to confirm any further details about this patient.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

21 January, 2019

[redacted] The Sun
Hi,

I was wondering if someone from the press office may be able to confirm this afternoon whether children have been moved wards at the Queen Elizabeth Hospital and if this is as a result of the recent pigeon infection inquiry?

If we could confirm the information above we have is correct and have detail on how many children have been moved as a result of this that would be most helpful.

Thanks

## NHS GREATER GLASGOW AND CLYDE STATEMENT

A small group of adults and children have been identified as being potentially at risk because of their clinical condition. These patients have been given prophylaxis and some have been moved to another ward in the hospital as a further precaution.

**ENDS**

For further information either telephone [redacted] or email [redacted]

21 January, 2019

[redacted] **i** - Hi, I cover Scotland for the i newspaper, based in Edinburgh.
On the radio this morning Alex Neil MSP said there were suggestions that a shortage of immunology staff at the QEUH was partly to blame for the recent deaths.
Does the board have a response to this specific claim please? I'd appreciate if you could send me your latest statement on the incident as well, plus any updates you may issue today.
Thanks,
[redacted]

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Immunology were not involved in the testing this was carried out by our own microbiology team.

Cultures have to be grown and tested and this takes time but we can confirm that while we waited for conclusive results we took precautionary measures and installed HEPA filters and commenced prophylaxis treatment to the small group of patients potentially at risk.

As we have confirmed in our statement issued earlier this afternoon these controls have been effective and there have been no new cases since December.

**ENDS**

For further information either telephone [redacted] or email [redacted]

21 January, 2019
Hello
Thought it best to email this as it may be quite long!
Firstly, will there be an update on the pigeon infestation for tomorrow? Have any other patient developed symptoms? Can you give me more detail on the patients who have
been prescribed anti-biotics? How many are there now and is it adults or children?
Is there any update on the child who died – I have been told it was a child with cancer – can you confirm this? Is there any update on the work that is being done to remedy the pigeon infestation?
Have other plant rooms been checked for pigeon ingress which could be feeding other areas of the hospital with less acutely ill patients?
On a wider scale – can you tell me if Brookfield or Multiplex have been called back in to answer to some of the problems that have occurred since the new hospital was built? Surely there is some accountability?
**Specifically** - The water contamination, the panels falling off the building, the doors having to be replaced because there was a problem with the glass panels, the sewage leak in the main hospital, and now the pigeon infestation. It does seem like quite a large number of problems for a hospital that was only built 3 years ago. Surely it can't all be put down to teething problems.

Hi Claire
Just one extra component. I don't want there to any surprises in our article.
I interviewed Robert Menzies- he's a healthcare architect and was involved in putting together an exemplar design for the new hospital – along with another team of architects, engineers etc.
He claims that when Brookfield were appointed, his team were excluded and therefore he believes there was not enough "scrutiny" of potential problems with the new hospital when it was built.
He says he is not sure they would have picked up on all the problems but potentially some.
He said it's always been apparent there is a problem with pigeon infestation. He was involved in planning the Shiehallion unit at Yorkhill and says steps were taken to ensure the water supply would be safe. He said there were no problems in 20 years, therefore why are there problems with a new build.
He also questions why the public is footing the bill for new cladding if it was defective.
Thanks,

## NHS GREATER GLASGOW AND CLYDE STATEMENT

No other patients have developed symptoms of Cryptococcus infection. There have been NO cases apart from the two we have confirmed since December.

We can only confirm that we have identified small number of adult and paediatric patients who are potentially at risk of infection because of their clinical condition and they are receiving prophylaxis tr4eatment which is proving effective.

We can add no further information on either of the patients.

We have taken further steps to reduce the presence of pigeons on the QEUH site including the fitting of extra nets and spikes and we are consulting with pest control experts about possible further steps. We checked all plant rooms and identified one as a likely source. We took immediate action to deal with the risk.

Brookfield are not part of our ongoing investigations into this incident.

Other individual issues such as cladding have been or are being resolved.

**ENDS**

For further information either telephone [redacted] or email [redacted]

21 January, 2019

[redacted] **Daily Mail** - Hello, just looking for any comment on this story in the Evening Times, (link below) or any other updates today on the Cryptococcus incidents. I think we are still trying to confirm with you the dates of the deaths and whether one was a child; also the outcome of the second investigation into the death (said to be a child)

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have taken further steps to reduce the presence of pigeons on the QEUH site including the fitting of extra nets and spikes and we are consulting with pets control experts about possible further steps.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[redacted]

**From:** Director Of Communications
**Sent:** 21 January 2019 16:14
**Subject:** Core Brief - 21 January 2019

**Update on Cryptococcus cases**

In light of the continuing public interest in the cases of Cryptococcus at the Queen Elizabeth University Hospital, we wanted to share the latest update with all staff.

**Copy of media statement issued today**

The investigation remains ongoing into the cause of two isolated cases of Cryptococcus at the Queen Elizabeth University Hospital.

At present, the clinical, management and infection control teams are focussed on ensuring a safe clinical environment for our patients and are actively managing this incident.

These two cases of infection were identified in December and an Incident Management Team was formed.

A likely source was identified and dealt with immediately.

The small number of paediatric and adult patients who are vulnerable to this infection have been receiving medication to prevent potential infection and this has proved effective.

Air sampling was carried out and HEPA filters were brought in on 10 January to specific areas before conclusive results were available. Early indications suggest the filters are having a positive effect.

Results identifying the organism were obtained on 16 January.

These control measures have been effective as there have been no further cases.

The organism is harmless to the vast majority of people and rarely causes disease in humans.

Dr Jennifer Armstrong, Medical Director, said: “Our thoughts are with the families of the

two patients who have sadly died. An elderly patient has died of an unrelated cause while the factors contributing to the death of the second patient are being reviewed.

"We are pursuing rigorously the root causes of this incident to ensure all measures are taken to prevent it happening again.

"Health Protection Scotland are working closely with us in the investigations.

"I must stress again that this organism is harmless for the vast majority of humans and most people who are exposed to the fungus never get sick from it.

"The control measures that we have put in to place for the small number of patients who are vulnerable to the infection have been effective and there have been no further cases since December."

**It is important to share Core Brief with colleagues who do not have access to a computer. A full archive of printable PDFs are available on StaffNet**

**From:** Bustillo, Sandra
**Sent:** 21 January 2019 17:46
**To:** McLaws, Ally
**Subject:** Letter JG other patients
**Attachments:** Letter JG other patients.doc

Letter – other parents

Dear Parent

You will have seen recent media coverage regarding two isolated cases of an unusual infection in Queen Elizabeth University Hospital and about the ongoing control measure which have resulted in no further cases.

I wanted to write to you personally to offer reassurances that we are taking these issues very seriously and to apologise for any distress reading this media coverage may have caused you.

At present, our clinical, management and infection control teams are focused on ensuring a safe clinical environment for all of our patients and are actively managing this incident.

You'll be aware that we are investigating two isolated case of an unusual fungal infection, Cryptococcus, which is linked to soil or pigeon droppings.

These cases were identified in December and the likely source detected and dealt with immediately. We have put in additional control measures and these have proven effective as there have been no further cases.

During our detailed investigations in these isolated cases, a separate issue unfortunately arose with a sealant in a number of the shower rooms and urgent repairs are now underway to remedy this as soon as possible.

I can assure you that we are focused entirely on addressing these issues speedily and on the continued safety of our patients and their families.

If you would like to discuss this further with one of the management team, please contact xxxxx on xxxxxx who would be happy to answer any questions.

Yours

JG

IPN

Dear subscriber

You may have seen recent media coverage regarding two isolated cases of an unusual infection in Queen Elizabeth University Hospital and about the ongoing control measure which have resulted in no further cases.

I wanted to write to you personally to offer reassurances that we are taking these issues very seriously and to apologise for any distress reading this media coverage may have caused you or your family.

At present, our clinical, management and infection control teams are focused on ensuring a safe clinical environment for all of our patients and are actively managing this incident.

You may be aware that we are investigating two isolated case of an unusual fungal infection, Cryptococcus, which is linked to soil or pigeon droppings.

These cases were identified in December and the likely source detected and dealt with immediately. We have put in additional control measures and these have proven effective as there have been no further cases.

During our detailed investigations in these isolated cases, a separate issue unfortunately arose with a sealant in a number of the shower rooms and urgent repairs are now underway to remedy this as soon as possible.

I can assure you that we are focused entirely on addressing these issues speedily and on the continued safety of our patients and their families.

Yours

JG

**From:** McLaws, Ally
**Sent:** 21 January 2019 18:32
**To:** Redfern, Jamie; Hill, Kevin; Grant, Jane [Chief Exec]; Armstrong, Jennifer; Bustillo, Sandra; Dell, Mark; Rodgers, Jennifer; McLaws, Ally
**Subject:** Letter JG current patients
**Attachments:** Letter JG current patients.doc

**Importance:** High

Attached draft for parents of inpatients

Letter – current inpatients

Dear Parent

I know that you have been in regular discussion with your child's consultant about ongoing issues with relation to the wards in which your child in being cared for. I want to give you my personal reassurance that we are taking these issues very seriously and to apologise for the distress I am sure you must be feeling at what is already a difficult time.

At present, our clinical, management and infection control teams are focused on ensuring a safe clinical environment for all of our patients and are actively managing this incident.

You will be aware from your discussions with your consultant that we are investigating two isolated cases of an unusual fungal infection, Cryptococcus, which is linked to soil or pigeon droppings.

These cases were identified in December and the likely source detected and dealt with immediately. We have put in additional control measures and these have proved effective as there have been no further cases.

During our detailed investigations into these isolated cases, a separate problem was identified with sealant in a number of the shower rooms and these are urgently being repaired.

I am sorry that this has caused additional disruption to the care of your child however I can assure you that we are focused entirely on addressing these issues speedily and on the continued safety of our patients and their families.

If you would like to discuss this further with one of the management team, please contact xxxxx on xxxxxx who would be happy to answer any questions.

Yours

Jane Grant

**From:** McLaws, Ally
**Sent:** 21 January 2019 18:24
**To:** Dell, Mark; Bustillo, Sandra; McLaws, Ally; Redfern, Jamie; Hill, Kevin; Rodgers, Jennifer; Grant, Jane [Chief Exec]
**Subject:** Letter JG other patients
**Attachments:** Letter JG other patients.doc

**Importance:** High

Jane and colleagues,
This is the draft letter that could be sent to parents of patients NOT currently receiving inpatient care.
Jamie – we'll need a number to add in for anyone wanting to speak with a senior member of the team. Can you insert and share?
Jane are you okay with the content?

A second one will follow for parents of patients on the ward.

Ally

Letter – other parents

Dear Parent

You will have seen recent media coverage regarding two isolated cases of an unusual infection in Queen Elizabeth University Hospital and about the on-going control measures which have resulted in no further cases.

I wanted to write to you personally to offer reassurances that we are taking these issues very seriously and to apologise for any anxiety this situation may have caused.

At present, our clinical, management and infection control teams are focused on ensuring a safe environment for all of our patients and are actively managing this incident.

As you will have seen from media reports, we are investigating two isolated cases of an unusual fungal infection, Cryptococcus, which is linked to soil or pigeon droppings.

These cases were identified in December and the likely source detected and dealt with immediately. We have put in additional control measures and these have proven effective as there have been no further cases.

During our detailed investigations into these isolated cases, a separate issue was identified regarding shower room sealants issues that are now being urgently repaired. While this is being repaired some patients have been moved to another ward area.

Although your child is not currently receiving treatment as an inpatient and not directly affected by these ward moves I wanted to give you my personal assurance that we are focused entirely on addressing these issues speedily and on the continued safety of our patients and their families.

If you would like to discuss this further with one of the management team, please contact xxxxx on xxxxxx who would be happy to answer any questions.

Yours

Jane Grant

The first  pic shows the chair in situ in October. Pic three is the same chair in the same place but washed a bit with this morning's snow! Pic two shows the bridge between the old and new hospitals. Pic four shows the netting covering in but failing to keep pigeons out - as you can see from the couple sitting quite cosily inside it! The ground is also caked in pigeon droppings.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We recognise there are a number of pigeons around the hospital site and we have taken a number of measures including netting, spikes to help reduce this issue. It is a fact that large buildings in cities often attract a lot of birds.

Our Facilities staff will continue to use pest control measures to reduce the presence of pigeons and we are also consulting with pest control experts to seek other methods of control.

**ENDS**

For further information either telephone [redacted] or email [redacted]

NHS Greater Glasgow and Clyde

# Core brief

Tuesday, 22 January 2019

**Message from Jane Grant, Chief Executive**

Dear colleague

You will be aware that we are investigating two isolated cases of Cryptococcus at the Queen Elizabeth University Hospital.

The Cabinet Secretary for Health and Sport visited the hospital today to speak to staff, management and patients and families about the issue.

She has been reassured that patient safety is our top priority.

She has also agreed that an external expert advisor will work with us on a review of the fabric of the Queen Elizabeth University Hospital to include a review of the design, commissioning, and maintenance programme.

The Cabinet Secretary updated the Scottish Parliament on this review this afternoon. She also informed Parliament of a separate issue involving two patients who have tested positive with another fungal organism, one of whom is being treated for infection. The other does not require treatment.

The likely source has been identified and repaired but other investigations continue.

It's important to remind ourselves that the staff at the Queen Elizabeth University Hospital provide excellent care to the many thousands of patients admitted every year and that standardised mortality rates are lower than the Scottish average.

We will continue to update staff of any relevant developments.

**Are your contact details up-to-date? Click here to check**


22 January, 2019 (MD)

## NHSGGC statement on review

We were pleased to welcome the Cabinet Secretary for Health and Sport today to the hospital to speak to staff, management and patients and families.

We have reassured Ms Freeman that patient safety is our top priority.

We are pleased that an external expert advisor is to work with us on a review of the fabric of the hospital to look at issues relating to the design, commissioning, and maintenance programme.

In a separate issue, our infection control team led a meeting last night to manage a separate fungal infection totally unconnected to Cryptococcus. This involves two patients who have tested positive with another fungal organism, one of whom is being treated for infection. The other does not require treatment.

The likely source, a water leak, has been identified and repaired and other investigations continue.

It is important to recognise that the staff at the Queen Elizabeth University Hospital provide excellent care to many thousands of patients admitted every year and that the hospital has very good clinical outcomes.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[redacted]

**From:** Bustillo, Sandra
**Sent:** 24 March 2022 11:31
**To:** Clark, Andrew
**Subject:** FW: [ExternaltoGGC]Cryptococcus

**From:** NHS Greater Glasgow and Clyde [redacted]
**Sent:** 22 January 2019 18:38
**To:** Bustillo, Sandra [redacted]
**Subject:** [ExternaltoGGC]Cryptococcus


**Update from NHSGGC on Cryptococcus at Queen Elizabeth University Hospital**

You may already be aware that we are investigating two isolated cases of a rare fungal infection - Cryptococcus - at the Queen Elizabeth University Hospital.

This fungus is linked to pigeon droppings and while it is harmless to healthy humans it can pose a risk to the health of very sick people with extremely low immunity.

We want to inform you of developments today and of our continued commitment to patient safety and public confidence in the hospital.

The Cabinet Secretary for Health and Sport visited the hospital today to speak to staff, management and patients and families about the issue and she has been reassured that patient safety is our top priority.

She has also agreed that an external advisor will work with us on a review of the fabric of the Queen Elizabeth University Hospital to include a review of the design, commissioning, and maintenance programme.

The Cabinet Secretary updated the Scottish Parliament on these issues this afternoon when she stated that, “I am confident the Board have taken all the steps they should to maintain patient safety”.

She also informed Parliament of a separate issue involving two patients who have tested positive with another fungal organism, one of whom is being treated for infection. The other does not require treatment. The likely source has been identified and repaired but other investigations continue.

It is important to recognise that the staff at the Queen Elizabeth University Hospital provide excellent care to many thousands of patients admitted every year and that the hospital has very good clinical outcomes.

**Greater Glasgow and Clyde NHS Board**

[redacted]

[redacted]

www.nhsggc.org.uk

Date: 23rd January 2019
Our Ref: JG/LL02

Enquiries to: Jane Grant
[redacted]

Dear Parent

I know that you have been in regular discussion with your child's consultant about ongoing issues with relation to the wards in which your child in being cared for. I want to give you my personal reassurance that we are taking these issues very seriously and to apologise for the distress I am sure you must be feeling at what is already a difficult time.

At present, our clinical, management and infection control teams are focused on ensuring a safe clinical environment for all of our patients and are actively managing this incident.

You will be aware from your discussions with your consultant that we are investigating two isolated cases of an unusual fungal infection, Cryptococcus, which is linked to soil or pigeon droppings.

These cases were identified in December and the likely source detected and dealt with immediately. We have put in additional control measures and these have proved effective as there have been no further cases.

During our detailed investigations into these isolated cases, a separate problem was identified with sealant in a number of the shower rooms and these are urgently being repaired.

I am sorry that this has caused additional disruption to the care of your child however I can assure you that we are focused entirely on addressing these issues speedily and on the continued safety of our patients and their families.

If you would like to discuss this further with one of the management team, please contact Kevin Hill, Director of Women & Children's Services, on [redacted] who would be happy to answer any questions.

Yours sincerely

[redacted]

**Jane Grant**
**Chief Executive**
**NHS Greater Glasgow and Clyde**

**Greater Glasgow and Clyde NHS Board**

[redacted]

[redacted]

www.nhsggc.org.uk

Date: 23rd January 2019
Our Ref: JG/LL03

Enquiries to: Jane Grant
[redacted]

Dear Parent

You will have seen recent media coverage regarding two isolated cases of an unusual infection in Queen Elizabeth University Hospital, where Ward 2A has been temporarily relocated to, and about the ongoing control measures which have resulted in no further cases.

I wanted to write to you personally to offer reassurances that we are taking these issues very seriously and to apologise for any anxiety this situation may have caused.

At present, our clinical, management and infection control teams are focused on ensuring a safe environment for all of our patients and are actively managing this incident.

As you will have seen from media reports, we are investigating two isolated cases of an unusual fungal infection, Cryptococcus, which is linked to soil or pigeon droppings.

These cases were identified in December and the likely source detected and dealt with immediately. We have put in additional control measures and these have proven effective as there have been no further cases.

During our detailed investigations into these isolated cases, a separate issue was identified regarding shower room sealants issues that are now being urgently repaired. While this is being repaired some patients have been moved to another ward area.

Although your child is not currently receiving treatment as an inpatient and not directly affected by these ward moves, I wanted to give you my personal assurance that we are focused entirely on addressing these issues speedily and on the continued safety of our patients and their families.

If you would like to discuss this further with one of the management team, please contact Kevin Hill, Director of Women & Children's Services, on [redacted] who would be happy to answer any questions.

Yours sincerely

[redacted]

**Jane Grant**
**Chief Executive**
**NHS Greater Glasgow and Clyde**

A43296834

23 January, 2019

[redacted] **Daily Record -** Staff have told her they all received an email a year ago telling them not to feed pigeons. Been told air vents covers were being pulled back in order to feed pigeons. Apparently, the SSPCA was called out a handful of times but nothing changed.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have taken several measures to try to reduce the presence of pigeons on our sites; asking staff not to feed pigeons could well have been an initiative taken forward as part of this.

**ENDS**

For further information either telephone [redacted] or email [redacted]

23 January, 2019

[redacted] **The Herald –**

Can we just double check the numbers citied by Ms Freeman? She was referring a percentage infection rate at QEH and others. What is this a rate of?

Many indicators confirm that the infection rates in QEUH is within what would be expected numbers for the large, complex university hospital. Results from the last National Prevalence Survey record QEUH as having on overall rate of hospital acquired infection of 4% compared to the rate for Scotland which was 4.9%

1. Are there comparator numbers for previous years?

The only comparative data was Scotland as a whole as the hospital was not open when the previous survey was done in 2011.

2. Are there figures for HAI-related deaths at QEH and other hospitals?

Data is not collected on all HAI related deaths.

3. The Tories (see below) are linking deaths to reductions in maintenance staff. So a/ Why has this number come down? b/ Has this any bearing on HAI?

We have issued a statement on the reasons for the decrease in maintenance staff. **Please find attached**.

4. Do you have comparable figures for cleaning staff?

We have been unable to get this information today as we have been dealing with a significant volume of media enquiries. We will attempt to get this answered tomorrow.

5. On the phone, I asked about exactly when the two people died. Can you explain why we cannot know this, so our readers understand?

The identity of the patients is an issue of patient confidentiality and we are unable to give specific details that would lead to us revealing identity.

6. The Govt is suggesting both were in December. Are you confident this was the same episode/incident?

We are discussing the same incident.

7. How long did it take to realise what had happened? I./e how long between the deaths and the reports of a HAI-link to the deaths?

The timeline for the incident was confirmed in a statement issued on Monday.

8. When were board members briefed? We understand there was no mention of the case at a meeting of the acute services committee of the board on Jan 15. Why not.

The Chairman of the Board was informed within 24 hours and members of the acute Services Committee were briefed at the first available committee meeting on 15 January and this was followed up a further email briefing to all Board members on the evening of Friday 18 January.

9. Is there a line of inquiry in to whether heli ambulances spread pigeon poo when using the roof pad?

Investigation are still ongoing.

**ENDS**

23 January, 2019

[redacted] **The Times** - asking if there will be in FAI into the [redacted] death?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have not been informed of any FAI in relation to Cryptococcus.

**ENDS**

For further information either telephone [redacted] or email [redacted]

23 January, 2019

[redacted] **BBC Disclosure** - Here are our questions about Queen Elizabeth University Hospital pigeon droppings story.

1) We've had information that the health board is investigating the death of another child in relation to an infection linked to pigeon droppings. The patient was a girl who died over the New Year period. Can you confirm whether that is the case?

2) Can you confirm how many other deaths are being investigated where a cryptococcal fungal infection linked to pigeon droppings may be a contributory factor, or where the bacteria was identified in patients?

Our deadline for a response is 4.30pm today, for a story that we're planning to run this evening.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

1) No, this is not correct.
2) No other deaths or cases.

**ENDS**

For further information either telephone [redacted] or email [redacted]

23 January, 2019

[redacted] **ET -** The paper has been contacted by staff at the new Victoria saying that they have been complaining to management about pigeon dropping in the underground car park, particularly the middle stair well and it is being dragged into the hospital. They have been complaining about this for quite some time.

Been told by a source a patient in the QEUH has grown fungus on her lung and is now being tested for Cryptococcus. Can we confirm if this is the case.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Our pest control contractor has been called to respond to a complaint received yesterday about pigeon droppings in the car park at the New Victoria hospital.

We can confirm that there are no new cases of Cryptococcus.

Just to make clear, there is not a patient in the QEUH who has grown the fungus on her lung and is being tested for Cryptococcus.

**ENDS**

For further information either telephone [redacted] or email [redacted]


23 January, 2019 (MD)

Hi Lorraine, Claire,
Just wondering if NHS GGC would like to respond to the below release from the Scottish Tories?
Many thanks,
[redacted] **inews**

# Pigeon-death health board slashed maintenance staff, figures show

**Scottish Conservative and Unionist Party press office**

**Tuesday, January 23, 2019**

**FAO: all newsdesks**

**Embargo: for immediate release**

Maintenance staff at the health board at the centre of the pigeon disease death scandal have been significantly reduced in recent years, it has been revealed.

Analysis of figures by the Scottish Conservatives has shown there was an 11.5 per cent cut in maintenance and estate workers in the two years to September 2018.

And the ISD Scotland data states, at NHS Greater Glasgow and Clyde, the numbers have reduced by 18.6 per cent since 2009.

The SNP government is under increasing pressure over the deaths of two patients at the Queen Elizabeth hospital on Glasgow's southside, [redacted].

Reports today show the scale of hygiene problems at the "super hospital", which cost £850 million and was only officially opened in 2015.

The most recent statistics show there were 385 "maintenance and estate" staff in Glasgow's NHS in 2018.

That compares to 435 in 2016 and 473 in 2009.

Across Scotland, there were 1651 such workers in 2018, compared to 1749 in 2016 and 1963 in 2009.

Shadow health secretary Miles Briggs said the reduction in workers was one of many questions the SNP government had to answer about the crisis.

Ministers were informed of the deaths on December 21 last year, yet health secretary Jeane Freeman only addressed Holyrood yesterday on the matter.

**Scottish Conservative shadow health secretary Miles Briggs said:**

"Only now, after this scandal has been brought to light, is the SNP reviewing maintenance at Glasgow's super hospital.

"For Jeane Freeman to say infection control at the hospital is adequate is absolutely astonishing, particularly in the wake of two deaths, [redacted].

"That's a complacent attitude, and one which simply won't cut it with patients or staff.

"The big question is why ministers are failing to stop things like this happening in the first place, and why it takes a scandal like this for them to act.

"In Glasgow alone, dozens of maintenance staff have been cut in recent years in the lead up to this scandal.

"Across Scotland, patients will look at the nationwide reduction and wonder what other desperate consequences these SNP cuts could have.

"With that in mind, is it any wonder that – more than a month after a patient has died - we are still seeing rooms plastered in pigeon droppings?"

**Ends**

**Notes to editors:**

**ISD Scotland figures show the following number of maintenance and estate staff at NHS Greater Glasgow and Clyde in recent years:**

**September 2018 – 385**

**September 2017 – 396**

**September 2016 – 435**

**September 2015 – 432**

**September 2014 – 451**

**September 2013 – 452**

**September 2012 – 449**

**September 2011 – 453**

**September 2010 – 491**

**September 2009 – 474**

**Below are the equivalent figures for the whole of Scotland:**

**September 2018 – 1651**

**September 2017 – 1704**

**September 2016 – 1749**

**September 2015 – 1753**

**September 2014 – 1795**

**September 2013 – 1775**

**September 2012 – 1785**

**September 2011 – 1817**

**September 2010 – 1956**

**September 2009 – 1964**

**Source:** https://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2302#2302

## NHS GREATER GLASGOW AND CLYDE RESPONSE TO CONSERVATIVE PARTY MEDIA RELEASE

NHS Greater Glasgow and Clyde (NHSGGC) has invested heavily in new buildings during a 10 year programme of major modernisation.

This has seen the delivery of four brand new hospitals, a new major cancer centre and several new build health and social care centres.

All new buildings are fitted with the very latest modern plant and building management systems which require lower levels of maintenance.

The funding arrangements for some of these major new-builds has seen the responsibility for maintenance transferred outwith NHSGGC. For those we are

still responsible for, we require fewer staff due to lower maintenance requirements.

During this period of modernisation we have also been training our workers to be multi-skilled technicians rather than single trade workers.

These multi-skilled technicians are employed at a higher grade than a single trades worker.

This investment plan and staff training is common across all of the NHS throughout the UK and in throughout public and private business and industry.

**ENDS**

For further information either telephone [redacted] or email [redacted]

24 January, 2019

[redacted] **SWNS -** Would you like to comment on allegations made by an unnamed source at QEUH on the pigeon dropping story.

Specifically:

- [redacted] who had been moved to an adult area due to contamination of water supply in children's hospital

- That the [redacted] room was not fitted with a HEPA filter

- That other rooms 'should have been fitted with HEPA filter but weren't'

- That the other patient who died was [redacted]

- That the [redacted] room was "filthy" with bird feathers and droppings, which was known about on Dec 23

I've also seen this line and was seeking clarification on it --

NHS Greater Glasgow and Clyde said a “small crack” was identified in the wall of the hospital’s plant room – identified as the source of the infection – and spores from the droppings “may have entered the air supply via the ventilation system."

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We cannot give out specific details about either patient involved, however we can confirm that a report in a newspaper connecting Grampian to one of the patients is incorrect.
You ask about a patient room being “filthy” with bird feathers and droppings. The answer to this is absolutely not. The reference to evidence of bird droppings was to a presence in a machine room that is not a patient or public accessible area.
We have installed portable HEPA filters in all the rooms identified as requiring them as part of the management of the incident.
Your last point can be clarified by our statement that was issued to the Evening Times last night: Whilst there was no gap visible by the naked eye from the floor of the plant room we still regarded the plant room as a potential source. We decontaminated the room and on further investigations found a small gap which was sealed off.
**ENDS**

24 January, 2019

[redacted] **Daily Record -** As discussed, here is Labour's line from FMQs. Please confirm if cleaning staff have now been formally briefed, or if there is a plan to do so.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Senior members of our Facilities team are an integral part of the Incident Management Team and we can confirm that Domestic Services staff at QEUH directly involved were briefed by Domestic Services Supervisory staff on the current situation to ensure that appropriate infection control measures have been and continue to be fully implemented.

**ENDS**

For further information either telephone [redacted] or email [redacted]

24 January, 2019

[redacted] **STV** - At FMQs, Richard Leonard said facilities management workers staff (including cleaners) haven't been briefed by infection control (as of last night).

Is that the case?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Senior members of our Facilities team are an integral part of the Incident Management Team and we can confirm that Domestic Services staff at QEUH directly involved were briefed by Domestic Services Supervisory staff on the current situation to ensure that appropriate infection control measures have been and continue to be fully implemented.

**ENDS**

For further information either telephone [redacted] or email [redacted]

24 January, 2019

[redacted] **Sunday Post -** For illustrative purposes, I am on to ask if a copy of some kind of map/layout of floor 12 at the Queen Elizabeth Hospital in Glasgow would be available.

Floor 12 has been mentioned by the health secretary this week during the ongoing story about the pigeons infection and we would like to use an illustration of the plan/layout for this floor.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

You'd asked for 'some kind of map/layout of floor 12'. There is no such single document. Our drawings are large and complex and there are a great many plans for that single floor. We are unable to provide you with these detailed plans for security reasons.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

25 January, 2019

[redacted] **The Sun** - We understand that [redacted] who passed away as a result of the illness relation to pigeon droppings was being treated in hospital for [redacted]. Was the air in the ward in which [redacted] was being treated being filtered?

If not, why not?

And if the air was being filtered by a specialised system - usually HEPA - was this being maintained and monitored?

If this was being done routinely - why did the pigeon problem go unnoticed?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

This information contains patient confidential information and so we are unable to confirm any details other than to confirm that are pursing rigorously the root causes of this incident to ensure all measures are taken to prevent it happening again.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Friday, January 25, 2019 (LD)

[redacted] **Sunday Sun** - see email in press office in box

**NHS GREATER GLASGOW CLYDE RESPONSE TO QUESTIONS**

1 - Dr Teresa Inkster and a colleague I'm told resigned from their infection role positions in 2015 in a resignation letter in anger at the hospital's approach to infections. They didn't bring up pigeons, but I'm told complained about facilities, especially the paediatric ward and provisions for patients with infectious disease and also about being bullied and undermined. I think the feeling is that complaints they raised are pertinent to what happened in this tragedy and the attitude to maintenance still isn't good enough. Dr Inskter was convinced back to a more senior role months after, and is obviously more senior now, so was looking for a response to this

We never comment on personal matters regarding members of our staff. We have an open and robust system for considering staff concerns or areas for improvement.
We have a highly experienced infection control team, including specially trained doctors and nurses. Clinical environments are assessed on an ongoing basis with actions taken to assess risks and where appropriate, put in place measures to ensure safe patient care.

A key outcome of any incident of infection is to provide opportunities for learning and improvement and this process is continuous.

The Queen Elizabeth University Hospital admits more than 100,000 patients a year. The hospital's infection rates and lower than the Scottish average. We have some of the most experienced clinical teams in the country and effective infection management and control is a top priority.

2 - I'm told parents of cancer kids had a meeting with bosses at the hospital on Tuesday about the whole situation, and to vent their anger about everything. I'm told some are considering legal action. Just to flag up I will be mentioning this

Our clinical teams have been having regular discussions with the relatives of patients who are vulnerable to infection because of their low immunity to explain the precautionary measures that have been put in place. The Chief Executive has also written to the families to apologise for the distress being caused and to offer her

personal assurances that we are taking the issue very seriously. The Cabinet Secretary also met some of the families when she visited the hospital on Tuesday.

3 - Story also mentions that parents are scared to go public about their concerns because they're worried it will affect their treatment. Also a parent stating the tragedy might never have been made public unless they'd brought it to media's attention, given child died weeks previously

We can absolutely assure your readers that patient safety and the treatment of our patients is always our top priority irrespective of any other factors. In the recent case of these two patients it was NHSGGC, not a relative, who put this into the public domain.

4 - Also mentions two families bringing legal action against the health board over unrelated complaints. [redacted]

We cannot comment on on-going legal claims.

[redacted]

**From:** Director Of Communications
**Sent:** 25 January 2019 13:57
**Subject:** FW: Core Brief - 25 January 2019 (Appointment of new Chief Operating Officer and a Thank you from the Chief Executive)

**New Chief Operating Officer appointed**

I am pleased to inform you that, following a competitive recruitment process, Jonathan Best has today been appointed Chief Operating Officer.

Jonathan is already well known to many of you and has many years of experience at a senior level including as Chief Executive of the former Yorkhill NHS Trust and more recently as Director of North Glasgow Division.

His substantive appointment as Chief Operating Officer follows a period as Interim Chief Operating Officer and Executive Lead for our Moving Forward Together Programme.

I am sure you will join me in wishing Jonathan well in his new role.

**Thank you**

On Tuesday I shared with you the outcome of a meeting the Chairman and I and some of my senior team had with the Cabinet Secretary to discuss issues surrounding the on-going investigations into the two cases of Cryptococcus at the Queen Elizabeth University Hospital.

The days since have continued to see fairly intense political and media commentary which undoubtedly has an impact on all of us as well as our patients.

When one media organisation issued a Tweet asking people to share their experiences of the QEUH the overwhelming response was of praise for the staff and for the care and services they received when they needed it.

This response came as no surprise to me as I know that you are all committed to our patients and provide excellent care and support to patients and their families.

At times such as this it is important not to lose sight of the quality of your work and the high regard people have for staff right across NHSGGC.

**It is important to share Core Brief with colleagues who do not have access to a computer. A full archive of printable PDFs are available on StaffNet**

25 January, 2019

[redacted] **Daily Mail -** Hello, just looking for any comment on this story

'MONSTER HOSPITAL' AT CENTRE OF PIGEON DROPPINGS PROBE SLAMMED BY ARCHITECT

[redacted] Political Reporter, Press Association Scotland

An architect has criticised the design of Scotland's flagship hospital, where an infection linked to pigeon droppings contributed to the death [redacted].

[redacted] was one of two patients who died at the Queen Elizabeth University Hospital in Glasgow after contracting the disease, although the second death was not connected to the infection.

Health Secretary Jeane Freeman has ordered a review of the design, build, handover and maintenance of the £842 million Queen Elizabeth University Hospital in Glasgow, which opened in 2015.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The Cabinet Secretary has already announced a review into the design, commissioning, construction and maintenance of the Queen Elizabeth University Hospital and we understand that terms of reference will be announced today.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

25 January, 2019

[redacted] **PA -** below is what we're planning to quote architect Malcolm Fraser on, from his interview on Good Morning Scotland earlier.

Speaking on the BBC's Good Morning Scotland programme, architect Malcolm Fraser said the 12-storey "monster hospital" is not a "happy building" and bigger places tend to "cut corners".

He said: "In this case it appears to be an issue with the mechanical ventilation and a gap that's been left that pigeons can get in.

"Mechanical ventilation ducts are perfect places for cooking up virulent nasties, basically."

He said hospitals tended to be built with mechanical ventilation but it was possible to design them with natural ventilation.

"If the building's not built perfectly we have these places where disease can come in and problems can happen," Mr Fraser added.

"At some point we're going to have to understand that making buildings machines is not conducive to health and recovery."

He said the inquiry should start with how the hospital was built and the processes in place.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The Cabinet Secretary has already announced a review into the design, commissioning, construction and maintenance of the Queen Elizabeth University Hospital.

You may wish to contact Scottish government for further information.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

25 January, 2019

[redacted] **Daily Record -** I am just doing a piece on this re: a clean up earlier today. Just looking for a comment. It's for tomorrow's paper.

---
A team of masked cleaners worked on the area around the neurology building at the Queen Elizabeth University Hospital in Glasgow early yesterday morning.
A chair previously pictured covered with bird droppings appeared to have been removed.
An eyewitness said: “I was in early and saw them carrying out some sort of deep clean of the droppings. They were suited and booted and had masks over their face, presumably to stop them inhaling anything nasty.
“But who knows what they may have stirred up into the air just as a lot of staff are starting to come in. They were there when it was dark and as soon as it started getting light, they were away.
“It’s as if they wanted to do it under the cover of darkness so that they didn’t cause any panic and weren’t seen by the folk coming in.”
Greater Glasgow and Clyde Health Board admitted they have called pest control contractors to another four of their hospitals - Glasgow Royal Infirmary, Gartnavel General, New Victoria and Stobhill.

**ADDITIONAL**: Is the person wrong? There were no cleaning teams there this morning?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The chair was removed three days ago and the area has since been cleaned. We confirmed this to the Labour MSP, Monica Lennon, on Twitter on Wednesday.

**ADDITIONAL** - The chair was reported to facilities at 6pm on Tuesday and had been removed by 9pm that evening.

**ENDS**

For further information either telephone [redacted] or email [redacted]

25 January, 2019

[redacted] **Sunday Post**

## NHS GREATER GLASGOW AND CLYDE STATEMENT

1) Has NHSGGC made a complaint or is NHSGGC taking legal action against Brookfield Multiplex?

Answer: No.

2) Can you tell me whether the assertjion by the ET source that an air filter was not fitted in the [redacted] room is accurate?

Answer: This information contains patient confidential information and we are not commenting about a report in another newspaper.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

Friday, January 25, 2019 (LD)

[redacted] **BBC** - Does NHS Glasgow use birds of prey to help keep down or scare off the pigeon population? Or has it employed a company which uses birds of prey to do this? If so, when and was it successful?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have taken a number of measures including netting, spikes to help reduce this issue. It is a fact that large buildings in cities often attract a lot of birds.

Our Facilities staff will continue to use pest control measures to reduce the presence of pigeons and we are also consulting with pest control experts to seek other methods of control.

**ENDS**

For further information either telephone [redacted] or email [redacted]

25 January, 2019

[redacted] **Herald on Sunday** - So I just wanted to check – Pigeon droppings – the pigeons came in through some sort of crack or gap in the roof, did their thing, and this ended up filtering down into the hospital floor in some way? Or did the pigeons get into the actual plant room itself? I'm just unclear on that part of how it actually worked.

Also – You've not said [redacted]. Just wondering what the reason for this is.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The organism is a Cryptococcus species, which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus ***Cryptococcus***. These fungi are primarily found in soil and pigeon droppings.

A number of control measures were immediately put in place, and there have been no further cases.

We have found a likely source in a non-public area away from wards and the droppings were removed.

Re the two patients: we can't go into any details about the patients and we are unable to give out details as this would breach patient confidentiality.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Saturday, January 26, 2019 (LD)

[redacted] **Mail on Sunday**

## NHS GREATER GLASGOW AND CLYDE RESPONSE

[redacted] so we are unable to issue a condition check on he patient. The other patient is not infected (the organism "colonised" which means detected on the ski) and therefore requires no treatment for this.

1. *How many patients, aside from the two we know about, have contracted Cryptococcus at premises under the control of NHS Greater Glasgow and Clyde?*

None.

2. *How many patients, aside from the two we know about, have died after contracting Cryptococcus at premises under the control of NHS Greater Glasgow and Clyde?*

Apart from the two cases we confirmed there have been no other cases.

3. *What measures have NHS GGC put in place to stop the spread of the fungus and to prevent patients from becoming infected?*

Hepa filters and prophalixis

4. *What support has NHS GGC given the* [redacted] *who passed away because of the fungus*

We are supporting a family with one of our experienced outreach nursing staff.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Saturday, January 27, 2019 (LD)

[redacted] **Herald on Sunday**

## NHS GREATER GLASGOW AND CLYDE RESPONSE

As discussed, I'm working on a story about the hospital for tomorrow's paper and want to put a few things to you:

Q. I know the other fungal infection being treated at the hospital is Mucorales, and is another very rare fungus. It was classed as HIIAT red, and according to your guidelines a statement should have been released about this within 24 hours. It wasn't released, at all. There was only mention of it in public by Jeane Freeman on 22nd Jan – a week after it was identified and your medical staff notified about it. Why was this not announced immediately after the infection was discovered, and why was the seriousness of the infection not revealed?

**A**. The IMT met on Monday 21st and a proactive release was issued on Tuesday 22nd on the two mucor cases.

NHSGGC report incidents and outbreaks in accordance with Chapter 3 of the National Infection Control manual. All outbreak and incidents are assessed and reported through a HIIORT, (Hospital Incident and Outbreak Reporting Template), and any assessed as amber or red are reported to Health Protection Scotland after the Incident Management Team (IMT) have met. All incidents and outbreaks assessed as green are reported to HPS weekly.

The National Manual stipulates that for amber and red incidents a holding press statement should be prepared and that the decision to go proactive is at the discretion of the chair of the IMT. In deciding this a number of factors, including patient confidentially, are considered."

Internally within the Board all Outbreaks and Incidents are reported on a weekly basis to senior clinicians and managers. The NHS Board and Infection Control Committees receive regular report reports on HAI metrics including outbreak and incidents. The Board and Infection Control Committee reports are placed on the NHSGGC website.

The Board's systems and processes for surveillance and reporting of incidents and outbreaks was reviewed in January 2018 by Health Protection Scotland and deemed compliant.

Q. Can you also tell me exactly where the infection came from – I believe the Sun say it was from water, but I need more detail on this. Where was the source how did the fungus get in to the water in the first place and what was done to fix this, and when? I understand the infected patient is in critical care unit and not responding well to treatment, is this still the case?

**A.** The investigations continue but is not connected to the domestic water system. [redacted] The other patient is not infected (the organism "colonised" which means detected in the skin) and therefore requires no treatment for this.

Q. The cryptococcus infection – again should the public not have been informed of this sooner than they were? If it was first identified in November, again according to your guidelines something of this seriousness should have been communicated to the public rapidly, not two months later.

**A.** The Incident Management Team (IMT) on cryptococcus convened on December 20th to begin a detailed investigation into two cases of this rare infection, to put in place appropriate control measures and to carry out further air quality testing.

Thereafter there were regular meetings with a focus on ensuring safe patient care and control measures were in place as well as an active investigation underway with results awaited.

On January 16th , air sampling results, taken in the previous week, confirmed traces of Cryptococcus, the IMT reconvened, and, in line with the protocol for managing such of such incidents, agreed that NHS GGC would issue a public statement.

Q. I have some experts saying that due to the sheer number of very rare serious infections happening at the hospital, there is something 'fundamentally flawed' with it. I have comments from an expert stating that these infections, even in immunocompromised patients, should not be happening. Hospitals are full of immunocompromised patients, everywhere, and there has never been a cryptococcus outbreak in a hospital setting before in the UK, and only one other – in Arizona in 2004.

**A.** To ensure due diligence, GGC are actively reviewing data on fungal infections in collaboration with Health Protection Scotland and this work is at an early stage.

ENDS

For further information either telephone [redacted] or email [redacted]

**From:** Dick, Lorraine
**Sent:** 28 January 2019 13:54
**To:** Harkness, Anne; Hill, Kevin
**Cc:** Redfern, Jamie; Rodgers, Jennifer; Gay, Fiona; Scott, Lynne
**Subject:** Herald Article

**Importance:** High

The Herald and Evening Times are both running articles today on claims that children at the RHC are being instructed not to drink the tap water. We in turn have had a number of other media outlets asking for our comment and we have issued the following. Is it possible this can be shared with your teams so the rumours are very quickly dispelled.

Thanks everyone.
Lorraine

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON TAP WATER AT QEUH

The claim that all children are not allowed to drink tap water is totally untrue.

We have not instructed either staff or patients not to drink the tap water at the Royal Hospital for Children (RHC) or any other building on the QEUH campus.

We have a normal stock of bottled water which is provided to patients who are immuno-compromised or any other patient who requests it and demand is no higher than usual.

The domestic water supply is tested on a regular basis and meets the drinking water quality standard for domestic water supplies.

**ENDS**

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]
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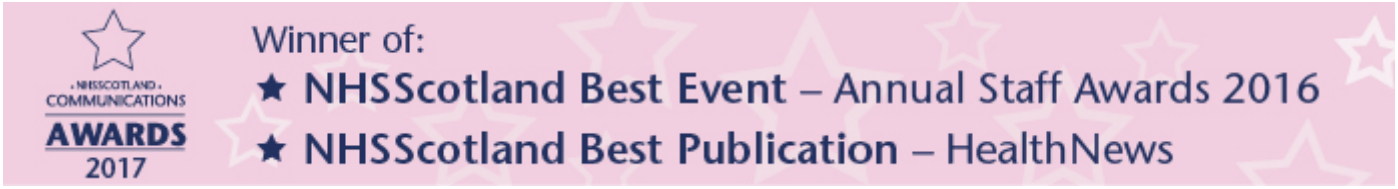
NHSSCOTLAND
COMMUNICATIONS
AWARDS
2017
Winner of:
★ NHSScotland Best Event – Annual Staff Awards 2016
★ NHSScotland Best Publication – HealthNews

**From:** Dick, Lorraine
**Sent:** 30 January 2019 10:59
**To:** Powrie, Ian; Steele, Tom
**Subject:** RE: Herald Article

Apologies Ian that I never got back to you last night. Got caught up with other issues. No concerns with your suggested response.

Best wishes
Lorraine

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

[redacted]

[redacted]
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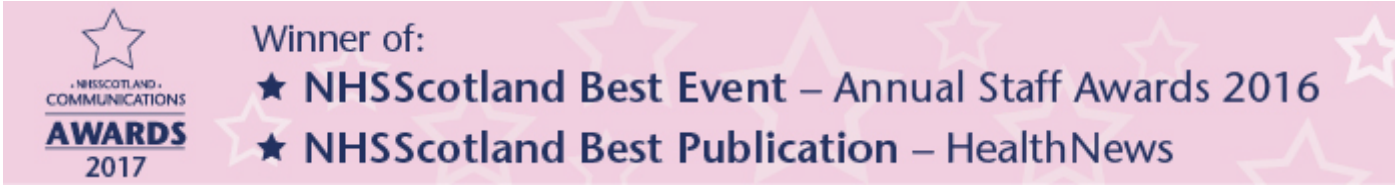


**From:** Powrie, Ian
**Sent:** 29 January 2019 17:31
**To:** Steele, Tom; Dick, Lorraine
**Subject:** RE: Herald Article

Lorraine,

I would propose the following response.

***The RHC water IMT have previously advised that the water is of drinking water quality, this position has been notified to all wards & departments by the RHC management team.***

Let me know if this is acceptable for issue to Ben.

Regards

Ian

[redacted]
***Deputy General Manager (Estates)***

Queen Elizabeth University Hospital Campus
Property, Procurement & Facilities Management Directorate
Facilities Corporate Services Dept
[redacted]

[redacted]

SUSTAINABILITY ACTION
Our NHS Our People Our Planet



---

**From:** Steele, Tom
**Sent:** 29 January 2019 17:24
**To:** Dick, Lorraine
**Cc:** Powrie, Ian
**Subject:** Re: Herald Article

Lorraine can you review beforehand, less is more here with Ben.

Regards, Tom

Sent from my iPhone

On 29 Jan 2019, at 17:22, Dick, Lorraine <[redacted]> wrote:

> Hi Ian
>
> If you could respond that would be helpful. Thank you for all your help today.

Bets wishes.
Lorraine

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

[redacted]

[redacted]
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**From:** Powrie, Ian
**Sent:** 29 January 2019 17:22
**To:** Dick, Lorraine; Steele, Tom
**Subject:** RE: Herald Article

Hi Lorraine,

This would have been previously advised by the ICD (Teresa Inkster) at the RHC IMT, for dissemination to all wards, I have discussed with Teresa and she confirmed this is the case. I have confirmed this with Jamie Redfern who will liaise directly with Ben on this matter.

Would you like to respond to Ben on this or would you like me to respond?

Regards

Ian

[redacted]
***Deputy General Manager (Estates)***

Queen Elizabeth University Hospital Campus
Property, Procurement & Facilities Management Directorate
Facilities Corporate Services Dept
[redacted]

[redacted]

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Think SAFE ENVIRONMENT.. ....please help cut carbon.....don't print this email unless you really have to.....and remember to recycle.....SAVE ENERGY - THE EASY WAY TO SAVE MONEY!

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**From:** Dick, Lorraine
**Sent:** 29 January 2019 16:50
**To:** Steele, Tom; Powrie, Ian
**Subject:** FW: Herald Article

Dear Tom and Ian

Can you provide advise to Ben Reynolds below from ward 3c on tap water as requested below.

Best wishes.
Lorraine

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

[redacted]

[redacted]
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**From:** REYNOLDS, BEN
**Sent:** 29 January 2019 16:46
**To:** Graham, Fiona; Dick, Lorraine
**Cc:** Ramage, Ian
**Subject:** RE: Herald Article

Hi Lorraine,

Just had the below forwarded to me.

All the medical staff on ward 3C were indeed under the impression that the tapwater was not appropriate for consumption, and have been using bottled water since the initial identification of bacterial contamination several months ago. There was no communication that this was no longer the case, and so standing advice to ward in-patients has been exactly as reported in the Herald.

Can you advise (or indicate who can) when the advice was changed, so that we can review where our communication has failed in this regard?

Many thanks,

Ben Reynolds

---

**From:** Graham, Fiona
**Sent:** 29 January 2019 16:42
**To:** REYNOLDS, BEN
**Subject:** FW: Herald Article
**Importance:** High

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**From:** Maclean, Anne
**Sent:** 29 January 2019 16:31
**To:** Graham, Derek; McWhinnie, Claire; Wallach, Peri; Pilkington, Charlene; Gallant, Allyson; White, Monica; Adam, Sarah; Bremner, Sarah; Buchanan, Elaine; Buttle, Janette; Cairns, Lorraine; Cardigan, Tracey; Cochrane, Barbara; Cooper, Caroline; Crocker, Julie; Devine, Jane; Duncan, Hazel; Flannagan, Laura; Graham, Fiona; Graham, Jane; Hay, Jacqueline; Johnstone, Nicola; Law, Vicky; Livingstone, Jennifer; Maclean, Anne; Maclean, Kirsty; Mcdermott, Lucy; Mcguinness, Orlaith; Mochrie, Rachel; Morrice, Anne; Mulcahy, Rachel; Neill, Esther; Pollock, Morven; Rankin, Emma; Rennie, Carla; Sinclair, Lyndsay; Woods, Fiona
**Subject:** FW: Herald Article
**Importance:** High

FYI

anne

**Anne Maclean**
**Dietetic Services Manager -Paediatrics**
**NHSGGC**

[redacted]

---

**From:** Robertson, Lynne
**Sent:** 29 January 2019 15:07
**To:** Prince, Karen; Armstrong, Allison; Blair, Andrea; Brown, Kim; Buchanan, Irene; Dixon, Melville; Fraser, Karen; Gallagher, Judith; Grant, Alison; Harper, Lorraine; Harrigan, Jim; Hedley, Claire; Horsburgh, Gillian; Johnson, Elinor; Lawson, Lynda; Lilley, Stuart; Maclean, Anne; Mccrossan, Elaine (NHSmail); Morley, Andrew; Pirie, Mary; Sheila Shepherd
**Subject:** FW: Herald Article
**Importance:** High

fyi

**From:** Redfern, Jamie
**Sent:** 28 January 2019 17:28
**To:** Hutton, Melanie; Robertson, Lynne
**Cc:** Rodgers, Jennifer; Hill, Kevin
**Subject:** FW: Herald Article
**Importance:** High

For onward circulation please

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**From:** Dick, Lorraine
**Sent:** 28 January 2019 13:54
**To:** Harkness, Anne; Hill, Kevin
**Cc:** Redfern, Jamie; Rodgers, Jennifer; Gay, Fiona; Scott, Lynne
**Subject:** Herald Article
**Importance:** High

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We have a normal stock of bottled water which is provided to patients who are immuno-compromised or any other patient who requests it and demand is no higher than usual.

The domestic water supply is tested on a regular basis and meets the drinking water quality standard for domestic water supplies.

**ENDS**

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]
[redacted]
[redacted]
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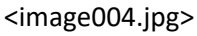

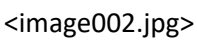

**From:** Powrie, Ian
**Sent:** 27 March 2019 15:45
**To:** Dick, Lorraine; Steele, Tom
**Cc:** Inkster, Teresa (NHSmail); Inkster, Teresa
**Subject:** RE: Herald Article
**Attachments:** RE: Herald Article

Tom,

The status reported as per the attached mail chain, I provided a statement that you requested was reviewed by Lorraine, basically you advise less is more.
I did not receive a response from Lorraine on this and therefore did not issue.

Teresa Inkster confirmed in January that ICD\ICT had issued a formal communication to all departments that the water was of wholesome drinking quality.
I have tried to contact Teresa to obtain a copy of this notice? But have been unable to make contact.

Jamie Redfern has confirmed that all wards have been advised of this several times via the RHC huddle.

Can you and or Loraine advise if you are happy for me to issue my initial statement to Ben? If so I would suggest that this is followed up by a hospital wade statement via Adults & RHC management structures.

Regards

Ian

[redacted]
***Deputy General Manager (Estates)***

Queen Elizabeth University Hospital Campus
Property, Procurement & Facilities Management Directorate
Facilities Corporate Services Dept
[redacted]

[redacted]

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**From:** Dick, Lorraine
**Sent:** 27 March 2019 15:33
**To:** Steele, Tom; Powrie, Ian
**Cc:** Inkster, Teresa (NHSmail); Inkster, Teresa
**Subject:** RE: Herald Article
**Importance:** High

Hi Tom

My understanding was that this was already dealt with through Ian and the IMT as I raised it at one of the IMT's and discussed it with Ian. Can I have confirmation that communication was issued. Perhaps it was missed by Ben?

Best wishes
Lorraine

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]
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---

**From:** Steele, Tom
**Sent:** 27 March 2019 09:49
**To:** Powrie, Ian
**Cc:** Dick, Lorraine
**Subject:** Re: Herald Article

Ian can you confirm our position on this please ASAP, any reply needs to go through Comms

Regards, Tom

Sent from my iPhone

On 27 Mar 2019, at 09:27, REYNOLDS, BEN [redacted] wrote:

> Hi Tom,
>
> Just chasing up the below enquiry. I am keen that we ensure our lines of communication are appropriate.
>
> Ben
>
> ---
>
> **From:** Dick, Lorraine
> **Sent:** 29 January 2019 16:52
> **To:** REYNOLDS, BEN; Graham, Fiona
> **Cc:** Ramage, Ian; Steele, Tom; Powrie, Ian
> **Subject:** RE: Herald Article
>
> Dear Ben
>
> I have passed your email to Tom Steele, our Director of facilities, Capital and Procurement, and Ian Powrie, Deputy General Manage for the QEUH and asked them to provide advise to you as you have requested.
>
> They are best placed to answer your questions. Hope this is helpful.
>
> Best wishes.
> Lorraine
>
> ---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

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**From:** REYNOLDS, BEN
**Sent:** 29 January 2019 16:46
**To:** Graham, Fiona; Dick, Lorraine
**Cc:** Ramage, Ian
**Subject:** RE: Herald Article

Hi Lorraine,

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Can you advise (or indicate who can) when the advice was changed, so that we can review where our communication has failed in this regard?

Many thanks,

Ben Reynolds

---

**From:** Graham, Fiona
**Sent:** 29 January 2019 16:42
**To:** REYNOLDS, BEN
**Subject:** FW: Herald Article
**Importance:** High

---

**From:** Maclean, Anne
**Sent:** 29 January 2019 16:31
**To:** [redacted]
**Subject:** FW: Herald Article
**Importance:** High

FYI

anne

**Anne Maclean**
**Dietetic Services Manager -Paediatrics**
**NHSGGC**

[redacted]

**From:** Robertson, Lynne
**Sent:** 29 January 2019 15:07
**To:** [redacted]
**Subject:** FW: Herald Article
**Importance:** High

fyi

---

**From:** Redfern, Jamie
**Sent:** 28 January 2019 17:28
**To:** Hutton, Melanie; Robertson, Lynne
**Cc:** Rodgers, Jennifer; Hill, Kevin
**Subject:** FW: Herald Article
**Importance:** High

For onward circulation please

---

**From:** Dick, Lorraine
**Sent:** 28 January 2019 13:54
**To:** Harkness, Anne; Hill, Kevin
**Cc:** Redfern, Jamie; Rodgers, Jennifer; Gay, Fiona; Scott, Lynne
**Subject:** Herald Article
**Importance:** High

The Herald and Evening Times are both running articles today on claims that children at the RHC are being instructed not to drink the tap water. We in turn have had a number of other media outlets asking for our comment and we have issued the following. Is it possible this can be shared with your teams so the rumours are very quickly dispelled.

Thanks everyone.
Lorraine

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Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

[redacted]

[redacted]
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<image002.jpg>

**From:** Powrie, Ian
**Sent:** 29 January 2019 17:31
**To:** Steele, Tom; Dick, Lorraine
**Subject:** RE: Herald Article

Lorraine,

I would propose the following response.

***The RHC water IMT have previously advised that the water is of drinking water quality, this position has been notified to all wards & departments by the RHC management team.***

Let me know if this is acceptable for issue to Ben.

Regards

Ian

[redacted]
***Deputy General Manager (Estates)***

Queen Elizabeth University Hospital Campus
Property, Procurement & Facilities Management Directorate
Facilities Corporate Services Dept
[redacted]

[redacted]

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**From:** Steele, Tom
**Sent:** 29 January 2019 17:24
**To:** Dick, Lorraine

**Cc:** Powrie, Ian
**Subject:** Re: Herald Article

Lorraine can you review beforehand, less is more here with Ben.

Regards, Tom

Sent from my iPhone

On 29 Jan 2019, at 17:22, Dick, Lorraine [redacted] wrote:

> Hi Ian
>
> If you could respond that would be helpful. Thank you for all your help today.
>
> Bets wishes.
> Lorraine
>
> ---
>
> Lorraine Dick
> Senior Media Relations Officer
> NHS Greater Glasgow and Clyde
> J B Russell House
> Gartnavel Royal Hospital
> [redacted]
>
> [redacted]
>
> [redacted]
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>
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> <image001.jpg>
>
> <image002.jpg>

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**From:** Powrie, Ian
**Sent:** 29 January 2019 17:22
**To:** Dick, Lorraine; Steele, Tom
**Subject:** RE: Herald Article

Hi Lorraine,

This would have been previously advised by the ICD (Teresa Inkster) at the RHC IMT, for dissemination to all wards, I have discussed with Teresa and she confirmed this is the case. I have confirmed this with Jamie Redfern who will liaise directly with Ben on this matter.

Would you like to respond to Ben on this or would you like me to respond?

Regards

Ian

[redacted]
***Deputy General Manager (Estates)***

Queen Elizabeth University Hospital Campus
Property, Procurement & Facilities Management Directorate
Facilities Corporate Services Dept
[redacted]

[redacted]

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---

**From:** Dick, Lorraine
**Sent:** 29 January 2019 16:50
**To:** Steele, Tom; Powrie, Ian
**Subject:** FW: Herald Article

Dear Tom and Ian

Can you provide advise to Ben Reynolds below from ward 3c on tap water as requested below.

Best wishes.
Lorraine

---

Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital
[redacted]

[redacted]

[redacted]
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**Sent:** 29 January 2019 16:42
**To:** REYNOLDS, BEN
**Subject:** FW: Herald Article
**Importance:** High

---

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**Sent:** 29 January 2019 16:31
**To:** [redacted]
**Subject:** FW: Herald Article
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FYI

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**Anne Maclean**
**Dietetic Services Manager -Paediatrics**
**NHSGGC**

[redacted]

[redacted]

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Thanks everyone.
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NHS Greater Glasgow and Clyde
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[redacted]

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<image002.jpg>

**From:** Powrie, Ian
**Sent:** 27 March 2019 17:42
**To:** REYNOLDS, BEN; Ramage, Ian; Steele, Tom
**Cc:** Dick, Lorraine; Inkster, Teresa; Redfern, Jamie; Robertson, Lynne
**Subject:** RE: Herald Article

Good Afternoon Ben,

Tom has asked me to respond to your request, I can confirm that RHC water Incident Management Team (IMT) have previously advised that the water is of drinking water quality, this position has been notified to all wards & departments by the RHC management team.
*I trust that this is in line with your current understanding, but should you have any outstanding concerns on this please let me know.*

*Best Regards*

*Ian*

[redacted]
***Deputy General Manager (Estates)***

Queen Elizabeth University Hospital Campus
Property, Procurement & Facilities Management Directorate
Facilities Corporate Services Dept
[redacted]

[redacted]

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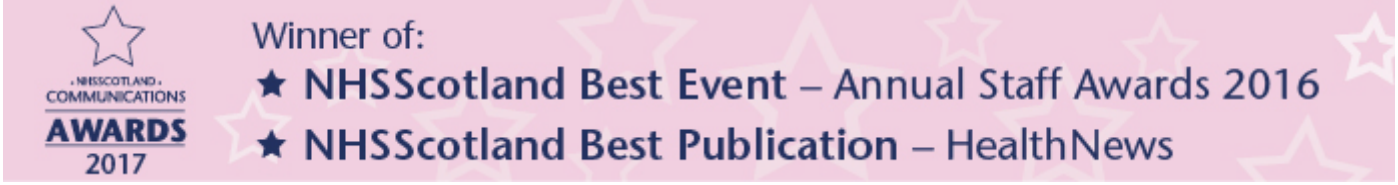

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**Anne Maclean**
**Dietetic Services Manager -Paediatrics**
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Lorraine Dick
Senior Media Relations Officer
NHS Greater Glasgow and Clyde
J B Russell House
Gartnavel Royal Hospital

[redacted]

[redacted]

[redacted]

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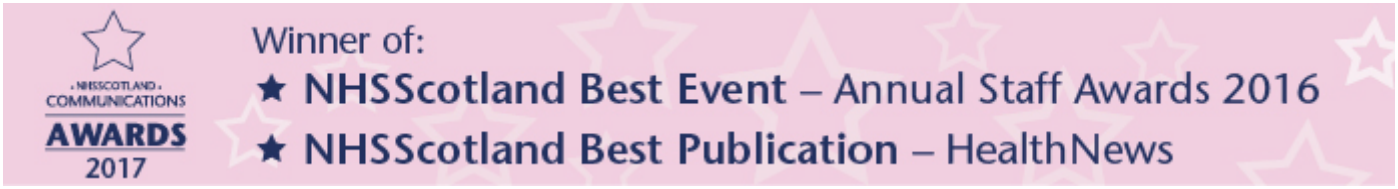

Monday, January 28, 2019 (LD)

[redacted] **ET -** Can I just check – we haven't really written about thing about the symptoms of two types of fungal infections. Is there anything patients should look out for, if they have been discharged from hospital. Is the hospital recalling any patients for tests or sending out any public health message? Perhaps this is not a question for the board though?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

These two incidents both relate to fungal organisms which are harmless to healthy people and only a small group of patients who are immuno-compromised are at potential risk.

We have put in place a number of measures which have been effective and there have been no further cases of either organism.

Our infections rates are lower than the Scottish average, and as our Medical Director, Dr Jennifer Armstrong, has already stated our hospitals are safe for patients.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Monday, January 28, 2019 (LD)

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**ENDS**

For further information either telephone [redacted] or email [redacted]

# Media Statement

NHS Greater Glasgow and Clyde

Tuesday, January 29, 2019 (LD)

[redacted] **Evening Times** - comments on their Facebook page about water not being safe to drink

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

We would like to offer our reassurance once again that the tap water is safe to drink in all buildings on the Queen Elizabeth University Hospital (QEUH) campus.

Last year, when bacteria was found inside the taps of two wards at the Royal Hospital for Children (RHC), we took a range of contingency measures while the matter was being addressed.

This included the shut down of all water dispensers in the RHC and providing a supply of bottled water.

The tap water is now available for drinking and meets the drinking water quality standard for domestic water supplies and we have decided not to reinstate the water dispensers at this time.

We have always and will continue to offer bottled water to any patients in the RHC who request it.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

Wednesday, January 30.2019 (LD)

[redacted] **BBC** - I am trying to confirm whether anything has changed. Originally we understood that the elderly patient with Cryptococcus had died but that the infection was not a contributory factor. Is it now the case that it was a contributory factor ? alternatively is it still the case that it is not and it is part of a wider review?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

From our perspective nothing has changed in that we believe this patient died of causes other than Cryptococcus.

The fact that the Fiscal is investigating this does not mean that Cryptococcus was a contributory factor....it means the Fiscal is investigating and will confirm in due course if it was or wasn't a contributory cause.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Wednesday, January 30, 2019 (LD)

[redacted] **Sunday Post** - We would like to know if the patient, [redacted], who died at the Queen Elizabeth University Hospital was treated in the Greater Glasgow and Clyde health board area prior to being transferred to Glasgow? I am referring to the [redacted] who died after contracting the infection linked to pigeon droppings?

## NHS GREATER GLASGOW AND CLYDE RESPONSE

We are bound by strict rules of patient confidentiality and any information that could lead to breaching patient confidentiality has not, and will not be issued by NHSGGC.

**ENDS**

For further information either telephone [redacted] or email [redacted]

# Cryptoccoccus – QEUH Staff Briefing

Our Occupational Health and Infection Control colleagues want to reassure staff about Cryptococcus infection risk.

The winter months normally result in an increase in chest infections, flu like illness and skin rashes.

While some staff have been concerned that such symptoms could be related to Cryptococcus our Infection Control teams want to stress that a Cryptococcus infection is extremely rare and that the organism is harmless to healthy humans. It cannot be spread from person to person.

Since the two patient cases late last year there have been no new infections.

If anyone has had a prolonged cough or chest infection they should arrange an appointment with their GP as per normal guidance from the NHS.

[Type text]

# Media Statement

NHS Greater Glasgow and Clyde

Friday, February 1, 2019 (LD)

[redacted] **Sun** - spike and netting at QEUH to deal with pigeons. We have images from last week and today that show netting has been changed below a walkway linking two of your buildings. We also have pictures that show spikes on windows that were not present last week. Could you kindly confirm when these updates were carried out and why?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have taken a number of measures since 2015, including netting and spikes, to help reduce the presence of pigeons. It is a fact that large buildings in cities often attract a lot of birds.

We have now taken further steps on the QEUH site including the fitting of extra nets and spikes.

Our Facilities staff will continue to use pest control measures to reduce the presence of pigeons and we are also consulting with pest control experts to seek other methods of control.

**ENDS**

For further information either telephone [redacted] or email [redacted]

1 February, 2019

**From:** [redacted]
**Sent:** 01 February 2019 18:27
**To:** Office, Press
**Subject:** [ExternaltoGGC]press query

Dear press office,
We are looking to run another line in this week's paper and I am looking for a statement from the health board. Tomorrow midday (Sat) should be sufficient.
Politicians have raised questions over why state of the art ventilation systems weren't installed across the Royal Hospital for Children when it was created.
This is on the back of Health Minister Jeane Freeman announcing a £1.25 million investment for new units.
We understand "only part of" the hospital was originally kitted out with them.
Why was investment not needed when the hospital was built, if it is now deemed necessary?
Could you kindly comment on this.
Kind regards,
[redacted]

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

Following works on the RHC at the end of last year we decided to take the opportunity to upgrade the ventilation system in the rest of Ward 2A.

The Cabinet Secretary has already announced a review into the design, commissioning, construction and maintenance of the Queen Elizabeth University Hospital and this will include the ventilation system.

**ENDS**

For further information either telephone [redacted] or email [redacted]

4 February, 2019
Dear press office

A Twitter account, supposedly run by a worker QEUH, has claimed a “systematic” flaw in the facility’s ventilation system was to blame for the recent Cryptococcus outbreak.
This is the account: https://twitter.com/qeuhworker
The account admin insists the issues are caused by the design of the new hospital rather than staff.
We are looking to run a story about this claim. Could you kindly comment on this?
I require a response by midday tomorrow (Sat).
Thanks for your help.
Kind regards, [redacted]
Scottish Sun on Sunday
[redacted]

# NHS GREATER GLASGOW AND CLYDE STATEMENT

There is NOT a systematic flaw in the ventilation system. Our IMT investigations into Cryptococcus infection continues.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[redacted]

**From:** Executive, Chief
**Sent:** 05 February 2019 09:14
**Subject:** Team Brief - February 2019

I usually update you on two or three developments in my regular monthly Team Brief but this month I wanted to concentrate on events over the past couple of weeks, which have been challenging for a number of staff, patients and families.

As you will know, from previous Core Briefs and from media reports, there has been considerable focus on three separate, and unconnected, outbreaks of infection in Glasgow hospitals. Our thoughts are with the families affected by these incidents and we need to continue to support them and all the other families needing our care.

Our immediate priority in responding to these incidents has been the safety of our patients and staff. Additional measures have been put in place to reinforce our strict infection control processes, including environmental improvements.

It is right that we now look to see what lessons can be learned from these incidents so that we can further improve our safety and the quality of care we provide. Over the coming weeks, there will be separate internal and external reviews of our services and environment. The external review, announced by the Cabinet Secretary for Health and Sport, will report in due course. Our own review will assess whether we need to make any further immediate changes beyond those that we have already made to respond to these incidents.

Within NHSGGC we've seen infection rates in our hospitals steadily reduce over the past few years. This has been achieved by embracing best practice such as the Scottish Patient Safety Programme. Working together, we must keep focused on this and strive to improve further the control and prevention of infection in our hospitals.

I want to thank you all for your hard work and understanding over the last few weeks. I fully appreciate that it has been a challenging time for staff and your dedication to providing high quality services is truly appreciated by myself, the senior management team and the NHS Board.

**Team Brief – February 2019**

Comments/feedback: [redacted]

[redacted]

**From:** Director Of Communications
**Sent:** 19 February 2019 19:19
**Subject:** Core Brief - 19 February 2019 (Board meeting update)

**The Board of NHS Greater Glasgow and Clyde met today, Tuesday 19 February 2019.**

**All the papers are available on our website at:** www.nhsggc.org.uk

**Here is a summary of key items discussed at today's meeting:**

**New Quality Strategy**
At today's Board meeting, a new strategy was approved in principle, detailing how we will take forward healthcare quality over the next five years.

'The Pursuit of Healthcare Excellence' sets out three key areas of quality care - effective, person-centred and safe – giving examples of what NHSGGC does well at the moment and areas where this can be strengthened.

Nurse Director Dr Margaret Mcguire said: "Our patients are at the centre of everything we do. Many of our patients already tell us the care they receive is compassionate and our staff are kind, competent and professional.

"But we know that there is always room for improvement and this new strategy sets out our priorities for action over the next five years to embed quality – not as another task – but as a normal way of working for everyone."

Click here to read the full Board paper.

**Public Health Screening Annual Report**
Also published today was the Board's Public Health Screening Programme Annual Report for 2017-2018.

The Board heard about the very important role that screening plays in detecting early disease or risk factors among people who have not yet developed symptoms. The full

report includes analysis of these different screening programmes and uptake amongst different groups and this intelligence is used to enable targeted local delivery.

Click here to read the full Board paper.

**Update on Healthcare Associated Infections**
Medical Director Dr Jennifer Armstrong updated the Board on a number of recent incidents of healthcare acquired infections.

The investigation into two isolated cases of Cryptococcus continues. Despite exhaustive tests of the hospital environment, there have been no traces found of the specific Cryptococcus strain that affected two patients and there have been no further cases.

An Expert Advisory Group has been set up to report to the Incident Management Team to help establish whether a definitive source of the Cryptococcus can be found, although it was noted that an American study has reported that the organism can lie dormant in a healthy human and only become harmful when a person becomes extremely unwell with suppressed immunity.

Dr Armstrong also gave an update on three cases of Staphylococcus aureus (S.aureus) infection in the Princes Royal Maternity Hospital (PRMH). She advised that this is an extremely rare strain which is resistant to the two antibiotics normally prescribed for S.aureus and is also resistant to the skin cleaning agent routinely used in hospitals across the UK.

This is the first time this strain of bacteria has been identified in Scotland. Whilst there have been no further cases of infection, four babies have tested positive for S. aureus on their skin. Enhanced infection control measures continue, including screening of babies in the PRMH, RAH and RHC, changes to the antibiotic treatment and hand cleaning agent and staff screening at the PRMH neonatal unit.

Dr Armstrong advised of the continued rigorous management of infection within our hospitals and the Board were reassured by her comments and her update.

Click here to read the full Board paper.

**Reviews into Queen Elizabeth University Hospital**
We have a culture of continuous improvement and learning and as part of this we routinely review our practices and procedures to ensure that we continue to provide the highest standards of care to our patients.

The Queen Elizabeth University Hospital has been open for four years and in that time a number of issues have been identified with the facility.

Whilst these issues were immediately addressed, it is right that we now look to see what lessons can be learned so that we can further improve the quality of care we provide.

The Board have therefore agreed today to a co-ordinated approach to provide assurance

about the hospital and address the public concerns that have been raised in recent weeks. Three reviews are being commissioned to examine our facilities, patient demand and clinical outcomes.

Our own teams will be supported in these reviews by national experts.

Our reviews will also link with the external review commissioned by the Cabinet Secretary for Health and Sport.

The reviews will report back in due course to the appropriate governance committees and staff will be kept informed.

Click here to read the full Board paper.

**Staff Governance Committee Annual Report**

Each year the Staff Governance Committee produces an Annual Report, outlining the key areas of its activity. The 2017-2018 report was approved today and highlighted activities, achievements and challenges and sets out priorities for 2018-19.

Key highlights included NHSGGC being awarded Level 2 Disability Confident status and publishing Guidelines for Managers to support them in making adjustments for staff with a disability. The committee also reported that a Succession Planning and Career Development Framework is now available for all staff, to support managers and staff on their career pathways.

Click here to read the full Board paper.

Click here to view the full set of Board papers.

***To view all papers presented to the Board visit: www.nhsggc.org.uk/boardpapers***
***To view news releases issued on behalf of the Board visit: www.nhsggc.org.uk/mediacentre***

**It is important to share Core Brief with colleagues who do not have access to a computer.**
**A full archive of printable PDFs are available on StaffNet**

# Media Statement

NHS Greater Glasgow and Clyde

Thursday, February 21, 2019 (LD)

[redacted] **BBC** - see questions below

**NHS GREATER GLASGOW AND CLYDE RESPONSE**

**Q.** Has Ward 6 reopened after the Cryptococcus infections and have patients moved back into it?

**A.** Yes

**Q.** Are all the infection control measures to filter air etc still in place?

**A.** Yes

**Q.** Does the Schiehallion ward (2A/B) in the Royal Hospital for Children remain closed following the bacteraemia infections last year?

**A.** The ward is not closed it moved to ward 6A.

**Q.** Are there still issues with the water supply in that ward and do they extend to any other areas of either of the two hospitals?

**A.** No

**Q.** Have any patients been advised not to drink the tap water at QEUH or the Royal Hospital for Children? If so, why?

**A.** The tap water is safe to drink and we have confirmed this previously.

**Q.** When do you anticipate cancer patients moving back into the children's hospital?

**A.** Have attached our release issued in December which sets out the timeline.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[redacted]

**From:** Director Of Communications
**Sent:** 08 March 2019 10:45
**Subject:** Core Brief - 08 March 2019

**HIS inspection report on Queen Elizabeth University Hospital and Royal Hospital for Children**

Healthcare Improvement Scotland (HIS) carried out an unannounced inspection at the Queen Elizabeth University Hospital, the Institute of Neurosciences and the Royal Hospital for Children on 29 - 31 of January 2019. The report of the visit is published today. Please find below the HIS press release which contains a link to the report and following that our response to the report.

**HIS PRESS RELEASE**

Healthcare Improvement Scotland today, (Friday, 8th of March), published its report relating to an unannounced safety and cleanliness inspection visit to Queen Elizabeth University Hospital, (QEUH), NHS Greater Glasgow and Clyde.

The unannounced inspection was carried out at the request of the Cabinet Secretary for Health and Wellbeing to the Queen Elizabeth University Hospital, the Royal Hospital for Children and the Institute of Neurosciences, from Tuesday the 29th to Thursday the 31st of January 2019, and will help to inform the Scottish Government's wider independent review into QEUH.

Our inspection team inspected 27 wards throughout the main Queen Elizabeth University Hospital building, the Royal Hospital for Children and the Institute of Neurological Sciences.

Speaking of the report, Alastair Delaney, Director of Quality Assurance, Healthcare Improvement Scotland, said: "Inspectors found areas of good practice in relation to infection control. However, there were also areas of concern, such as developing a strategy to ensure the hospital environment and patient equipment in the emergency department is clean and ready for use, and that any estates and facilities issues around repairs and maintenance are carried out to ensure infection prevention and control can be maintained.

"Following our inspection, NHS Greater Glasgow and Clyde have developed an action plan

and must address the areas which require improvement as a matter of priority."

The full inspection report is available to view here

**NHSGGC RESPONSE**

Jane Grant, Chief Executive, said: "I welcome today's report from Healthcare Improvement Scotland into the recent inspection of the Queen Elizabeth University Hospital and the Royal Hospital for Children. The report contains a number of positive findings, including good staff awareness of infection control and high levels of hand hygiene compliance. The inspectors have also confirmed that infection rates are within acceptable levels.

"The report has, however, highlighted a number of areas that we need to address. Work is already underway to action the requirements and recommendation that Healthcare Improvement Scotland have identified.

"Patients should be assured that the prevention and control of infection has always been, and remains, a top priority for NHSGGC.

"Infection rates in the Queen Elizabeth University Hospital and the Royal Hospital for Children are low – lower than the average rate of infection in Scotland's hospitals.

"For further reassurance on infection control we asked Health Protection Scotland to carry out a detailed review of our infection performance compared to similar large hospitals over the past three years. Their findings confirmed that at no time during this period did infection rates at QEUH and RHC exceed expected levels.

"Our highly dedicated staff are committed to quality care and patient safety and we are determined to ensure that our hospitals are clean and as safe as they can be for our patients."

**It is important to share Core Brief with colleagues who do not have access to a computer.**
**A full archive of printable PDFs are available on StaffNet**

[redacted]

**From:** NHS Greater Glasgow and Clyde <ipn@nhsggc.net>
**Sent:** 08 March 2019 12:26
**To:** Bustillo, Sandra
**Subject:** [ExternaltoGGC]HIS Report


**Publication of report into Queen Elizabeth University Hospital and Royal Hospital for Children**

Today sees the publication of a report by Healthcare Improvement Scotland into the findings from an unannounced inspection at the Queen Elizabeth University Hospital, the Royal Hospital for Children and the Institute of Neurosciences on 29 - 31 of January 2019.

Inspectors found areas of good practice in relation to infection control. However, there were also areas highlighted where improvements were needed including in the adult hospital's Emergency Department where dust was found.

In response to the report, Jane Grant, Chief Executive, said: "I welcome today's report from Healthcare Improvement Scotland into the recent inspection of the Queen Elizabeth University Hospital and the Royal Hospital for Children. The report contains a number of positive findings, including good staff awareness of infection control and high levels of hand hygiene compliance. The inspectors have also confirmed that infection rates are within acceptable levels.

"The report has, however, highlighted a number of areas that we need to address. Work is already underway to action the requirements and recommendation that Healthcare Improvement Scotland have identified.

“Patients should be assured that the prevention and control of infection has always been, and remains, a top priority for NHSGGC.

“Infection rates in the Queen Elizabeth University Hospital and the Royal Hospital for Children are low – lower than the average rate of infection in Scotland’s hospitals.

“For further reassurance on infection control we asked Health Protection Scotland to carry out a detailed review of our infection performance compared to similar large hospitals over the past three years. Their findings confirmed that at no time during this period did infection rates at QEUH and RHC exceed expected levels.

“Our highly dedicated staff are committed to quality care and patient safety and we are determined to ensure that our hospitals are clean and as safe as they can be for our patients.”

The full inspection report is available to view here

**Find out more about Moving Forward Together**

Friday, March 8, 2019 (LD)

[redacted] **Sunday Post** - see email

[redacted] Daily Mail 20.03.19

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON CRYPTOCOCCUS

There has been no definitive cause identified for the source of the Cryptococcus at the Queen Elizabeth University Hospital.

There are a number of hypotheses including the plant room and the helipad. We also contacted other health boards to discuss associated matters.

An expert advisory group has now been established as part of the Incident Management Team process.

**ENDS**

For further information either telephone [redacted] or email [redacted]

The Herald

Date 10 March 2019
Page 47

Precise.

**In our opinion**

# Safety at city hospital must take priority

IT is concerning to see that up to £50m may have to be spent upgrading and repairing the site of Glasgow's newest flagship hospital.

What is also troubling is the apparent catalogue of errors, safety concerns and problems at the Queen Elizabeth University Hospital itself, despite it being just four years old.

Staff have told watchdogs that their concerns have been ignored, and inspectors just this week found more evidence of dust, dirt and improper practices at the £842m facility.

Clinicians who raised concerns in 2017 say their worries were not dealt with, and more than 300 jobs are still awaiting repair at the new building.

If [redacted] dying at the site and numerous others becoming ill with strange and rare infections isn't enough to prompt instant and permanent change, what is?

Hospital staff themselves are hard-working, dedicated and care deeply about what they do, as would be expected from our National Health Service.

NHS senior management, Scottish Government staff and the health minister must now do all they can to resolve the problems.

Difficulties between leading staff in key departments must be put aside in order to protect the lives of those most in need of care.

When the NHS works, it is the country's greatest asset and we must not allow this fantastic service or the reputation of its incredibly dedicated staff to be eroded.

The Herald

Date 10 March 2019
Page 6

Precise.

# Revealed: photos of bird droppings at the hospital

NEWS FOCUS

IMAGES of the bird droppings at the Queen Elizabeth University Hospital can be revealed for the first time today.

They highlight the extent of the contamination which sparked an inquiry into the facility in Glasgow earlier this year. A [redacted] died after being exposed to Cryptococcus - a fungus which comes from bird mess - while an [redacted] was also found to have contracted the infection.

These images, seen by NHS Greater Glasgow and Clyde chiefs at the time of the scandal, show a large amount of excrement in an inner courtyard at the site covering pipes and metal work. Feathers can also be seen covering some areas of the courtyard. Inside the facility, feathers and bird faeces can also be seen in several areas of the 12th floor plant room, where health chiefs said the contamination was first uncovered.

In January, health minister Jeane Freeman said the bird excrement had entered the hospital building "via a small break in the wall which was invisible to the naked eye" but added that there were investigations ongoing into how the fungus managed to enter a "closed system".

When the Herald on Sunday asked NHS Greater Glasgow and Clyde about these images, they initially said they were "unaware" of their existence.

When asked if these had been passed on Jeane Freeman, a spokeswoman said: " NHSGGC did not send any images to the Cabinet Secretary. Investigations continue into the potential source and we are working with external experts on this."

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

# £50m repairs bill for flagship city hospital

## NHS chiefs hear shock cost for work across QEUH campus

**Exclusive**

By Hannah Rodger

NHS chiefs are facing a £50m repair bill to upgrade and fix problems at the site of Glasgow's super hospital.

It comes as the Herald on Sunday can exclusively reveal the first images of bird dropping contamination at the hospital which sparked a major public inquiry and caused the death of [redacted].

Health inspectors have identified a number of flaws at the site including ventilation ducts being the wrong size, alarm system failures and isolation room issues.

Chronic infighting between two key departments has also caused hold-ups with infection control procedures, which are vital to keep patients and staff safe.

Tomorrow bosses are due to hold their annual meeting, where cabinet secretary Jeane Freeman and members of the public will get the chance to scrutinise the performance of Scotland's largest health board.

**Turn to Page 6**

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

The huge cost of repairing the four-year-old facility and associated buildings was raised earlier this year

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

# £50m repair bill for troubled city hospital

**Exclusive**

by Hannah Rodger

THE catalogue of problems at the Queen Elizabeth University Hospital site could cost as much as £50 million to repair, the Herald on Sunday can reveal.

The staggering cost of repairing the four-year-old facility and associated buildings was raised earlier this year among senior staff at NHS Greater Glasgow and Clyde (NHSGGC), following a number of high-profile infections at the the £842m super hospital.

Today, we can also reveal a number of other issues at the scandal-hit site including ventilation systems not of the correct size, safety alarm failures, chronic infighting among staff and a lack of input from infection control teams on the project before it even opened.

NHSGGC has already admitted it will cost £2.75m to sort out problems with the water system and ventilation at the new hospital, however a report released on Friday by Healthcare Improvement Scotland revealed there are more than 300 outstanding repairs to be done – without any plan to complete them.

It is understood the health board's estates and facilities manager told the corporate management team in January that it could cost as much as £50m to rectify the issues at the site.

NHSGGC refused to officially give a figure for the repairs, but admitted problems with older buildings on the campus do require a "significant investment".

A source close to NHS senior management told the Herald on Sunday: " Early figures quoted to bring the critical areas up to speed are £50m, plus the disruption of closing down areas. The corporate management team were told this earlier in the year, when the issues across the estate were brought up."

Two other senior sources also said they were informed of the staggering costs involved. Problems already identified by auditors at Health Facilities Scotland are believed to include the size of the ventilation ducts, which may not be large enough to fit certain air filters needed for a hospital the size of the QEUH, and alarm systems supposed to detect failures with ventilation and contamination which did not function at all.

Special isolation rooms which are essential to stop the spread of infections are also missing from the facility – an issue now being probed by the Health and Safety Executive.

Infighting between infection control teams and the health board's facilities and estates team is rife, according to various senior NHS sources, who say that staff who previously raised concerns about the state of the new hospital were ignored.

One senior health source told the Herald on Sunday: "Concerns about the ventilation and water were raised as far

The Herald
Date 10 March 2019
Page 1,6,7
Precise.

back as 2015, and these weren't listened to. It was as if they didn't want to know.

"In 2017 various microbiologists also raised concerns in a report and they were ignored too. People are being bullied and right now it is clear that the board and directors at NHSGGC are trying desperately to find someone to blame."

Healthcare Improvement Scotland inspectors picked up on the problems in their report last week, citing "challenges in the working relationships between senior staff" which they say must be resolved.

Trade union BMA Scotland also raised concerns about treatment of an employee who reported the bird droppings issue in December, although no official complaint was made. It has also emerged that the board's infection control manager has been shifted to a project manager job following the bird faeces discovery, and will now be involved in the independent inquiry and internal investigations into the outbreak – a move critics say will stop an impartial investigation taking place.

One source close to the investigation said: "It is ludicrous that someone linked so closely to infection control would now be managing the investigation into infection problems. How can it be independent and balanced if this is the case?"

Hugh Pennington, professor of bacteriology at Aberdeen University, said the fault lies with the health board management and warned there will be further outbreaks if issues are not resolved quickly. He said: "Clearly the management is not on top of these issues. There are communication problems between infection control and other areas. These are all management issues.

"While the infection rate is no higher than anybody else's the problem really is that if the issues carry on – some of them seem to have been there for two or three years – sooner or later they will have a higher number of outbreaks and infections.

"Prevention is the name of the game here. It was very disappointing to see this in a hospital that has only been running for a short period.

"If it was an old building that was going to be pulled down, you might say 'that explains it'. This is a new hospital with problems with routine maintenance, routine cleaning, people raising problems and nothing being done."

Dr Lewis Morrison, Chair of BMA Scotland, said: "While it would be wrong to jump to conclusions around individual infection outbreaks, there now seems little doubt that there are serious issues to address at the QEUH hospital site. The report from Healthcare Improvement Scotland makes that absolutely clear.

"For a report to find that parts of the site are in such a poor state of repair that they therefore cannot be effectively cleaned would seem completely unacceptable in a modern NHS. That there are at least 300 outstanding maintenance jobs without evidence of a plan to complete these, suggest the scale of the challenge of rectifying the situation.

"A further theme that comes through is shortages of staff – including infection control doctors, who play a crucial role with the assessment and mitigation of infection risks presented by the built environment. Without the right staff in place, it is hard to see how real improvements can be made. Equally, there would also appear to be issues with senior management acting on concerns of the clinical staff who are in place – for example in estates meetings. The board must act urgently, as they have set out in their action plan in response to the report, to deal with these critical issues and make improvements across the board.

"But it would also be wrong to suggest these are isolated problems. Our NHS is under resourced and understaffed as we have been warning for some time. Therefore it is no surprise that building maintenance is suffering, with a resulting negative effect on cleanliness. And if this is the case at one of the most modern facilities in Scotland, then it is hard to believe that there are not similar issues at some of the more dated buildings in use.

"Finally, it is welcome that there is a review into the design and building of the QEUH, and we hope there may be lessons for the NHS as a result. For example, and without pre-empting results of the review, an increased and more effective role for infection control experts in the design and building of NHS facilities is an area where real improvements can potentially be made."

A report into water contamination issues at the hospital site revealed there was "no documented evidence of

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

NHSGGC Infection Prevention and Control Team involvement in the commissioning or handover process of the project" although infection control and prevention nurses had been seconded to work on the project team.

The lack of involvement by infection control in new medical projects was raised by BMA Scotland in submissions to the Scottish Government earlier this year, where they said: "It is an uncommon event for an infection control team to oversee a major build – although they are often consulted as the project progresses. However, there may not always be enough time and experience to optimally deliver this input despite expert knowledge clearly being needed. Added to this, the NHS experts and the builder's experts often don't agree on points of design and how this may relate to infection risk."

NHS Greater Glasgow and Clyde didn't respond to specific enquiries regarding safety alarm failures or ducting being the wrong size.

A spokeswoman said that the special HEPA filters required in some areas of the hospital were "not generally required throughout hospitals, but only in Bone Marrow Transplant units" and added: "The Bone Marrow Transplant unit in the QEUH has been fitted with HEPA filters. There are no current issues with the ventilation system and the ducting for the general wards within the adult hospital and the children's hospital.

"There is however work currently underway to upgrade the haemato-oncology ward in the Royal Hospital for Children to the latest specification while patients are temporarily relocated to another ward in the QEUH. We have previously announced that this work is being carried out."

On staff concerns about the site problems being ignored, the spokeswoman said: "We believe that all concerns have been addressed", and added they were "unaware" of any concerns discussed about staff treatment by BMA Scotland.

On the upgrade costing £50m, she said: "We do not know where you have obtained the £50m figure but can confirm that some of the older buildings on the QEUH campus do require significant capital investment but not the two new hospitals. There will always be significant numbers of repair requests ongoing at any one time in any hospital, but a campus as large as the QEUH will have proportionately more. To clarify, the 300 outstanding repair requests are routine repairs like a broken blind, broken door handle, broken hinge etc and do not represent a significant investment."

The Health and Safety Executive said: "HSE is currently investigating the circumstances surrounding the outbreak of Cryptococcus infection at Queen Elizabeth University Hospital. Initial enquiries commenced on 24 January 2019 but it is not possible at this stage to provide a date for completion of the investigation.

"Our investigation will examine the range of control measures in place to reduce and mitigate the risks of such infections. This will, as a matter of course, include the adequacy of ventilation systems but we cannot comment further on the detail of this ongoing investigation."

Health Facilities Scotland did not respond to our request for comment.

The Scottish Government refused to address specific issues highlighted by the Herald on Sunday, but re-iterated the statement made by Cabinet Secretary Jeane Freeman following the HIS report released on Friday.

Ms Freeman said: "Patients and the public deserve to have complete confidence in the cleanliness of Scottish hospitals and the quality of NHS services. I am clear that Scotland's hospitals should be clean and safe, and that we have a strong record on infection control and prevention. However, this report highlights a number of areas where immediate action is required, and we will work with the board to ensure these are addressed as soon as possible.

"The findings of this report will of course feed into the independent review into the design, commissioning, construction, handover and maintenance of Glasgow's Queen Elizabeth Hospital."

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Twitter: @heraldscotland
Web: heraldscotland.com

Concerns about the ventilation and water were raised as far back as 2015, and these weren't listened to. It was as if they didn't want to know

The Herald

Date 10 March 2019
Page 1,6,7

Precise.

Hugh Pennington, professor of bacteriology at Aberdeen University

Outstanding repairs and the discovery of bird droppings have heightened infection fears at QEUH


Sunday, March 10, 2019 (LD)

**NHS GREATER GLASGOW AND CLYDE RESPONSE**

**TO HERALD ON SUNDAY ARTICLE**

Today's Herald on Sunday claims that there is a £50m repair bill at the Queen Elizabeth University Hospital (QEUH). This is completely inaccurate and we made clear to the paper that we do not recognise the £50m quoted in the article.

We confirmed that we are upgrading the ventilation and the water treatment system at the Royal Hospital for Children (RHC) which will cost approximately £2.75m and this is already in the public domain.

We made it very clear to the Herald on Sunday that no such figure (£50m) applies to the QEUH.

We also confirmed that the campus is large and has other older buildings which require capital investment, which is already in the public domain, and is unrelated to the QEUH or the Royal Hospital for Children.

Our statement to the paper confirmed that there will always be significant numbers of repair requests ongoing at any one time in any hospital, but a campus as large as the QEUH will have proportionately more.

To clarify the 300 outstanding repair requests referred to in the HIS report are routine repairs like a broken blind, broken door handle, broken hinge etc and do not represent a significant investment.

We have today complained to Herald on Sunday about their inaccurate reporting.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Thursday, 21 March, 2019 (CC)

**Daily Mail -**

Dear Colleague,

Thanks for talking with me just now. To recap, I am a health correspondent for the Daily Mail, writing on the rise of fungal infections in the UK.

I understand from a Daily Record report, 14 March, that since December five people have died after contracting a hospital-acquired fungal infection in the Glasgow area served by your trust.

At least two of these are reported to involve infection by the fungus Cryptococcus and two by mucor fungus.

Could you please confirm if this is true?

Are any of these infections considered to be dug resistant?

What infection control protocols have been instituted?

And what are the rates of fungal infection among patients over the past five years at your trust?

If you could respond before 6.30pm this evening, I would be extremely grateful.

With thanks for your time,

[redacted]

## NHS GREATER GLASGOW AND CLYDE STATEMENT

You have asked about five recent deaths from fungal infections. We can confirm there have been three deaths of patients who had previously been treated for a fungal infection in NHS Greater Glasgow and Clyde.

Two of these were treated for Cryptococcus. One of these patients was treated for Mucor. Neither of these fungi are drug resistant.

These deaths are currently being investigated by the Procurator Fiscal.

We put in place a number of measures which have been effective and there have been no further cases of either organism.

**ENDS**

For further information either telephone [redacted] or email [redacted]

# NHS GREATER GLASGOW AND CLYDE STATEMENT ON HIS INSPECTION REPORT ON QEUH

Jane Grant, Chief Executive, said: "I welcome today's report from Healthcare Improvement Scotland into the recent inspection of the Queen Elizabeth University Hospital and the Royal Hospital for Children.

"The report contains a number of positive findings, including good staff awareness of infection control and high levels of hand hygiene compliance. The inspectors have also confirmed that infection rates are within acceptable levels.

"The report has, however, highlighted a number of areas that we need to address. Work is already underway to action the requirements and recommendation that Healthcare Improvement Scotland have identified.

"Patients should be assured that the prevention and control of infection has always been, and remains, a top priority for NHSGGC.

"Infection rates in the Queen Elizabeth University Hospital and the Royal Hospital for Children are low – lower than the average rate of infection in Scotland's hospitals.

"For further reassurance on infection control we asked Health Protection Scotland to carry out a detailed review of our infection performance compared to similar large hospitals over the past three years. Their findings confirmed that at no time during this period did infection rates at QEUH and RHC exceed expected levels.

"Our highly dedicated staff are committed to quality care and patient safety and we are determined to ensure that our hospitals are clean and as safe as they can be for our patients."

**ENDS**

Media Statement

NHS Greater Glasgow and Clyde

24 May, 2019 (MD)

**NHS GREATER GLASGOW AND CLYDE STATEMENT ON QEUH HIS REPORT FOI**

**1)The two other infections I mentioned – the aspergillus from the ceiling void leak and the Exophiala from the dishwasher – Can you tell me when these outbreaks were detected and how many patients were infected in each case? The only reason I ask if that there seems to be a few different responses in the documents I have, mentioning an 'increased' number of cases of aspergillus and it also mentions 2016 and 2017, but elsewhere it just mentions 2017, and I want to make sure I have the correct information. I understand the aspergillus was found in the Royal Hospital for Children ward 2C- Haemato-oncology, is this correct? And the dishwasher issue – can you tell me which area of the hospital this was detected?**

In 2016 one patient was successfully treated for an Aspergillus infection in the Royal Hospital for Children. Investigations included air sampling and review of the environment for any dampness. One hypothesis was that this could have been caused by a tear on a vent duct and this was repaired. No other patients were infected and this was reported in accordance with national guidance to HPS.

In 2017, two further probable cases of Aspergillus were investigated in RHC. This investigation also included a review of the case from 2016.
No source was confirmed as some of the patients were in and out of the hospital during the period in question and construction work (which is a risk factor) was ongoing at the time.

Actions taken included the replacement of damaged ceiling tiles. In accordance with the national guidance, the investigation was reported to HPS.

In 2017 exophiala was identified in an environmental sample taken from a dishwasher. As a precaution dishwashers were removed from some areas in both the adult and children's hospital. No patients were affected. A report was sent to HPS in line with national guidance.

**2) I realised I asked you about the concerns raised in 2015 and 2017 in my original email last week. But you only came back to me on the concerns raised in 2017, which action was taken on 18 of the 27 issues, with eight more actions planned this year and one not technically feasible. Can you tell me what you did about the concerns raised in 2015? I understand from the documents I**

**have that similar issues were raised then as in 2017? And of the 27 issues, can you tell me which have been implemented and which are outstanding?**

In 2015, there were a number of opinions offered about issues highlighted by microbiologists in relation to the Institute and arrangements for managing isolation patients in the new hospitals. At the time there wasn't clinical consensus about the issues raised but they were all actively looked at.

There were no issues raised in 2016.

In 2017, as previously confirmed, a process was put in place to agree an action plan in response to ongoing issues raised by the microbiologists. This was reported through an open and transparent process to the Board. Our previous statement confirms the detail of this process.

A later Stage 2 whistleblowing investigation in 2018 found that the concerns raised, whilst legitimate, had already been dealt with.

Additional background information:
Of the 27 actions set out in the report, one was not technically feasible (no 3). Twenty have been fully completed and three will be completed by June (no 1,2 and 26). These have required capital investment to complete.
The remaining three require more significant capital investment and these are being progressed. The work on Ward 2A (no 7) will be completed by December and a plan is being progressed for the Institute (nos 23 and 24).

**3) Why are the ICE theatres not opened?**

The ICE theatres are part of a build project for the University of Glasgow and they would need to comment on the issues relating to the delayed opening of the facility.

**4) The asset register – I know we had discussed that some buildings on here are derelict. I want to ensure I discount these from any reporting, as we previously discussed. I also think I have misinterpreted the data in terms of the column headings. Can you please tell me what the 'year' column refers to – is this the year in which improvements were last made? I know it is not the year the buildings were built, but unsure what this column means. I have the following list of buildings, if you could tell me which are derelict and which are not:**

**Acute Medical East**
**Central Medical Block**
**Central Medical Wards**

- These all closed in 2015. It would be wrong to suggest they are derelict as they are all secured.

**Neurosurgical Wards**
**Neurology and Wards**

- These are open and a proposal is being developed to upgrade the Institute in a significant capital programme.
- In the meantime, those areas highlighted by the audit have either been replaced e.g. damaged tiles and vinyl flooring, or as in the case of the boiler and other building systems, remain operational and maintained in working condition.

**ENDS**

For further information either telephone [redacted] or email [redacted]

The Herald

Date 26 May 2019
Page 9

Precise.

**Update**

# Early fungal outbreaks at hospital revealed

TWO fungal outbreaks were linked to defects at the QEUH years before [redacted] contracted a disease from bird droppings.

The Herald on Sunday has obtained hundreds of documents which detail problems at the hospital site including details of two outbreaks linked to defects.

In 2016, a child on the cancer ward at the Royal Hospital for Children (RHC) was infected with Aspergillus – a mould found on bread – followed by two others in 2017. The later infections were suspected to have come from mould in a ceiling void, which developed following a leak.

Another fungus, Exophiala, was detected in 2017 from dishwashers which hadn't been installed or cleaned properly.

In 2017, three microbiologists blew the whistle over a catalogue of safety concerns, following concerns also raised in 2015.

Their report states: "There was an outbreak of Aspergillus in the unit and there is still a risk to patients. There were two cases associated with a leak in the ceiling. This was investigated and the tiles were removed and replaced, with no further cases of Aspergillus.

"Dishwashers had not been cleaned, installed or operated according to manufacturing instructions. Water jugs and cups had been washed in these dishwashers.

"This was brought to light with the investigation into patients with Exophiala."

NHSGGC said Exophiala had been detected and as a precaution some dishwashers were removed, but added that no patients were treated for the infection and all patients recovered from Aspergillus infections.

A spokeswoman said all incidents were reported to Health Protection Scotland and added: "In 2016, one patient was successfully treated for an Aspergillus infection in the RHC.

"Investigations included air sampling and review of the environment for any dampness. One hypothesis was that this could have been caused by a tear on a vent duct and this was repaired.

"In 2017, two further probable cases of Aspergillus were investigated in RHC. This investigation also included a review of the case from 2016.

"No source was confirmed as some of the patients were in and out of the hospital and construction work (which is a risk factor) was ongoing at the time.

"Actions taken included the replacement of damaged ceiling tiles.

"In 2017, Exophiala was identified in an environmental sample taken from a dishwasher. As a precaution dishwashers were removed from some areas in both the adult and children's hospital. No patients were affected."

The Herald

Date 26 May 2019
Page 8,9

Precise.

# Troubled super hospital's £7m white elephant

## Fresh questions over design as brain surgery theatres left useless after failing safety tests

**Exclusive**

By Hannah Rodger

STATE-OF-THE-ART brain surgery theatres have been lying empty for more than a year at Glasgow's super hospital site after failing critical safety checks.

The £7 million operating facilities at the Imaging Centre for Excellence (ICE) were expected to open in February last year, but have been delayed after the ventilation systems failed vital tests.

The four new theatres, based at the Queen Elizabeth University Hospital campus (QEUH), were supposed to replace the older theatres in the nearby neurosciences building, which have been plagued with raw sewage leaks and plumbing issues since at least 2015.

Initially they were due to open in 2017, but this was later revised to 2018.

Brain and spinal surgeries were cancelled in the Institute of Neurosciences after reports of raw sewage running down the walls, with NHS Greater Glasgow and Clyde saying at the time: "The board has already awarded a £7m contract to build a new state-of-the-art theatre suite, which will be ready in early 2017."

It is understood the latest issues with the ventilation were picked up just as the facilities were being prepared to be handed over to NHS Greater Glasgow and Clyde, putting the move on hold.

Critics have now called for Health Secretary Jeane Freeman to investigate the two-year delay – the latest scandal to hit the QEUH campus, following an outbreak of Cryptococcus linked to the death of [redacted] patient in December.

Mucorales, another rare fungal infection, also infected two patients at the QEUH in January with [redacted] later dying after becoming infected with it. The [redacted] had been in hospital [redacted].

A Government inquiry and an internal NHS inquiry are now under way, focusing on the design and commissioning of the new hospital building. Watchdog Health Protection Scotland also released a critical report into some of the problems at the £842m super hospital following an inspection in January.

One senior employee at NHSGGC told The Herald on Sunday: "They have spent millions getting these theatres up to spec so they could move patients out of the theatres which have got faeces leaking in them.

"They've failed once again. Here we have a situation where questions have

The Herald
Date 26 May 2019
Page 8,9
Precise.

to be asked about who is supervising this work, who decided on the specifications needed and why were these concerns not addressed at the design stage and or in building when the facility was being constructed?

"All this money has been spent and the facilities have failed at the end of it. I believe there are other problems too, that the theatres are not big enough, for example.

"How can we, once again, have a situation where there are potential ventilation problems inherent within the building itself, that cannot be fixed easily? It is an utter disaster.

"Many people here are shaking their heads, they just can't understand how this has happened. Is it problems with management? Are there fundamental issues with how building projects are being done here? It is starting to look like it. It's isn't a one-off."

Original plans for the project on the NHSGGC website gave an expected opening date of January 20, 2017, with the theatres hoped to provide "facilities which are fit for purpose supporting staff in providing a 21st-century clinical service" and "good-quality design".

The health board also agreed to appoint three technical advisers to the project, who would report back on the process of the build and "ensure that the contract is being administered correctly", according to documents.

The University of Glasgow, which owns the ICE building and is managing the project, has apologised for the delay but refused to provide further details on the extent of the problems other than acknowledge there had been "a number of technical issues".

The building is also home to a research centre, Scotland's only Tesla MRI scanner, and, according to the university, is "strengthening Glasgow's position as a world leader in precision medicine".

Politicians have now called for Health Secretary Jeane Freeman to "restore public confidence" and questioned whether she was aware of the delays.

Freeman toured the facility in August 2018, along with NHS Greater Glasgow and Clyde chief Jane Grant and Glasgow University principal Sir Anton Muscatelli.

Monica Lennon, Labour's health spokeswoman, said: "It's frankly shocking that a multi-million-pound state-of-the-art facility, intended to save lives, has been lying empty for over a year.

"The public will rightly be outraged that this problem has been allowed to persist for so long. These latest revelations do nothing to restore confidence in the safety and running of the QEUH.

"It raises a number of serious questions about when and how long the Scottish Government have been aware of this issue, and whether this latest mishap will be included in the independent review of the construction of the hospital.

"I'll be raising these matters with the Health Secretary Jeane Freeman to seek urgent clarification."

Miles Briggs, health spokesman for the Scottish Conservatives added: "This whole project once again just highlights the SNP's mismanagement of our Scottish NHS and the incompetence which has become the hallmark of this SNP Government. What is really unacceptable, though, is the fact that it is Scottish patients and their families who are really being failed.

"At a time when NHS waiting times are increasing this latest construction failure and delay to open new theatre capacity will anger patients.

"Questions clearly need to be asked over why these £7m state-of-the-art operating theatres have been lying empty for more than a year.

"This latest mismanaged project is also hugely embarrassing for SNP Health Secretary Jeane Freeman who visited the centre last year, and obviously failed to ask why no operations were actually taking place in these new theatres."

Alex Cole-Hamilton, the health spokesman for the Scottish Liberal Democrats, said: "Anyone waiting for a neurological procedure in Greater Glasgow and Clyde will be rightly astonished and appalled to learn this.

The Herald

Date 26 May 2019
Page 8,9

Precise.

"This comes after a string of hugely damaging revelations about the safety attached to newbuild projects in the NHSGGC estate.

"It is vital that the Cabinet Secretary moves to restore public confidence and ensure that these expensive facilities are operational as soon as it is safe for them to do so."

A spokeswoman for the University of Glasgow said: "The building was a collaboration between the university and the NHS and includes research facilities, along with a floor of operating theatres.

"We have been working closely with the NHS to resolve a number of technical issues. The delay in handing over the operating theatres has been unfortunate and we apologise for this, but our focus has been on ensuring that the facilities are completed to the highest possible standard.

"The work is now at an advanced stage and we are hopeful it will be completed within the next few weeks."

NHS Greater Glasgow and Clyde said that as the project was the responsibility of the University of Glasgow, it was unable to comment on the delays.

A Scottish Government spokeswoman said: "This project is being led by the University of Glasgow and has not received any direct funding from the Scottish Government.

"We are aware of the delay but understand work to deliver these state-of-the-art facilities is now at an advanced stage and is expected to be completed within the next few weeks."

> Questions have to be asked about who is supervising this work, who decided on the specifications and why were these concerns not addressed at the design stage

The Herald

Date 26 May 2019
Page 8,9

Precise.

**Left: an artist's impression of the new theatres which have lain empty since they were finished**

The Herald

Date 26 May 2019
Page 8,9

Precise.


**Right: the theatres are part of Glasgow University's Imaging Centre for Excellence**


21 June, 2019 (MD)

## NHS Greater Glasgow and Clyde statement

This mycobacteria is ubiquitous in the environment generally and therefore there are a variety of potential sources. No link with the hospital has been established.

**ENDS**

**Q and A**

**Is this bacteria in the water supply to the kids cancer ward?**

Water filters remain in areas with immune-compromised patients and we are confident these measures continue to be effective.

**Are any other patients affected?**

No – it would be rare for this bacteria to be transmitted between patients.

**Why are you installing POU filters in your theatres?**

We have been closely monitoring water in theatres and the water quality is good with no requirement for filters. This is purely a precautionary measure.

**Is the hospital safe?**

Absolutely. This mycobacteria is ubiquitous in the environment generally and no link with the hospital has been established.

**How many patients are affected?**

As this relates to a single case we are unable to discuss any details. We are bound by strict rules regarding patient confidentiality and our priority is to protect our patients.

**Does SG know?**

We have notified HPS as per normal protocols.

**Does the family know?**

The family are fully informed.

**ENDS**

For further information either telephone [redacted] or email [redacted]

[redacted] – Herald on Sunday

Pest control inquiry

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

We continuously and actively reviews pest prevention and control requirements through regular audits in all hospitals and premises. This integrated management approach significantly reduces pest issues through proactive and preventative systems. In addition to these preventative systems, if staff in a given area observe or suspect pest infection of any kind, a reactive service is provided immediately.

We have a large number of sites in a number of locations across our area. These sites are complex by nature and vary in age; consequently, their pest control needs vary. We cooperate fully with all interested parties such as Environmental Health.

Pest control services are supplied by specialist contractors GP Environmental.

GP Environmental is given a briefing usually by an Estates Manager on what the issue is and they will survey/investigate and come back with recommendations to eliminate or reduce risk. This can include: increased proofing measures to prevent pest access, removal of mess and sanitisation of the area. Multiple visits maybe required depending on scale of problem.

Communication between the contractor and relevant site management is maintained after each visit to ensure that the highest standards of environmental cleanliness can be maintained and any corrective action taken.

All sites across Greater Glasgow and Clyde operate a ‘pro-active service’ where they are routinely inspected for pest infestations. NHSGGC works closely with GP Environmental in a proactive pest preventative manner to preclude the establishment of intruding rodents and other pests within premises or grounds.

The pests can include insects, silverfish, pigeons, ants, flies, rats and beetles

As previously confirmed GP Environmental has been called to the Queen Elizabeth University Campus, on 421 occasions since the summer of 2015. It is important to note that this information relates to all sites on the campus. The costs for GP Environmental over this time period is £448,879.

As per your request the approximate costs for a four year period for the whole of NHSGGC is £850,000. It is important to note that these costs relate to not only call outs but also proactive pest preventative measures to preclude the establishment of intruding rodents and other pests within premises or grounds.

For example as also confirmed to you recently GP Environmental undertook work at our request following the discovery of pigeons and their droppings in one of the plant rooms during the investigation for possible source of the Cryptococcus infection. As a result of the findings the decision was taken to have all plant rooms inspected and address any of the issues found.

There were approximately 2,500 call out across NHSGGC over a four year period.

26 July, 2019 (MD)

[redacted] **Herald on Sunday -** So I have just got something else, along with this second infection thing. I understand HSE has started requesting to interview, and interviewing a large number of staff at the health board, and also I've been told HPS and HFS have been told by jean Freeman to do a "fingertip search" of all technical and legal documents to ensure compliance. I'm going to go to the Scottish government, obviously. But for the sake of transparency I wanted to let you know also that I'm looking at that. I don't know what you'd comment on but if you want to comment then feel free…As I say, I'm trying to be more open about what I'm doing. The HSE investigation, I understand is different to the internal and external reviews going on at the same time… TBH I forgot about it, but I do see the crown mentioned it after the [redacted] died. I don't know if there is a new HSE investigation or if it's just the one after the [redacted] died.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The purpose of the investigation is to look at governance and processes relating to the Queen Elizabeth University Hospital and the Royal Hospital for Children on areas highlighted in January's HIS report as a basis.

The meetings, with a small number of staff, are to assist the inspectors in their understanding of the processes and procedures and how things work in practice.

They are not investigating any individual as part of their investigation.

**ENDS**

**For info: the 'fingertip search' by HPS and HFS is regarding new and recent builds and doesn't include the QEUH or RHC.**

For further information either telephone [redacted] or email [redacted]


26 July, 2019

[redacted] **Herald on Sunday** - Have you got a water-based infection outbreak going on in children who are being accommodated at the QEUH?

I understand there is another water-based infection, different to the last one, which has affected some young patients. I'm being up front – that's all I know.

I would hope you would confirm if this is the case, what type of infection it is and how many patients are affected. I also think one parent had to be taken to Edinburgh for treatment (that might be rubbish though).

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

We have investigated a single case of infection. There is no outbreak and no other patient is affected.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Client: NHS Greater Glasgow and Clyde Media Coverage
Source: The Herald
Date: 28/07/2019

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Page: 8
Reach: 27655
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# Super hospital caught in the spotlight again

Another infection has been discovered at a scandal-hit super hospital as an investigation – which could see criminal charges brought – is launched into the death of a [redacted] child. **Hannah Rodger** reports

AN investigation which could end up in criminal proceedings is under way at Glasgow's super hospital following the death of a [redacted]

The Herald on Sunday can also reveal another infection has occurred in a child cancer patient, also linked to the water system at the hospital.

The Health and Safety Executive (HSE) has summoned more than 20 staff at the Queen Elizabeth University Hospital for interview as part of their investigation into an earlier infection linked to the death of a [redacted]

The regulator said prosecution could be an outcome of their findings, should they uncover serious breaches of health and safety rules which contributed to the [redacted] death.

Meanwhile, Health Secretary Jeane Freeman has instructed other health bodies to conduct a "fingertip search" of documents to ensure other new and recently built projects in Glasgow comply with all regulations and standards.

The Herald on Sunday has learned that a child with cancer has contracted a fresh bacterial infection linked to the water system at the QEUH, which is now being investigated by NHS Greater Glasgow and Clyde (NHSGGC).

It is the latest in a series of healthcare-associated infections to hit the Queen Elizabeth University Hospital and the adjacent Royal Hospital for Children since they opened in 2015.

In February 2016, months after the hospitals opened, a child with cancer developed a bloodstream infection from a water-born bacteria and another child became unwell from the same bacteria a year later.

Between January 29 and September 20, 2018, 21 children with cancer were struck down by infections from 12 separate types of fungi and bacteria.

NHSGGC announced in June 2018 it would be moving patients from wards 2A and 2B at the RHC due to the infections and they would be treated in the QEUH.

However, in December 2018, a [redacted] with cancer, who was being treated in the QEUH, contracted an infection of Cryptococcus linked to pigeon droppings and later died.

[redacted] also passed away after contracting another fungus, Mucor, having been admitted to hospital [redacted]

We previously revealed that the pest control bill for the QEUH campus had reached more than £400,000, with pests such as rats, ants and beetles among those eradicated or deterred from the site.

One source told The Herald on Sunday that tests are ongoing to determine if other children have been affected by the latest bacteria, said to be a type of Mycobacterium linked to the water system.

Another senior NHSGGC source said: "This is very serious. These children are vulnerable, their parents are going through a difficult enough time as it is.

"They are trying to fight cancer. They do not need to be infected with anything else. Yes, infections can happen in hospital, but as we have seen before, these types of bacteria are relatively or extremely uncommon.

"They're not something you want in your body. These children need all the help they can get to overcome cancer, and with these additional infections, that isn't happening."

Labour health spokesperson Monica Lennon MSP said the latest incident proves there is something "seriously wrong", and questioned whether Freeman now had to take action similar to that with the Edinburgh children's hospital.

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**Page:** 8
**Reach:** 27655
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The Health Secretary halted the opening of the new hospital earlier this month, just days before it was due to open, after she was informed about problems with ventilation.

Lennon said: "There is no doubt that many patients receive excellent care at the QEUH, but it appears there is something seriously wrong at Scotland's flagship hospital that is compromising patient safety.

"Patients have already died as a result of infections caused by the hospital, triggering the ongoing major investigation into the building, but how many more people need to get ill or die before the Health Secretary takes serious action?

"Jeane Freeman's honeymoon period is long over and she's failing to get a grip of the big problems she inherited from previous SNP ministers. In fact, some things are getting worse and she has failed to reassure the public that the QEUH is safe.

"If she can't guarantee the safety of patients in every part of the QEUH she's going to have to explain why, unlike the new Edinburgh Sick Kids which she's deemed unsafe, it's still open."

Within the last few weeks, HSE staff investigating the pigeon droppings Cryptococcus infection have asked more than 20 NHSGGC employees to attend interviews as part of a criminal probe into the incident.

NHSGGC emphasised that staff were offering to "assist the inspectors in their understanding of the processes and procedures and how things work in practice".

It also said that no individual person was being investigated.

A source close to the investigation said one employee had been grilled for seven hours by regulators, who will make recommendations and pass their findings to the Crown Office once complete. The source said: "HSE are looking at breaches in the Health and Safety at Work Act, any systemic failures, any organisational or individual failings, from top to bottom.

"They can request access to every piece of documentation going, they have their field investigators in now. The investigation is massive in scale.

"They have issued a notice to a large number of staff, in excess of 20 people, telling them they of their intent to interview them."

The source added that staff being interviewed include those from nursing, occupational health, estates and facilities, health and safety and nursing, as well as medical employees.

Jeane Freeman has asked Health Facilities Scotland (HFS) and Health Protection Scotland (HPS) to conduct a fingertip search of technical and legal documentation associated with new and recently built projects.

The bodies have been asked to ensure that all projects are compliant with regulations, sources say. The QEUH and RHC are not included in the fingertip search, as they are already subject to an internal investigation by NHSGGC, as well as an external inquiry being chaired by Dr Brian Montgomery, the former medical director and interim chief executive of NHS Fife, and Dr Andrew Fraser, the director of public health science at NHS Health Scotland.

An NHS Greater Glasgow and Clyde spokesman said of the HSE investigation: "The purpose of the investigation is to look at governance and processes relating to the Queen Elizabeth University Hospital and the Royal Hospital for Children on areas highlighted in January's HIS [Healthcare Improvement Scotland] report as a basis. The meetings, with a small number of staff, are to assist the inspectors in their understanding of the processes and procedures and how things work in practice.

"They are not investigating any individual as part of their investigation."

On the new bacterial infection, the spokesman said: "We have investigated a single case of infection. There is no outbreak and no other patient is affected."

A Scottish Government spokesman said of the latest infections: "Our primary concern, and that of NHS Greater Glasgow and Clyde, is the safety and wellbeing of all patients and their families.

"No details of any patient cases can be provided as both we and the health board are bound by strict rules regarding patient confidentiality.

"We expect NHSGGC to ensure that the necessary control measures remain in place and are continually reviewed to ensure patients, families and visitors at the hospital are safe."

A spokeswoman for the HSE confirmed that as the criminal probe was ongoing, it could not provide further details of the inquiry or those being asked to interview, and added: "HSE's investigation following the Cryptococcus outbreak at the Queen Elizabeth Hospital is ongoing and as this is an ongoing investigation, we cannot go into any further detail."

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The Herald
**Date:** 28/07/2019

**Keyword:** NHS Greater Glasgow and Clyde
**Page:** 8
**Reach:** 27655
**Size:** 1011
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> This is serious. These children are vulnerable, their parents are going through a difficult enough time as it is. They are trying to fight cancer

**Following a series of issues at the QEUH, Health Secretary Jeane Freeman has ordered a 'fingertip search' of documents to ensure other new and recently built projects comply with regulations and standards**

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| **Client:** | NHS Greater Glasgow and Clyde Media Coverage | **Keyword:** | NHS Greater Glasgow and Clyde |
| **Source:** | The Herald | **Page:** | 8 |
| **Date:** | 28/07/2019 | **Reach:** | 27655 |
| | | **Size:** | 1011 |
| | | **Value:** | 6500.73 |

Client: NHS Greater Glasgow and Clyde Media Coverage
Source: The Herald
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Keyword: Queen Elizabeth University Hospital
Page: 37
Reach: 27655
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**In our opinion**

# Issues at super hospital must be addressed

THE LATEST incident at Scotland's flagship hospital is undoubtedly a cause for concern among patients and staff.

One of the most vital forms of public service is a healthcare system which not only protects people and keeps them safe but helps to make them better.

It is by no means taken for granted that we have a free healthcare system in this country, but the value of such a critical service is undermined when the very thing supposed to be healing people is making them ill.

The investigation into what happened at the Queen Elizabeth University Hospital that led up to the death of a [redacted] is proceeding at some pace now.

The 20-odd staff being interviewed by investigators will do everything they can to help the proceedings, even if they would ultimately prefer to be on the frontline helping treat patients in need. Let's hope they are able to shed some light on what, if anything, has gone wrong here.

When the facility opened four years ago, it is fair to say nobody would expect prosecutions for health and safety failings to be uttered in the same sentence as the £842 million hospital.

Sadly, if there have been fundamental failings or breaches in law, it is only right and proper that the truth is discovered so that we may learn from these mistakes.

The concern is that while these investigations are ongoing, there still seem to be further infections coming from within the hospital, still making patients ill. It is essential that any problems are uncovered as soon as possible to protect anyone else from suffering.


29 July, 2019

[redacted] **Daily Record -** I am looking for a reaction to a story about a construction boss who said there was evidence of a massive pigeon problem at the QEUH as far back as the construction phase. He banned his electricians from working on the twelfth floor because there was so much pigeon poo and he recognised it as a health and safety issue.

He said both he and several other contractors raised the issue at weekly meetings with the health board but nothing was done - he assumes because of the added cost implications.

He said that all these concerns should be in minutes of the meetings.

Looking for reaction to this and, in particular, if the problem existed then why were patients transferred before something was done.

Also looking for an updated position on the child with mycobacterium and asking if further children have been identified following tests . . or if the tests have been carried out yet.

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

The construction of the building was carried out between 2009 and 2015. Any issues during this time were the responsibility of Brookfield, the contractor. As with all construction work, any issues raised by sub-contractors should have been raised with them at the time.

The building became the responsibility of the NHS when it was handed over to us in early 2015.

As part of the handover from the builder to the NHS, and in preparation for opening, more than three months was spent fitting out, testing and cleaning 7,600 rooms. A full inspection of the building was then completed before opening to patients.

**ENDS**


Monday, July 29, 2019

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Our Public Health experts have looked into the risks to humans from birds and concluded that the presence of birds in the grounds of a hospital is an environmental nuisance rather than a health risk.

In the same way that birds and wildlife are attracted to hospital buildings they are attracted to any large buildings in any town or city.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Dear Parent

You may have seen some activity on ward 6A in over the past few days and we wanted to give you an update on what is happening.

We continue to monitor infection rates carefully. These remain within expected levels for the patients treated on this ward.

Our monitoring has however identified two uncommon infections within the children's cancer ward which we are investigating further.

These are two different infections and not linked. We have not found a source for either infection.

As you may know, we have previously introduced a number of additional control measures within the ward to maintain a safe environment for patients.

We would like to assure you that the additional measures in relation to water quality have been successful. Our rigorous water quality testing is demonstrating good results alongside the ongoing use of water filtration devices. The water supply is not a source of infection.

The HEPA filters remain in use in the rooms and we continue to monitor the air quality regularly within the unit. The air quality results are within acceptable levels and there are no links between the air quality and the two cases being reviewed.

In order to carry out further investigations, we now need to create capacity within the ward area. We have therefore taken the decision to temporarily suspend admissions to the ward to allow this to take place over the weekend.

As a precaution, patients in the unit are also being given prophylactic antibiotic medication.

Outpatients and day cases are unaffected and will go ahead as normal next week.

Please be assured of our continued and total commitment to delivering the best medical and nursing care in a safe environment for our patients.

You can assist us by paying attention to hand hygiene and limiting the number of other family members visiting at one time.

Please let a member of our clinical staff know if you wish to discuss anything further and we will arrange this with a member of senior medical, nursing and infection control teams.


Friday, August 2, 2019

[redacted] **Herald on Sunday** - Have you identified the source of this infection yet and if so, what is it and what steps are being taken to address that? Was this infection discussed by an incident management group, was there a report to HPS, and was it given a HIIAT score? Just looking at doing a small update for this week. I presume no other patients have tested positive for this infection apart from the one patient? And no other issues with hospital-acquired infection in this ward at present?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

As previously reported, a number of measures have been taken to enhance the environment within Ward 6A and to improve the quality of the water supply and of the air quality. These measures are having good effect with positive results.

Infection rates remain within expected levels for the patients treated on Ward 6A. However in light of two rarer infections, we are taking the precaution of reviewing infection control practices and procedures and the ward environment.

These are two different infections and at this stage there is nothing to link the infections to the ward's infection control practices or the environment.

In order to facilitate our investigations, we require to keep part of the ward unoccupied for a short period.

New admissions are therefore temporarily being diverted. Outpatients and day cases continue as normal.

In addition we are taking the precaution of prescribing prophylactic antibiotics for patients on the ward.

We would also reiterate all the advice previously given and ask visitors for their assistance by observing hand hygiene.

Due to patient confidentiality we are unable to give any information on individual patients other than to confirm that both are receiving treatment for their infection.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Sunday, August 4, 2019

## NHS GREATER GLASGOW AND CLYDE STATEMENT

As previously reported, a number of measures have been taken to enhance the environment within Ward 6A and to improve the quality of the water supply and of the air quality. These measures are having good effect with positive results.

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In order to facilitate our investigations, we require to keep part of the ward unoccupied for a short period.

New admissions are therefore temporarily being diverted. Outpatients and day cases continue as normal.

In addition we are taking the precaution of prescribing prophylactic antibiotics for patients on the ward.

We would also reiterate all the advice previously given and ask visitors for their assistance by observing hand hygiene.

Due to patient confidentiality we are unable to give any information on individual patients other than to confirm that both are receiving treatment for their infection.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Monday, August 5, 2019 (LD)

[redacted] **ET** - A parent whose child has cancer and is in there says parents don't feel reassured that the hospital is safe. What can you say to reassure them?

## NHS GREATER GLASGOW AND CLYDE ADDITIONAL STATEMENT ON WARD 6A

We can absolutely offer our reassurance to the parents and families that Ward 6A is safe.

As our statement makes clear infection rates are within the expected levels for the patients treated on Ward 6A.

At this stage there is nothing to link the infections to the ward environment, however in light of two rarer infections, we are taking the opportunity to review our infection control practices, hand hygiene and the ward environment.

We have already spoken to the parents on the ward and provided them with written information which includes the offer to meet with our clinical, nursing and infection control staff to discuss any concerns they may still have.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Friday, August 9, 2019 (LD)

[redacted] **Herald on Sunday** - see questions below

## NHS GREATER GLASGOW AND CLYDE RESPONSE TO FURTHER QUESTIONS

The investigations into the infections continue. Whilst they relate to unique and separate cases, they are being considered and reported to Health Protection Scotland as a single investigation. There have been different ratings at different stages of the investigation, including green, amber and red ratings in response to varying factors including public interest/anxiety (through media coverage etc), impact on service and assessment of the patients concerned.

At this stage there still remains nothing to link the infections to the ward environment or to the infection control practices within the ward.

We are continuing to take precautions. The ward remains open but to allow ongoing investigations to continue, the temporary divert of new patients remains in place.

**ENDS**

**In email….**

**You asked us to also the reasons why we are unable to name the bacteria/fungi involved in each infection.**

Our primary responsibility is to our patients and their families. When considering what information to put in to the public domain there are a number of issues to consider. This includes questions of whether there is a public interest in learning of the specific nature of the infection and whether there is any public health implication for the wider health of the population.

A further key consideration is clearly whether we would breach patient confidentiality if we shared information about a single case.

In this case, there is no risk of transmission of these infections from patient to patient and no public health consequence.

These are three unique cases which mean that we would be releasing confidential information to the media about individual patients.

**The NHS code of practice on confidentiality sets out that key identifiable information includes:**

- **patient's name, address, full post code, date of birth;**
- **pictures, photographs, videos, audio-tapes or other images of patients;**
- **NHS number and local patient identifiable codes;**
- **anything else that may be used to identify a patient directly or indirectly. For example, rare diseases, drug treatments or statistical analyses which have very small numbers within a small population may allow individuals to be identified.**

Whilst we have reported on single cases in the past, lessons learned from previous incidents, including criticism from the families concerned, have led us to review this position and in view of the above, we will not in this instance be confirming the specific nature of the infections.

Scottish Government have also made clear that they will not discuss these specific patients due to the strict rules of patient confidentiality.

We will of course continue to be open and transparent about any issue of material interest on the management of the infections.

Dear Parent / Carer

We have been giving you regular updates on the measures we have been taking to enhance the environment on the ward.

As you are aware we have already taken a range of measures including a programme of enhanced cleaning.

We have undertaken extensive testing of all the water systems in the ward and there still remains no source to link the infections to the ward environment or our infection control practices.

As a precautionary measure we are continuing to undertake further investigations and testing and to facilitate these we will continue to divert a small number of admissions. Outpatients and day cases are continuing as normal

We also undertook a range of audits of infection control practices within the ward. The results from these audits were within the accepted limits and our plan is to continue these on an ongoing basis.

Prophylactic antibiotics are being prescribed to patients on the ward and we continue to work closely with Health Protection and Health Facilities Scotland.

We would once again like to thank all the parents for their continued support whilst these measures remain in place and further investigations continue.

We would also ask the parents and visitors to continue to assist us by adhering to our advice on good hand hygiene practice when in the ward.

As you are aware our clinical, nursing and infection control staff are available if you wish to discuss anything further.


Friday, August 16, 2019

## NHS GREATER GLASGOW AND CLYDE RESPONSE TO QUESTIONS

1)The infection that I reported on the 28th July
Can you tell me, simply, if you have identified the source of this infection? I asked this twice before, and still haven't got a straight answer. I don't need an official comment on this, I'm happy to talk off the record so I can understand exactly what you are saying, but the previous comments on it do not make it clear what you are actually saying about this infection.

**No source has been found. This investigation has been closed down.**

2)The other two infections I reported on August 4th
You said last week that they have been reported as one incident to HPS, and you are investigating but there is no indication at this stage they are linked to anything within the hospital environment. Is this still your stance?

**Yes. There is nothing to link the infections to the ward's infection control practices or the environment**

3) Have you had any further infections on the ward since the two above?

**There have been no more confirmed cases of these unique infections.**

**ENDS**

For further information either telephone [redacted] or email [redacted]

# NHS GREATER GLASGOW AND CLYDE STATEMENT

Guidance is being issued nationally that bottled water coolers should not be used in NHS Scotland healthcare premises. This is due to the fact that there is potential for bacteria in the nozzle and the water bottle if not routinely used, which could pose an infection risk to vulnerable patients.

This guidance has been issued to all Boards in Scotland who have either removed or are in the process of removing all bottled water coolers. NHSGGC is complying with this.

Patients and staff will have access to drinking water from ward kitchens or suitably assessed plumbed in water coolers.

**ENDS**


Tuesday, August 20, 2019

[redacted] **Herald** - £1.7m for ventilation at QEUH. Was this because of crypto?

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON VENTILATION SYSTEM

No. We announced the upgrading of the ventilation system at the beginning of December following work on the drainage and water.

We decided to take the opportunity whilst the wards had been decanted to upgrade the ventilation system.

**ENDS**

For further information either telephone [redacted] or email [redacted]


20 August, 2019

**NHS GREATER GLASGOW AND CLYDE**
**STATEMENT**

Patients with cancer have increased exposure to harmful bacteria which means there will be a background level of bloodstream infections.

There have been eleven cases of gram negative bacteraemias and one case associated with a type of mycobacteria since April. This is in keeping with recognised background rates of two to three per month.

Three of the cases were of an unusual type of bacteria and an Incident Management Team was convened to review all of the cases. It has found that nine of the 12 patients had their symptoms before being admitted to the hospital.

None of the three unusual cases are linked to each other however one has been linked to the water.

There is evidence that the filtered water in the haematology/oncology ward is free of bacteria but as a precaution, point of use filters were placed on outlets in other areas of the hospital this vulnerable group of patients might visit.

The bacteria linked to water is harmless to the vast majority of patients and the public and published studies show this type bacteria can be found in raw water, such as reservoirs, lochs and rivers, in public mains, household water systems and in public buildings such as hospitals. Infections with this bacteria are very rare.

The authorised engineer has reviewed all the water reports from the QEUH and describes the water supply as ‘wholesome’. The part of the incident related to water was closed by the Board and Health Protection Scotland on 08 August

**ENDS**

For further information either telephone [redacted] or email [redacted]


Wednesday, August 28, 2019

[redacted] **Freelance** - see questions below

## NHS GREATER GLASGOW AND CLYDE RESPONSE

On page 8 of latest HAIRT report it talks about the sub-group looking into the Cryptococcus neoformans infection. Can I see the minutes of the group meetings?

***These are not available.***

Has the final report been completed and, if so, is it possible to read that?

***The report has still to be concluded.***

And who are the US experts consulted?

***The group have been seeking opinion from microbiology colleagues in both the UK and USA.***

**ENDS**

For further information either telephone [redacted] or email [redacted]


Wednesday, August 28, 2019 (LD)

[redacted] **Freelance** - My other query is about the rare blood stream infections in the children's cancer ward. I wanted to check whether the situation remained as it was when the story was covered on August 4 - does the ward remain closed to admissions; are patients still receiving antibiotics and have any other cases of the rare bacteria been identified? Was the source of the infections pinpointed?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

There are no further confirmed cases of the unusual infections which prompted a review of infection control practices and the environment of Ward 6A.

There is nothing to link the infections to the ward and the investigation into one of the cases has been closed down.

Investigations continue on the other unusual cases.

A further meeting has been set for early September, when a decision will be taken on re-opening the ward.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Dear Parent / Carer

We are committed to keeping you informed of the work that has taken place in the ward and to reiterate our thanks and gratitude for your continued co-operation and support.

Our team investigating a number of unusual infections amongst patients continue to meet. The latest meeting was today, Friday 06 September

We have already made you aware of the extensive testing of all the water systems in the ward and that this testing has shown no source linking the ward environment to the infections.

We are arranging for an external expert from NHS England to join us to review the measures we continue to take.

We do expect further media coverage in a paper at the weekend. We have included our media statement for your information.

We would also reiterate that parents and visitors continue to assist us by adhering to our advice on good hand hygiene practice when in the ward, and that our clinical, nursing and infection control staff are available to discuss anything further.


## NHS GREATER GLASGOW AND CLYDE STATEMENT

The risk of infection can never be completely eliminated and some people have a higher chance of acquiring an infection than others. Our responsibility when caring for our patients is to assess that risk and to put in place appropriate measures to stop infection or prevent its spread.

The infection rates within ward 6A are consistent with infection rates at the old Yorkhill Hospital. This is in keeping with recognised background rates which are approximately two-three per month. These rates have been reported and scrutinised at our public board meetings. One further infection – within accepted background levels - has been reported since this time.

There is nothing to link the infections to the ward's infection control practices or the environment.

In one case, we found the type of bacteria to be widespread in the general domestic water supply and in the water supply to public buildings.

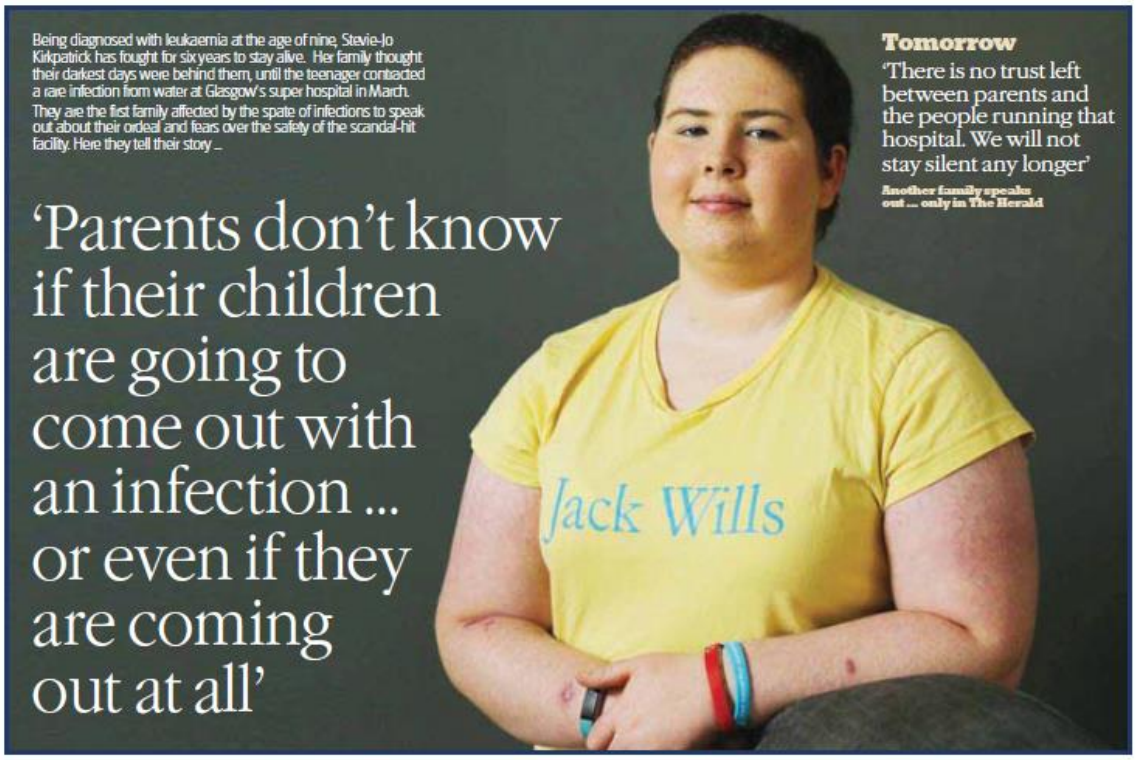
As a further precaution to our well established infection control practices, we therefore extended the fitting of point of use filters on taps to other areas of the hospital.

We have been committed throughout to keeping all parents/carers informed of the work we have undertaken to enhance the environment on the ward. Ward 6A remains closed to new admissions as a precaution.

At no time have we instructed patients not to drink the tap water. Bone Marrow Transplant patients are supplied bottled sterilised water in line with UK-wide practice.

**ENDS**

For further information either telephone [redacted] or email [redacted]




**Special report**

By Hannah Rodger

A FAMILY whose child has had to have her chemotherapy stopped after contracting an infection at Glasgow's super-hospital has accused health bosses of misleading them about the safety of the site.

Stevie-Jo Kirkpatrick, 15, has been left with untreatable lesions all over her body after becoming infected with a rare bacterium – Mycobacterium chelonae – from the water supply at the Queen Elizabeth University Hospital (QEUH).

The teenager has huge infected sores on her arms, chest and legs due to the rare bug, which is related to the same bacteria which causes tuberculosis.

Along with putting a halt to her chemotherapy six months early, the youngster now has to have fortnightly blood tests, put daily dressings on her wounds and will almost certainly be left with lifetime scars.

Weeks before she contracted the bacteria, NHS Greater Glasgow and Clyde bosses and Health Secretary Jeane Freeman told her parents that their daughter was safe and the hospital was not a risk.

Her mum Annemarie Kirkpatrick has questioned the reassurances, and has called for "complete honesty" about the hospital problems.

In May, after Stevie-Jo's infection was identified, medics told Annemarie that only one antibiotic was available to treat it but the side-effects were severe.

They said the 15-year-old would become resistant quickly, so they were left with no choice but to leave it untreated. Medics also said they would have to stop the teenager's chemotherapy six months early to allow her immune system to recover.

Her dad Steven, 47, and Annemarie, 35, are now afraid their daughter could relapse, and have been left "angry, scared and anxious" for Stevie-Jo, who was first diagnosed with leukaemia at the age of nine.

Speaking to The Herald on Sunday, criminology student Annemarie, from Dumfries, said: "I think the hospital hierarchy sitting in offices need to come down and actually meet with the parents. I don't think they are appreciating what these kids go through just to stay alive.

"They are getting toxins, poison, pumped through them every single day to save their lives, and the hospital is putting them in more danger. The kids

should be getting better, they shouldn't be getting these infections from the hospital.

"The consultants and nurses, we feel, are getting the brunt of this and it's not their fault. They've worked above and beyond to save my daughter's life, and the lives of many other children."

Stevie-Jo was first treated in Glasgow's Yorkhill hospital when she was diagnosed with leukaemia in 2013.

She relapsed in July 2017, exactly a year after her first bout of treatment finished, and was admitted to the Royal Hospital for Children at the QEUH site.

Her mum explained: "To start with she was totally fine, but she got quite a few spiked temperatures. That can happen with the chemotherapy, but then she started getting weird things.

"For some reason, we don't know why, she needed oxygen. She got an infection, it never came back what it was but when she was walking she needed oxygen.

"We got home a few days before Christmas in 2017, but she ended up back in hospital, she had para-flu. She hasn't had much time out of the hospital to be honest since then."

On Christmas Day last year, the teenager was rushed to the QEUH after scans showed Stevie-Jo had an infection in her brain, which turned out to be listeria meningitis. Her family thought they might lose her for good.

She spent eight weeks in hospital recovering, first in intensive care then in ward 6A at the QEUH, which has now been closed to new admissions following concerns about water-related infections.

It was during this time that her mum thinks she picked up the Mycobacterium chelonae infection, which medics later confirmed had come from the hospital water supply.

As revealed by The Herald on Sunday, three children with cancer have been struck down by infections on the same ward, 6A, in the last few months with at least one of the infections linked to the water supply.

NHS Greater Glasgow and Clyde said two of the infections were rare but there was no evidence that they were related to the hospital environment, but further investigations are ongoing.

As a result, health chiefs closed the ward to new admissions, with patients understood to be now travelling to Edinburgh and Aberdeen for treatment.

Annemarie explained: "I think people who are making the decision to keep children in that hospital when they know something is wrong, it's unbelievable. It's not right.

"They hopefully have never had to deal with a child who has cancer. That is bad enough, but to be worrying constantly about that, never mind about the safety of the place your child is getting treatment, it shouldn't be happening. I don't know if the people in charge actually know what this is like.

"They think the infection came from when they were removing the central line [a tube inserted in the chest to administer medication] in surgery, it got through that way.

"The water they are using in surgery should be sterile, so who knows how it was infected with this Mycobacterium.

"It has had a huge effect on her, both physically and mentally. She has to keep the lesions covered up, so during the summer it was terrible as it was so hot and she had to cover everything.

"She won't take part in PE at school, as she doesn't want to change in front

**Continued on Page 6**

> The kids should be getting better, they shouldn't be getting these infections from the hospital

> The hospital hierarchy sitting in offices need to come down and actually meet the parents. I don't think they appreciate what these kids go through just to stay alive

**Continued from Page 5**

of people or let anyone see her. She loves football, but she can't play that or go swimming because she doesn't want people to look at her.

"It's just horrible. The worst part is, she will probably be scarred for life from these when they do heal. She's had them since April and really they're not getting much better. We've tried all sorts of things but as she can't have the antibiotic that treats it, and her immune system is weakened because of her cancer, we don't know when they're going to heal properly.

"It's been four months already."

Annemarie first started becoming concerned about the safety of the hospital when a child died following a Cryptococcus infection linked to bird droppings. The [redacted] who was being treated for cancer, became infected with the fungus which was later linked to [redacted] death.

Stevie-Jo was being treated at the hospital around the time of the outbreak. Annemarie explained: "When the Cryptococcus incident happened, before it came out in the press, we noticed that there were all these HEPA filters in the ward and one night they came round and were checking the showers.

"I had asked for a meeting with Stevie-Jo's consultant and the infection control doctor and asked what was going on. They told me everything is fine. They said it wasn't in this ward but patients within the hospital who have caught a fungal infection.

"I asked if Stevie-Jo was at risk, and they said her immune system wasn't compromised enough to be at risk. I don't know how they could say that given her immune system is absolutely zero, and they've had to take her off the chemo to try and improve it.

"I felt like at the time they weren't telling me the truth. It feels like they were trying to minimise what the risks were. I can understand trying to reassure parents, of course, but if you are not being fully truthful about the safety of the hospital – that's a different thing. There's no point in reassuring people when they don't actually know what they are saying is true."

Annemarie said Stevie-Jo now "dreads" going to the hospital for treatment or tests, and has frequently pointed out to her the differences between the new hospital and the old wards at Yorkhill, where she was treated initially for her leukaemia.

She said: "The new hospital, it has a feeling, you can tell something is not right. The kids are always in 'source' – that's when they're not allowed out of their rooms due to infection.

"Stevie-Jo commented on this the other day. In the old Yorkhill, if kids had a cold obviously they had to go into source to protect the other kids, but most of the time they were out of their rooms, in the playroom or going up and down the corridors.

"Since they've moved to the new hospital they are always in source, someone has always got something. Stevie-Jo asked if I had noticed it. You don't see kids up and down the corridors like you used to at Yorkhill, it's just a completely different atmosphere.

"The adult hospital is worse as there are no facilities for the children really and for parents, you can't even make a cup of tea. The kids there really are just in their rooms all the time, it's not a relaxing environment. Somebody needs to take responsibility. They need to be honest about the risks and the severity of the problem, and stop thinking that parents are stupid.

"If they were straight up and honest, people could understand and know they are trying to do something. Just now it feels like they are trying to wipe everything, sweep it under the carpet and hope it goes away, but it's not going to go away. They have already had a child who has lost their life, there's children who are having to come off chemotherapy and are not getting rid of the infections. Where does it end? When do we say 'enough is enough'?

"The reality is, these children are very sick. They are struggling and fighting to stay alive as it is. I would never want anyone to ever experience having a child with cancer, but I don't think people appreciate how hard that is on its own, without the added stress of the problems and the fear of

hospital. You should never be afraid of taking your child to hospital, but parents are. They don't know if they are going to come out with an infection, or if they are coming out at all. It needs to change."

An NHS Greater Glasgow and Clyde spokesman said: "The risk of infection can never be completely eliminated and some people have a higher chance of acquiring an infection than others. Our responsibility when caring for our patients is to assess that risk and to put in place appropriate measures to stop infection or prevent its spread.

"The infection rates within ward 6A are consistent with infection rates at the old Yorkhill Hospital. This is in keeping with recognised background rates which are approximately two-three per month. These rates have been reported and scrutinised at our public board meetings.

"There is nothing to link the infections to the ward's infection control practices or the environment.

"In one case, we found the type of bacteria to be widespread in the general domestic water supply and in the water supply to public buildings.

"As a further precaution to our well-established infection control practices, we therefore extended the fitting of point-of-use filters on taps to other areas of the hospital.

"We have been committed throughout to keeping all parents/carers informed of the work we have undertaken to enhance the environment on the ward. Ward 6A remains closed to new admissions as a precaution."

**See Leader Comment Page 43**

> I can understand trying to reassure parents, of course ... but there's no point in reassuring people when they don't actually know what they are saying is true

> She loves football, but she can't play that or go swimming because she doesn't want people to look at her. It's just horrible

Annemarie Kirkpatrick has been left with a feeling of disbelief over what has happened to her daughter at the QEUH
Top right: just some of the lesions that Stevie-Jo has been struggling with

# ‘There’s no trust left’ as hospital infection row grows

## Father of toddler hits out as 13 children fall sick while being treated for cancer

EXCLUSIVE

**HANNAH RODGER**

PARENTS claim there has been a “fundamental breakdown” of trust at Glasgow’s super-hospital amid calls for a public inquiry.

The Herald can reveal 13 child cancer patients have contracted infections while being treated at the Queen Elizabeth University Hospital (QEUH) over the past five months, and patients are being given bottled water to drink while investigations are going on.

A row erupted over the tap water ban after NHS Greater Glasgow and Clyde (NHSGGC) initially told this newspaper that patients had never been advised that the water was not suitable for drinking.

Health chiefs then issued a letter to parents on Friday evening, following contact from The Herald, stating that “at no time have we instructed patients not to drink the tap water” but encouraging them to speak to nurses if they had concerns.

It prompted several parents, who have never spoken out before about their concerns over the situation, to come forward and make the startling claims over a loss of trust in the QEUH management.

Annemarie Kirkpatrick, from Dumfries, was among those to share her experiences at the hospital.

Yesterday, the 35-year-old told our sister paper The Herald on Sunday how her 15-year-old daughter Stevie-Jo had become infected with Mycobacterium chelonae from the QEUH water supply.

She said children were told to stop drinking the hospital’s tap water when they moved from the Royal Hospital For Children to the adjacent QEUH after dozens of children were struck down with infections at the children’s hospital.

Now father Alfie Rawson, 47, from Glasgow, has joined Ms Kirkpatrick in speaking out about his family’s concerns, saying there is simply “no trust” left in hospital management.

Mr Rawson’s [redacted] has been receiving treatment at the super-hospital since a cancer diagnosis in August 2018.

He said: “There is no trust left between parents and the people running that hospital – and we will not stay silent any more.

“I don’t know how they can say that the kids can drink the tap water. There are signs all over the ward and above all the sinks, saying it is for hand washing only. The nurses have told us to use bottled water, and they have even shown us where to get it.

“I just didn’t feel like I could sit in silence any more – they have gone too far and it feels as though they are not telling us the truth.”

[redacted] has caught three infections, including a pseudomonas, while at

**Continued on Page 5**

# 'Every day is torture... There is no certainty in the life we are living'

**Continued from Page 1**

the Govan site but none of them have been confirmed as having come from the hospital.

Mr Rawson said: "The situation is just terrible, not just for us but for every family that's in there. My [redacted] has got three infections – at least one of them is related to water but they say it's not from the hospital.

"Every day is torture. There is no certainty in the life that we are living. We don't know about things that are going on now, and we have to take a stand and ask for proof and see that it is a safe environment to bring our kids."

Mr Rawson added: "My [redacted] has got three infections – at least one of them is related to water but they say it's not from the hospital.

"Every day is torture. There is no certainty in the life that we are living. We don't know about things that are going on now, and we have to take a stand and ask for proof and see that it is a safe environment to bring our kids.

"There is no trust left between parents and the people running the hospital, and we will not stay silent any more.

"Everything is a cover-up. They don't like to tell you what's going on, it feels like when you ask questions they try to push you out the door.

"Our consultants have been incredible – I can't say anything bad about the medical staff, they care so much about the children, they've saved my child's life.

"But it feels like they are being asked to explain the problems or try and reassure us, when the evidence that there is something wrong is right in front of our eyes."

NHSGGC board papers state that between April and August, 12 children were infected with various bacteria, including three with rare bloodstream infections. It confirmed last night it has investigated another infection since the documents were published on August 20 – a total of 13.

A spokesman said they found in one case "the type of bacteria to be widespread in the general domestic water supply and in the water supply to public buildings", but insisted the levels of infection were "within accepted background levels".

He added: "As a further precaution to our well established infection control practices, we therefore extended the fitting of point of use filters on taps to other areas of the hospital."

The spokesman went on: "The risk of infection can never be completely eliminated and some people have a higher chance of acquiring an infection than others.

"Our responsibility when caring for our patients is to assess that risk and to put in place appropriate measures to stop infection or prevent its spread.

"The infection rates within ward 6A are consistent with infection rates at the old Yorkhill Hospital. This is in keeping with recognised background rates which are approximately two-to-three per month.

"One further infection – within accepted background levels – has been reported since this time. There is nothing to link the infections to the ward's infection control practices or the environment.

"We have been committed throughout to keeping all parents and carers informed of the work we have undertaken to enhance the environment on the ward. Ward 6A remains closed to new admissions as a precaution.

"At no time have we instructed patients not to drink the tap water. Bone marrow transplant patients are supplied bottled sterilised water in line with UK-wide practice."

Asked again why parents were supplied bottled water, and about signs stating tap water was only for hand-washing, a spokeswoman said: "We have been providing bottled water to parents while the ongoing enhancements to the ward have been taking place.

"The water supply has been independently tested and is wholesome. This means the water is safe to drink, including the hand-washing sinks.

"However, we do not encourage patients in any of our wards to drink from these sinks as people are using them to wash their hands.

"We continue to offer bottled water to the parents."

Labour health spokeswoman Monica Lennon has again issued a call for a public inquiry, saying Health Secretary Jeane Freeman has "failed to rebuild public confidence" in the £842 million facility. She added: "Children with cancer are extremely vulnerable and it's worrying that families feel the Health Secretary is not taking their concerns seriously."

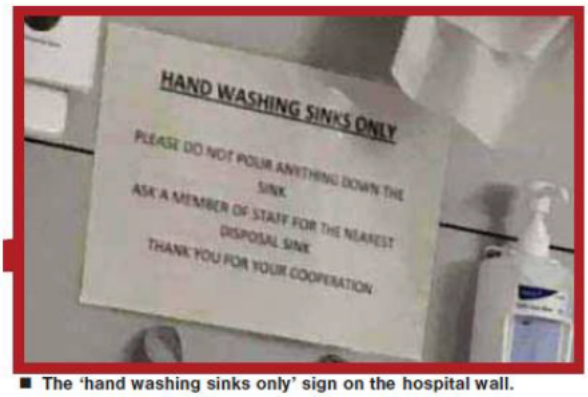
A Scottish Government spokeswoman said: "Ms Freeman has commissioned an independent review to look at the QEUH building's design, commissioning, handover and ongoing maintenance to establish how these matters contribute to effective infection prevention and the inquiry team have received evidence which they are currently reviewing."

> "I can't say anything bad about the medical staff, they care so much about the children

■ Annemarie Kirkpatrick with daughter Stevie-Jo, 15.

■ The super-hospital in Govan was built at a cost of £842m.


■ [redacted] is receiving treatment for cancer at the troubled QEUH.




■ The 'hand washing sinks only' sign on the hospital wall.

■ [redacted] from Glasgow, and her father Alfie.

[redacted] – Herald on Sunday

I'm coming back to you on the statement you made yesterday that the children who have cancer in ward 6A have never been advised not to drink the tap water. If this is the case, why are there signs above the sinks in their rooms saying they are for handwashing and clinical use only, and why are there now numerous parents, following your letter issued to them last night, contacting me telling me that your statement is not accurate, and the children all drink bottled water only, and they are not supposed to drink the tap water? Is it your position that these parents are misinformed, and their children are able to drink the tap water in ward 6A?

**NHS GREATER GLASGOW AND CLYDE FURTHER STATEMENT**

We have been providing bottled water to parents whilst the ongoing enhancements to the ward have been taking place.
The water supply has been independently tested and is wholesome. This means the water is safe to drink including the hand washing sinks. However we do not encourage patients in any of our wards to drink from the these sinks as people are using them to wash their hands. We continue to offer bottle water to the parents.

**ENDS**


09 September, 2019

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have been committed to keeping parents and carers fully informed of work which has taken place in the ward and we have been grateful for their co-operation.

To ensure we maintain this level of dialogue, we are currently arranging meetings for patients and carers with senior managers and senior clinicians to listen to their concerns and answer any questions they have.

These meeting will be held at the earliest convenience for parents and carers.

**ENDS**

For further information either telephone [redacted] or email [redacted]

# Media Statement

NHS Greater Glasgow and Clyde

Monday, September 9, 2019

[redacted] **Daily Mail** - see questions below

## NHS GREATER GLASGOW AND CLYDE RESPONSE

Have 13 child cancer patients contracted infections in the past 5 months?
This is in keeping with recognised long term rates which are approximately two-three per month. These rates have been reported and scrutinised at our public board meetings.

It is acknowledged that there will be a background level of bloodstream infections in this susceptible population. We closely monitor infection rate and the current numbers are in keeping with background rate.

These are not all infections being currently treated in the ward. The number of infections reported to the Board relates to a period from March to September. This is in keeping with recognised long term rates which are approximately two-three per month. These rates have been reported and scrutinised at our public board meetings.

The majority of these patients have gone home and none of the remaining patients are giving cause for concern.

Please make clear in your reporting that we are not treating 13 patients currently with an infection.

Have patients been given bottled water to drink,
The water is safe to drink, however patients and their families are discouraged from drinking water in the rooms as sinks are dedicated to handwashing.

Ward 6A is a temporary move for the current patients and does not have a parent kitchen. The water within the staff kitchen is safe to use however this is a restricted area. For convenience while patients remain temporarily on ward 6A we are therefore providing patients with bottled water.

**ENDS**

For further information either telephone [redacted] or email [redacted]

Media Statement

NHS Greater Glasgow and Clyde

Monday, September 9, 2019 (LD)

[redacted] **Daily Record** - questions below

## NHS GREATER GLASGOW AND CLYDE RESPONSE

Where are those needing treatment now being sent? Are they going to another ward in the QEUH or are they being sent elsewhere?
We have already issued a number of public statements confirming that, following a number of unusual infections, we were diverting new admissions to allow us to test the environment and to carry out work in Ward 6A. This took effect from 2 August.

It would be wrong to say therefore that it had 'now' closed.

Based on clinical need a small number of patients have either been diverted to NHS Lothian and NHS Grampian or are being treated elsewhere within Glasgow.

If the ward is shut to new admissions, what makes it safe for current patients to continue their treatment in ward 6A?
The decision on where to place patients is based on clinical decisions made on clinically appropriateness. The ward was closed to new admissions to create space to allow ongoing testing and improvements to the ward. Extensive testing of the ward has been undertaken and it this stage there remains no link between the ward environment and infections being investigated.

What percentage of child cancer patients have been affected? If there are 1300 patients and 13 have infections it would obviously be less significant than if there were 13 out of 26?
This is in keeping with recognised long term rates which are approximately two-three per month. These rates have been reported and scrutinised at our public board meetings.

It is acknowledged that there will be a background level of bloodstream infections in this susceptible population. We closely monitor infection rate and the current numbers are in keeping with background rate.

And how serious are the infections? Are any of the 13 life threatening?
No.

These are not all infections being currently treated in the ward. The number of infections reported to the Board relates to a period from March to September. This is in keeping with recognised long term rates which are approximately two-three per month. These rates have been reported and scrutinised at our public board meetings.

The majority of these patients have gone home and none of the remaining patients are giving cause for concern.

Please make clear in your reporting that we are not treating 13 patients currently with an infection.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Monday, September 9, 2019 (LD)

[redacted] **Times** - see questions below.

## NHS GREATER GLASGOW AND CLYDE RESPONSE.

1) Which paediatric cancer patients are being treated in the adult hospital and why

Ward 2A/B closed to allow remedial work to the drainage system following previous issues, which have been well reported, with the water supply. The patients transferred to Ward 4B and Ward 6A.

Ward 2A and 2B remain out of use whilst upgrading work is being carried out to the ventilation system. The opportunity to do so was taken whilst the ward was closed. A number of public statements have been made confirming this.

2) What advice those patients have received about drinking water on the wards

The water in the hospital is safe to drink and has been assessed as safe by the independent authorising engineer. There are sinks in each patient room (bed areas and en suite) in both the adult and children's hospitals. Whilst the water is safe to drink, patients are discouraged from drinking this water as the sinks are dedicated for handwashing.

Ward 6A is a temporary move for the current patients and unlike Ward 2a, does not have a parent kitchen. The water within the staff kitchen is safe to drink but this is a restricted area and parents are not able to access this kitchen. For their convenience, patients are therefore being provided with bottled water.

3) If that advice is the same as it was for that cohort of patients when they were in the paediatric hospital and when they were at Yorkhill

See above. The water is safe to drink, however the move from a children's ward to an adult ward means that parents do not currently have access to a kitchen within the ward. For convenience, whilst in the adult ward, bottled water is being provided. This is in no way related to the quality of water which is good and 'wholesome'.

4) If the advice is different why it was changed.

See above.

5) If there is any concern about drinking water at the Queen Elizabeth or sick children's hospitals for patients with compromised immune systems which did not exist at Yorkhill?

No

6) If there is any concern about contamination of the water at the Queen Elizabeth or sick children's hospitals and the nature of that concern.

No – the water is wholesome, which means it is safe to use.

7) why some parents appear to think differently from what NHS GGC is stating about the suitability of tap water at the hospital for cancer patient (as stated in THE Herald)

We are in regular communications with parents on the ward and we will now widen this out to include other families to clarify any misunderstanding with them.

8) How many NHS GGC paediatric patients have been sent for chemotherapy in Edinburgh and Aberdeen and why.

Based on clinical need a small number of patients have either been diverted to NHS Lothian and NHS Grampian or are being treated elsewhere within Glasgow.

Please also comment on the GMC placing the acute internal medicine department under enhanced monitoring. Please provide any reports that show what the concerns are about this dept or the IAU.

This is not our report to provide.

**ENDS**

QEUH Ward 6A

Family information

**Q:** Why are patients getting infections?
**A:** The risk of infection can never be completely eliminated and some people have a higher chance of acquiring an infection than others. Our responsibility when caring for our patients is to assess that risk and to put in place appropriate measures to stop infection or prevent its spread. Infection rates are monitored and scrutinised rigorously. Investigations show no link with the ward at this stage.

**Q**: Is the water on the ward, and wider hospital, safe to drink?
**A**: The authorising engineer has reviewed all the water reports from the QEUH and describes the water supply as 'wholesome' meaning it is safe. As a precaution, in addition to our well established infection control practices, we fitted point of use filters on taps to the ward and other areas of the hospital.

**Q:** Why are there signs in the ward bathrooms and bedrooms telling people not to drink the water?
**A:** The water is safe to drink, however patients and their families are discouraged from drinking water in the rooms as sinks are dedicated to handwashing.

**Q:** Do patients have access to the kitchen? If so, why the need for bottled water?
**A:** Ward 6A is a temporary move for the current patients and does not have a parent kitchen. The water within the staff kitchen is safe to use however this is a restricted area. For convenience while patients remain temporarily on ward 6A we are therefore providing patients with bottled water.

**Q:** Is the ward open?
**A:** The ward remains open to treat current patients, however a temporary divert of new patients remains in place.

**Q**: Is there any link between infections and ward 6A?
**A**: Extensive testing of the environment has been carried out and at this stage there is nothing to link the ward environment with the cases.

**Q**: what are the plans for the ward going forward?
**A:** We are looking to reopen ward 6A to new admissions following the implementation of a number of improvements including fitting of the made to order HEPA filters in the patients' bathrooms. The timeline is dependent on the delivery and installation of the units. We are arranging for an expert from NHS England to join us to review the measures we continue to take.

**Q:** When will wards 2A and 2B reopen? What work has been done to them?
**A:** The wards are due to reopen in March 2020.

Dear Parent / Carer

We appreciate that this is a difficult time and are sorry for any distress that has been experienced by you during this time.

We have been committed to keeping you up to date on the work we have been doing to enhance the ward environment.

Following every meeting of the Incident Management Team (IMT) we have provided you with both a verbal and written briefing.

We are extremely grateful to you for your continued co-operation and support but recognise that some parents have further concerns.

To help address these concerns we have prepared a short briefing to answer any questions you may have.

Our clinical, nursing and infection control staff are also available to discuss anything further.


Monday, September 9, 2019 (LD)

[redacted] **Radio Clyde** - running story on Ward 6A at QEUH that claims parents have lost all trust in Glasgow's Queen Elizabeth University Hospital have reignited calls for a public inquiry. Twelve children have contracted infections while being treated for life threatening illnesses. An investigation into the water supply earlier this year found "widespread contamination" but seven months on mums and dads claim they're still being told not to drink from the taps.

**NHS GREATER GLASGOW AND CLYDE STATEMENT ON QEUH**

We have been committed to keeping parents and carers fully informed of work which has taken place in the ward and we have been grateful for their co-operation.

To ensure we maintain this level of dialogue, we are currently arranging meetings for patients and carers with senior managers and senior clinicians to listen to their concerns and answer any questions they have.

The water is safe to drink, however, we do not encourage patients in any of our wards to drink from the hand wash sinks in the patient rooms as people are using them to wash their hands and tip clinical waste down the drains.

**ENDS**

For further information either telephone [redacted] or email [redacted]


16 September, 2019 (MD)

## NHS GREATER GLASGOW AND CLYDE RESPONSE.

Ward 6A remains open to treat current patients, however a temporary divert of new patients remains in place. The majority of patients are being treated in Glasgow with a small number of new patients being treated in Edinburgh and Aberdeen.

Infection rates within the Royal Hospital for Children are low. The most recent national survey of all hospital infections was carried out in 2016 and this showed the Royal Hospital for Children to be below the national average – with rates of 3.6%.

The next annual Scotland-wide survey is not due to take place until 2020. In the meantime, ongoing monitoring shows that our rates of bloodstream infections are significantly better than many other units and comparable to the renowned Great Ormond Street Hospital.

Extensive testing of the ward's environment has not demonstrated a link between the infections and the ward environment. We are therefore working towards reopening Ward 6A. Wards 2A and 2B in the Royal Hospital for Children are scheduled to reopen in March.

**ENDS**

Note to editors: The majority of the 13 infections reported to the Board between March-August had an infection on admission. These were not contracted in hospital and extensive testing of the environment has shown there is no link between the infections and the ward environment.


19 September, 2019 (MD)

[redacted] The Times - I know now that when the Glasgow hospitals opened the ventilation systems did not all meet with the standards stipulated in the Scottish Health Technical Memoranda.

The same problem caught ahead of opening at the sick kids.

Please can you comment.

If possible, please provide further details on the wards where the systems did not meet these standards

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Patient safety is of paramount importance to the Board. Infection rates at both hospitals are low and the hospitals are clinically safe.

The general air filtration system is of a high industry standard. This was designed in line with the national guidance including the application of derogations. This is a recognised and standard process for managing complex construction projects.

An upgrade was carried out in four paediatric Bone Marrow Transplant (BMT) isolation rooms in 2015. Testing confirmed full compliance with the appropriate technical building requirements. Over the years, the unit has successfully treated a number of patients with cancer related illnesses with good UK bench-marked outcomes.

Work was carried out on the adult BMT unit to ensure optimal air quality purification levels for this group of patients. The resulted in a significantly improved environment for BMT adults and again we have successfully treated many patients in this unit.

We are proactively investing £2 million to upgrade the ventilation system in Ward 2A and B to provide optimal, state of the art facilities for all our young haemato-oncology patients.

**ENDS**

For further information either telephone [redacted] or email [redacted]


19 September, 2019 (MD)

[redacted] **BBC** - What I am trying to ascertain whether the ventilation system had failed t meet safety standards when the hospital opened?

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Ventilation systems are primarily designed to ensure a flow of air through a hospital building and the general ventilation filtration system for QEUH and RHC is of a high specification. The Scottish health technical memoranda referred to in today's article are design standards - not safety standards.

In terms of safety, from an infection prevention and control perspective, data has shown that there is sound evidence our hospitals are safe – airborne infection rates are low indicating that our systems are providing good levels of protection against infection.

**ENDS**

For further information either telephone [redacted] or email [redacted]

THE TIMES

Date 20 September 2019
Page 1,2

Precise.

# Super-hospital opened despite 'not meeting safety standards'

Helen Puttick
Scottish Health Correspondent

Glasgow's "super-hospital" was permitted to open despite the ventilation systems failing to meet safety standards, *The Times* has learnt.

Outbreaks of infection, which may have spread through the ventilation system at the Queen Elizabeth University Hospital, have led to the deaths of two patients. A [redacted] cancer patient and a [redacted] died after testing positive for *Cryptococcus*, a fungus linked to pigeon droppings, which were found in air ducts.

The decision to open the Queen Elizabeth contrasts with the last-minute decision to postpone the transfer of patients to the new "Sick Kids" hospital in Edinburgh, which failed to meet the same ventilation standards.

Miles Briggs, health spokesman for the Scottish Conservatives, said: "Parents and staff will be deeply concerned about revelations that the Queen Elizabeth University Hospital opened without meeting the necessary standards on ventilation.

"This is just the latest troubling information regarding a hospital building project in Scotland that the SNP has mismanaged."

He said that the public deserved to know the full story and so he had written to Jeane Freeman, the Scottish health secretary, to seek clarification.

Last year young cancer patients were moved out of two wards in the Glasgow hospital after a spate of infections that were originally linked to water supply or drainage issues. Bosses at NHS Greater Glasgow and Clyde are

**Continued on page 2, col 1**


THE TIMES
Palace anger mounts as Cameron spills secrets

THE TIMES

Date 20 September 2019
Page 1,2

Precise.

CONTINUED FROM PAGE 1
Hospital problems

spending £2 million upgrading the ventilation systems connected to these wards.

A source has told *The Times* that not all ventilation systems at the hospital complex in Glasgow met standards stipulated in a document known as the Scottish Health Technical Memorandum when the building opened. According to previously leaked documents, an investigation by the private contractor Innovated Design Solutions found that air change rates did not comply with Scottish or UK ventilation guidelines.

A public inquiry into the Sick Kids and Glasgow hospital construction projects has been ordered by Ms Freeman. The accountancy firm KPMG has already looked into some of the issues that led to the move from the old Sick Kids building in Edinburgh to the new £150 million property at Little France, being cancelled.

Its report said: "The key issue which led to the delay was the non-compliance with the Scottish Health Technical Memorandum for air change rates in some of the critical care areas of the hospital."

NHS Greater Glasgow and Clyde said that "derogations" — or relaxations — of rules governing ventilation had been agreed when the ventilation design strategy was developed.

"The general air filtration system is of a high industry standard. This was designed in line with the national guidance including the application of derogations," it said.

It said upgrades had been carried out over the years and that "testing confirmed full compliance with the appropriate technical building requirements", noting that a number of patients had been treated in the relevant wards with good outcomes.

Upgrades were carried out in four paediatric bone marrow transplant isolation rooms in 2015 and on the adult bone marrow transplant unit, improving the environment for patients, the health board said, adding that it was "proactively investing £2 million to upgrade the ventilation system in Ward 2A and B to provide optimal, state of the art facilities" for its young patients.


THE TIMES
Palace anger mounts as Cameron spills secrets

The Herald

Date 22 September 2019
Page 32,33

Precise.

# A story that shows why the press needs our protection

It's has been a big week for The Herald on Sunday ... first, months of work by our Chief Reporter, **Hannah Rodger**, to report the true extent of problems at Glasgow's super-hospital paid off when the Scottish Government announced a public inquiry, and then we played a starring role in the BBC documentary The Papers. Here, Hannah explains just what went into winning an inquiry for parents of sick children, and why the work of journalists like her is something we should never take for granted

IT was just another deadline day and we were all putting the finishing touches to the next day's edition when the story dropped on the news wire.

According to the Press Association, there had been an outbreak of a fungus at the Queen Elizabeth University Hospital in Glasgow, only a few miles from our offices.

The date was Saturday, January 19, and I could not fully comprehend what the story was saying.

Apparently, a fungus called Cryptococcus, which is associated with bird droppings, had somehow infected very sick patients at the new £842 million hospital.

One hour later NHS Greater Glasgow and Clyde (NHSGGC) announced that two patients had died due to the outbreak.

The timeline around the scandal was confusing. Initially, it appeared the incident had just happened and that it was still evolving. But it was revealed in the coming days that the incident had, in fact, taken place a month earlier, in mid-December.

When this emerged, along with the fact that one of the people who had died was a [redacted] already battling cancer, and the other was an [redacted], the public was understandably outraged. Politicians demanded answers but everyone was thinking the same thing, namely how could this have happened?

While the incident itself is appalling, what nagged me most of all was the month-long delay before it was publicly revealed, despite two patients dying.

Rumours had been circulating among journalists that the scandal had been discovered by a Sunday tabloid reporter, who had been planning to run it as an exclusive.

Was it pressure from the media which caused the health board to finally reveal what had happened? If not, why had management chosen to wait so long before informing the public? If those in charge had kept this quiet for a month, what else might have happened that we still didn't know?

As soon as the Health Secretary Jeane Freeman confirmed the fungus was a contributing factor in the death of the 10-year-old patient, I began to submit requests under Freedom of Information laws to NHSGGC.

I asked for correspondence about the Cryptococcus infections, minutes of meetings about the incident, emails and documents. But nine months and hundreds of emails later, I am still fighting to get the information released.

While I managed to obtain some information, there are still hundreds of key documents which NHSGGC refuses to hand over, stating it would not be in the public interest to release the information, or that staff would be upset if their comments made it into the press. Sometimes they said it would cost too much to look out the documents, while in other cases they have simply refused to hand them over.

After six months of investigating, I had managed to find out many things about the hospital, its construction and concerns from staff which we ran over several months. However, our coverage had one vital thing missing – and that was people. Stories had become about design, complex contracts, budgets, engineering, it wasn't about the people impacted by all of it.

But that all changed when Annemarie Kirkpatrick agreed to speak. Her daughter Stevie-Jo has leukaemia, and was being treated at the

The Herald

Date 22 September 2019
Page 32,33

Precise.

QEUH at the end of last year when the outbreak happened.

She was the first person to speak publicly about the problems since the scandal first emerged, and her family's story had an instant impact as people could at last relate to another person's experience.

When The Herald on Sunday published Annemarie and Stevie-Jo's story, and told how the teenager had been left with infected lesions after contracting a bacteria from the hospital's water supply, their story was picked up across the country and the family were asked to go on the radio and TV.

Alfie Rawson and Charmaine Lacock then contacted me too, to talk about their fears while their [redacted] daughter [redacted] was being treated for cancer at the hospital, and that story appeared in the following day's Herald.

Last week, we published leaked documents showing that records about the £842m facility were missing or wrong, that ventilation problems may be across both the adult and children's hospital and that concerns over bone marrow transplant units were apparent just months after the hospitals opened.

While NHS Greater Glasgow and Clyde was unhappy that I had been passed the reports, it continued to insist there was nothing new in them and everything had already been "fully addressed".

The publication of these reports, along with my request on behalf of families to Jeane Freeman asking her to meet them, which appeared in The Herald, added to the pressure on the Government.

Freeman had been facing calls from Scottish Labour's health spokeswoman Monica Lennon to hold a public inquiry into the scandals at Glasgow and the Sick Kids in Edinburgh, which had until this week been rejected.

But when families started backing those calls, Freeman finally conceded.

On Tuesday morning I woke to a message saying there had been rumours the health board was preparing for a public inquiry, and that afternoon Freeman announced in Parliament she would agree to a full-scale, judge-led public inquiry into these sites.

I felt relieved that after months of investigation we may finally find out how and why this all went wrong.

Most of all, I felt I had achieved something for the families to whom I am so grateful for allowing me to share their stories.

So in the week where we have seen the best and worst of journalism, it is worthwhile reminding ourselves why we need it.

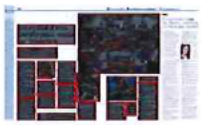
We need journalism to hold power to account, and to find out things that people don't want to be uncovered.

We need it to stand up for the patients who have died, or contracted infections despite the fantastic care of dedicated medical staff. For the staff who bravely blew the whistle in 2015, 2017 and 2018 and had their concerns ignored.

Most of all, we need it for the public whose taxes pay for these grandiose projects which they are entitled to expect to make their lives better – not worse.

> I felt relieved after months of work. Most of all, I felt I had achieved something for the families to whom I am so grateful for allowing me to share their stories

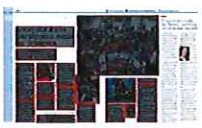
**Chief Reporter Hannah Rodger**



The Herald

Date 22 September 2019
Page 32,33

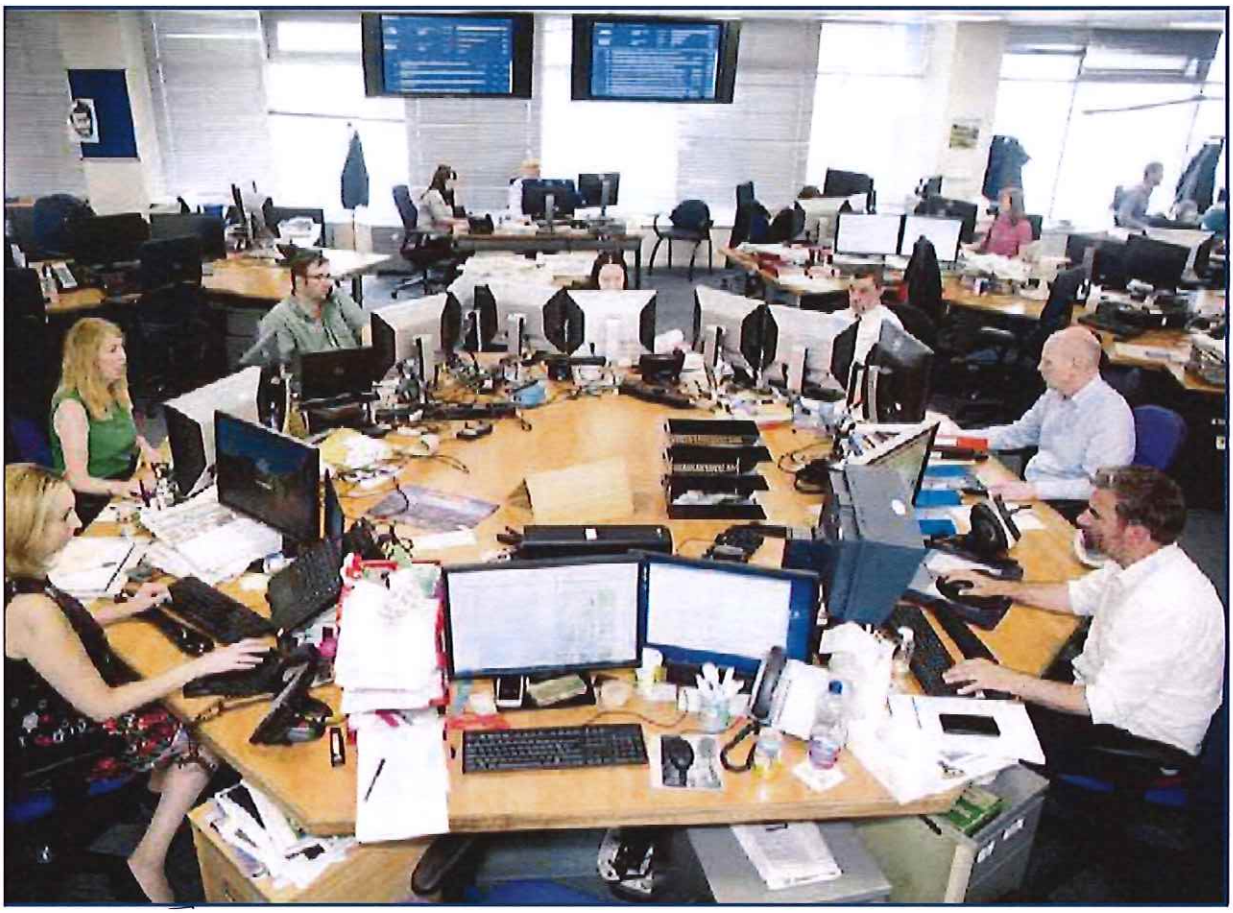
Precise.

The Herald

Date 22 September 2019
Page 32,33

Precise.



The Herald

Date 22 September 2019
Page 32,33

Precise.

**Behind the big headlines, Hannah's Queen Elizabeth hospital story took months, but despite hard slog, dead ends and frustration, her dedication was rewarded when news of a public inquiry broke this week**

9 October 2019

**Parent update on Incident Management Team**

Dear Parent / Carer

We have committed to updating you on our investigations into a number of unusual infections in the ward. Whilst these infections are uncommon the overall number of infections on the ward remain within accepted limits.

Our infection control, clinical, nursing staff and facilities teams along with senior management and national experts from Health Protection Scotland (HPS) continue to work together to investigate the current incident.

We have undertaken extensive testing of the ward environment and at this stage no link has been detected between the infections and the ward environment or our infection control practices.

In one previous case, we found the type of bacteria to be widespread in the general domestic water supply and in the water supply to public buildings. The investigation into this one case has now been closed.

A further Incident Management Team meeting took place last night and it was agreed that ongoing environmental sampling and testing will continue.

We are also continuing to divert a small number of new admissions and high risk patients. All other inpatients and day cases continue to be treated on the ward as does outpatients who are being seen and treated as normal.

A review of all the data relating to the number and nature of the infections is being carried out by HPS and this is ongoing.

The ward staff kitchen is currently out of use. This is the result of a leak from the sink taps. The cause of the leak has been identified as a faulty tap connector on a recently fitted tap. The leak has been repaired and work is being undertaken to re-open the staff kitchen next week.

We appreciate and understand how difficult things are currently and are sorry for any distress during this time. We are extremely grateful to you for your continued co-operation and support and want to ensure you have access to information updates.

To help keep you informed we have established a closed group on Facebook.

The page can be access through https://www.facebook.com/groups/515596955925791/ or by searching for *NHSGGC Haemato-Oncology Closed Facebook Group*

You can join by requesting to be a member of the group, once you have answered the two questions we will add you.

In addition, our Chief Executive and Chairman will be writing to every parent and carer to offer an opportunity to meet.  Our clinical, nursing and infection control and senior management staff are also available to discuss anything further.

Regards

23/10/19

Dear Parent,

We have listened to the ongoing concerns from you and other parents about the lack of facilities in the ward for both your child and yourself.

We are delighted to let you know that we have been able to create a parents' kitchen and social space which is now available for you and your family to access.

This area is a dedicated space where you can make tea and coffee or warm up food in the microwave. There is a comfortable seating area for you and other parents to meet and chat or you have some time to yourself.

You will also be able to access cold water in the parent's kitchen as often as you require and a water jug has been provided in your child's room.

As well as the kitchen there is a newly created separate children's play room which is also now available for your child to use.

We welcome the continued input from you and your child and any ideas you may have on the facilities within the ward.

Regards

To: Parents/Carers of patients on Wards 6A and 4B

12 November 2019

Dear Parent

I am writing to provide you with the latest update on our investigations into a number of unusual infections in Ward 6A.

As you are aware Ward 6A has been closed to newly diagnosed patients and infusional chemotherapy patients for a number of weeks. This has enabled us to carry out environmental testing and to make a number of enhancements to the ward.

We have been meeting regularly to review the actions taken and consider the test results, all of which have been satisfactory. Another meeting was held yesterday afternoon when it was confirmed that the remaining HEPA filters have been installed in the en-suite rooms in Ward 6A. Additional power points have also been installed in the playroom.

This completes the enhancements to the ward following feedback from families, which also include a new dedicated parents' social space and kitchen. We have also provided a kitchen and rest area for staff. In view of the improved kitchen facilities available to families, the ward will now prepare to switch back to filtered tap water for drinking purposes.

At the meeting, the latest environmental (water and surface) sampling reports were also presented, all of which were satisfactory.

We continue to work with Health Protection Scotland and clinicians to review the situation in Ward 6A and will provide you with a further update following our next meeting, scheduled for later this week.

In the meantime, we also are considering how we can continue to build on and improve our communications and engagement with families of patients under the care of our haemato-oncology team. A number of families recently took up our invitation to meet with our Chairman and Chief Executive when a key issue raised was the need to strengthen the relationship between the Board and parents and improve our communication with families.

Professor Craig White, who also attended the meeting, has been appointed by the Cabinet Secretary for Health and Sport as the point of liaison with the families. It was agreed that he would lead work to establish a parent/patient group to advise on communications and the flow of information to parents. It was acknowledged that the establishment of this group, which will also involve senior management from the Royal Hospital for Children, will help in rebuilding trust and confidence. This work will now be taken forward.

If you would like to be part of the parents' group, or to offer your suggestions for improved information sharing to parents, then we would be pleased to hear from you. Professor White can be contacted at c[redacted] or on [redacted].

Yours faithfully

Kevin Hill

Director

Women and Children's Directorate

**Greater Glasgow and Clyde NHS Board**

[redacted]

[redacted]

www.nhsggc.org.uk

**Private and Confidential**

Date: 14th November 2019
Our Ref: JG/LLPAE

Enquiries to: Jane Grant

[redacted]

Dear

Thank you for coming to meet the Chairman and me, together with our senior team, on Saturday 2nd November to discuss your concerns about the current situation in our paediatric haemato-oncology unit.

I am very grateful to you for sharing your experiences with us and I would re-iterate how sorry we are for the distress and anxiety caused to you at what is already a very challenging time.

Our team found the meeting very helpful. It provided us with a valuable opportunity to listen to your concerns and to respond to your questions. There were a number of specific areas that we agreed required further action. I thought it would be helpful to confirm the actions that we are now taking and also to provide you with an update on the latest position with Ward 6A.

A key issue that you raised with us was the need for us to improve our communication and engagement with affected families. Professor Craig White, who joined us for the meeting, has been appointed by the Cabinet Secretary for Health and Sport as the point of liaison with the families. It was agreed that he would lead work to establish a parent/patient group to advise on communications and the flow of information to parents. It was acknowledged that the establishment of this group, which will also involve senior management from the Royal Hospital for Children, will help in rebuilding trust and confidence. This work will now be taken forward.

A key source of information for any parent or relative should be the staff in the unit. At the meeting we explained that the investigations by the Incident Management Team (IMT) into infections in Ward 6A are still ongoing and there are a number of areas where we do not yet have the full answers. However, as we were able to share with you when we met, we do have answers to many of the questions being put to us by families. We have ensured that staff on the unit are fully informed of the current situation to support them to share this information with families.

You raised a number of issues about the ward, including access arrangements, location of the day care unit, the food choices available and problems with the ward temperature, particularly in the summer months. These issues are all now being reviewed by our Director of Estates and Facilities, Tom Steele, and his team.

Our Director of Nursing, Dr Margaret McGuire, and Chief Nurse for Hospital Paediatrics and Neonates, Jennifer Rodgers, are reviewing the issues raised relating to staffing levels, the concerns around attending for day care procedures at weekends and reported medication errors. Clinical teams will work individually with families in relation to the use of prophylaxis.

Finally we committed to ensuring you are kept informed about the ongoing investigation. We had a further meeting of the IMT on Monday when it was confirmed that the remaining HEPA filters have been installed in the en-suite rooms in Ward 6A. Additional power points have also been installed in the playroom. This completes the enhancements to the ward being made following feedback from families, which also include a new dedicated parents' social space and kitchen. We have also provided a kitchen and rest area for staff. In view of the improved kitchen facilities available to families, the ward will now prepare to switch back to filtered tap water for drinking purposes.

At the meeting, the latest environmental (water and surface) sampling reports were also presented, all of which were satisfactory.

We continue to work with Health Protection Scotland and clinicians to review the situation in Ward 6A and a further meeting has been planned for later this week, when it is expected that the final report from the Health Protection Scotland will be presented.

I trust this letter has been helpful. If you would like to be part of the parents group, or to offer your suggestions for improved information sharing with parents, then we would be pleased to hear from you. Professor White can be contacted at [redacted] or on [redacted].

Yours sincerely

[redacted]

**Jane Grant**
**Chief Executive**
**NHS Greater Glasgow and Clyde**

**From:** Bustillo, Sandra
**Sent:** 15 November 2019 11:03
**To:** 'Craig White'
**Subject:** letters to parents 141119
**Attachments:** letters to parents 141119.doc

Craig

Here is a copy of the letters distributed to parents on wards 6A and 4B following the publication of the article in yesterday's Daily Record, and also published on the Facebook page.

Sandra

14 November 2019

Dear Parents/Carers in Wards 6A and 4B

You may have seen the report in today's Daily Record on claims from a whistle-blower that a patient died from an infection linked to the water supply in 2017.

I wanted to write to you in response to this article and to reassure you that the water in the hospital is safe to use.

As you know, Health Protection Scotland (HPS) carried out a review of cases of infection from 2018 following a number of infections linked to the water supply for the hospital. This report was published earlier this year. Since then extensive measures have been put in place, including the installation of a water treatment system, as well as filters on water outlets.

We continually monitor and test to ensure the safety and integrity of the water. The water has been assessed by an independent water expert who has confirmed that it is 'wholesome', which is the recognised industry term to describe that it is safe to use.

Whilst the review by Health Protection Scotland was triggered by our investigation into cases from 2018, we have also completed an additional clinical review of cases from 2017. This was carried out by senior clinical staff and it was concluded that no further action was required.

Further to this, we have been working closely with external advisors Health Protection Scotland, assisted by Strathclyde University, on a review of cases of infection over a period from January 2015 to September 2019 and this report is due imminently.

I am sorry for any anxiety that will undoubtedly have been caused by this latest coverage. If you have any further questions please speak to a member of staff who will be able to help or will refer the matter on to an appropriate person.

Yours faithfully

Kevin Hill
Director
Women & Children's Directorate

[redacted] **Herald on Sunday**

I have several queries if you could take a look, I will need a response by this evening.

1) I understand your lead infection control doctor at the QEUH has resigned from their role, and three infection control nurses have left NHSGGC in the last few months also. Can you tell me if these people have been replaced, how many other members of your infection control team have left in the last six months and whether you now have a lead infection control doctor in the post left by the last one?
2) I understand the lead infection control doctor resigned as they felt they were not being listened to or being given honest answers about the safety of ward 6A/B. Would you like to comment?
3) If the water in ward 6A/B is safe, why have the taps got filters on them and why have you added additional filters recently, as parents were informed by letter from Jane Grant just yesterday?
4) Were HPS informed of the death in 2017 related to water which was reported by the daily record yesterday?

Thanks,
Hannah

## NHSGGC RESPONSES:

1) I understand your lead infection control doctor at the QEUH has resigned from their role, and three infection control nurses have left NHSGGC in the last few months also. Can you tell me if these people have been replaced, how many other members of your infection control team have left in the last six months and whether you now have a lead infection control doctor in the post left by the last one?

NHSGGC has a significant team of 45 experts working within infection control. We have individuals fulfilling the management role of Lead Infection Control Doctor on a temporary basis whilst we actively recruit a permanent replacement. All of the nursing staff except one have been replaced and remaining post is in the process of being replaced.

2) I understand the lead infection control doctor resigned as they felt they were not being listened to or being given honest answers about the safety of ward 6A/B. Would you like to comment?

The Lead Infection Control Doctor was the chair of the Incident Management Team until they resigned from their Lead role. The purpose of this meeting was to consider any hypotheses about infections and possible links to the ward. This process, overseen by the IMT chair, has carried out extensive investigations into the ward environment and found no links.

3) If the water in ward 6A/B is safe, why have the taps got filters on them and why have you added additional filters recently, as parents were informed by letter from Jane Grant just yesterday?

The water in the hospital is safe. Our on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide, which keeps it clean and safe. In addition, any patient cared for high risk areas have point of use water filters in place as an extra precaution. The safety of the water has been confirmed to be safe by the external Authorising Engineer, a specialist engineer who acts, and is employed, independently of NHS Greater Glasgow and Clyde. The Authorising Engineer has rated the water supply as 'wholesome', which is the industry term used to say it is safe.

Were HPS informed of the death in 2017 related to water which was reported by the daily record yesterday?
We have confirmed that we investigated two cases of Stenotrophomonas in 2017 and informed Health Protection Scotland about this investigation as per the national guidance.

**Follow-up question:**
Thanks Claire, all received. Is one of the people replacing the lead infection control doctor who resigned Alistair Leanord?

**NHSGGC response:**
We have nothing to add to our statement.

Friday, November 15, 2019

# NHS GREATER GLASGOW AND CLYDE STATEMENT

Following recent events, we would like to reiterate how sorry we are to the families who may have been caused additional pain and distress and we'd again like to share our condolences to those who have suffered the tragedy of losing a child.

Today's independent report from Health Protection Scotland is welcome and demonstrates the Queen Elizabeth University Hospital/Royal Hospital for Children is safe.

The report provides reassurance for the many families and the public who will have had concerns about the safety of the unit.

From the Health Protection Scotland review of the data on test results of blood samples over the past six years, their report finds:

- One occasion when the number of infections linked to environmental organisms was greater than expected for this group of patients (Table 5). The period in question was June 2018 which was already being investigated by the infection control team and was identified as being potentially linked to the water supply.
- At no other time between 2013 and 2019 did the rate of infections linked to environmental organisms exceed the upper range of expected levels. This includes 2016 and 2017.
- An increase in Gram negative infections (including both environmental and enteric, i.e. intestinal infections) was noted in 2017, however, this remained within expected levels for the unit. During this time there was an investigation into the possibility that two of these cases may have been linked which was later confirmed not to be the case. This investigation was reported to HPS as per mandatory guidance.
- Since the move to Ward 6A and 4B in September 2018, infection rates have been similar to other Scottish paediatric units.
- For a particular group of infections, known as gram positive infections, the rates have fallen and are now lower than elsewhere in Scotland.
- No single source of 'exposure' of infections has been identified across the six year period.

The purpose of the Health Protection Scotland report was to independently assess rates of infection in the haemato-oncology unit of the RHC over a number of years to help inform NHSGGC investigations into recent infections at the hospital and potential links between these infections and the ward.

The report considered six years of laboratory data during which period the unit has seen more than a thousand patients, with 2,894 admissions.

The report's findings are fully in keeping with our own Incident Management Team investigations that concluded the unit is safe.

We have fully tested the water supply and ward surfaces in Ward 6A and also reviewed individual infections and found no links between individual infections and no source of infections in the ward.

On the basis of the IMT investigation's findings and the results from the Health Protection Scotland review, the ward re-opened to new patient admissions on Thursday.

Jane Grant, Chief Executive, NHS Greater Glasgow and Clyde, said: "We completely understand this has been a distressing time for families and staff and we sympathise with them given the anxiety this has caused.

"Unfortunately there will always be a small number of patients who develop infections because of the seriousness of their illness and we are fully committed to supporting them and their families when this occurs.

"Families should be reassured that Infection rates at present are within expected levels and the hospital is safe.

"We continue to support families affected at this time and we welcome the opportunity to work with parents and Professor Craig White, who has been appointed by the Cabinet Secretary for Health, to improve our performance in this area.

"We are all fully committed to ensuring that questions are answered fully and parents reassured."

**Ends**

**Background**

It is important to note that patients in the haemato-oncology unit are susceptible to getting infections because of their illness and also because of their treatment.

Certain cancer treatments suppress the immune system and ability to fight off bacteria that can come from within your own system, or from external factors.

The key in managing infections is to identify unusual patterns that trigger grounds for investigations and ensure appropriate robust measures are in place.

For further information either telephone [redacted] or email [redacted]

**From:** Craig.White[redacted]
**Sent:** 16 November 2019 11:08
**To:** Grant, Jane [Chief Exec]; Bustillo, Sandra; Brown, John; Steele, Tom
**Subject:** [ExternaltoGGC]FW: Further Information - NHS Greater Glasgow and Clyde - Water Safety

Colleagues

Further to several communications received in response to the email the Cabinet Secretary asked me to send last night, I received some follow up questions relating to water safety. Thanks to Tom and Sandra for the late night responses. I have issued the below to the parents whose contact details I have [redacted]. As you will see is specifically drafted to move beyond some of the generic statements about 'water is safe', 'water is wholesome' etc by expanding on this, by listing the various processes in place and by committing to work with you to provide illustrative examples of the processes and outcomes of sampling in action, thereby demonstrating the rigour and vigilance with which this issue is being managed. I have made CabSec and FM's Chief of Staff aware of this further communication.

Hope this is helpful,

Best wishes

Craig

**Professor Craig White** | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| [redacted]

gov.scot

**From:** White C (Craig)
**Sent:** 16 November 2019 10:57
**To:** White C (Craig)
**Subject:** Further Information - NHS Greater Glasgow and Clyde - Water Safety

Summary of Arrangements for Determining Safety of Water

Dear All,

Further to some further communications about the water supply at the QEUH, I have prepared the following summary of my understanding of the position. As you will note, I intend to supplement this with the provision of some illustrative data from water sampling referred to below ,which I will be asking NHS Greater Glasgow and Clyde for on Monday morning.

The decision to switch back to filtered water was taken in light of the new kitchen facility being open and the standard precautions in place across all hospitals/the NHS that discourage drinking water from ward sinks dedicated for handwashing.

As you may recall from responses to prior questions and concerns, NHS Greater Glasgow and Clyde have confirmed that an independent engineer has confirmed that the water is 'wholesome', which is the industry term to say that it is safe. This is defined in legislation in the Public Water Supplies (Scotland) Regulations 2014. I thought it may be helpful to provide the link to this legislation by way of providing the background of the criteria set out in legislation that have been used to inform the independent expert's assessment of the water:
http://www.legislation.gov.uk/ssi/2014/364/regulation/4/made

I have been informed of several other ongoing actions and monitoring processes in place in respect of water safety:

- Sampling of the water system is undertaken by an external specialist water hygiene company and analysed in their laboratory.
- NHS Greater Glasgow and Clyde undertake additional sampling by their own laboratory staff and analyse this locally.
- Results of water sampling are reported and considered by the laboratory team and a group within NHS Greater Glasgow and Clyde called the 'Water Technical Group' – this has representatives from infection control, external advisors and local technical staff.
- The on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide added to keep it clean and safe.
- Any patient cared for high risk areas has point of use water filters in place as an extra precaution.

Recognising the understandable concern and anxiety that the media coverage this week has resulted in, I am going to ask NHS Greater Glasgow and Clyde to provide further information relating to water safety for parents such as data on the frequency of water sampling and the results from the tests on samples. I am confident from some of the data I have seen referred to in meetings that this will provide a further level of assurance as to the evidence being used to make decisions and inform communications on the safety of the water.

I remain yours sincerely,

Best wishes

Craig White

**Professor Craig White** | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| [redacted]

gov.scot


Thursday, November 7, 2019 (LD)

[redacted] **ET** - Adam Tomkins raised the kids hospital in parliament. When are paediatric cancer patients moving back to children's hospital from adult hospital? Is the kids hospital ward still closed to new admissions?

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON WARD 6A

The ward remains open to treat current patients, however a temporary divert of newly diagnosed patients remains in place.

The Incident Management team are working closely with Health Protection Scotland and the clinical staff to consider when the divert can be lifted.

In the meantime, a number of enhancements have been made to the ward, including a social space for parents and a children's dedicated play area.

The return to Wards 2A and 2B in the Royal Hospital for Children is expected to take place in March next year when the work to upgrade the ventilation system is complete.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Tuesday, November 19, 2019 (LD)

[redacted] **The Times** - investigation into crypto deaths - is it still ongoing or what were the findings

## NHS GREATER GLASGOW AND CLYDE STATEMENT

The investigation is ongoing and we continue to work with an expert advisory group with representatives from Health Protection Scotland, Health Facilities Scotland and UK experts.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**Greater Glasgow and Clyde NHS Board**

[redacted]

www.nhsggc.org.uk

Date: 21st November 2019
Our Ref: JG/LLPAE

Enquiries to: Jane Grant
[redacted]

Dear Parents/Carers

You will all be aware that over the past few months we have been investigating a number of cases of infection in Ward 6A to identify if there are any links between those infections and the ward environment.

As part of this, an independent review of the unit's infection rates was carried out. The purpose was to examine whether infection rates within Ward 6A are what we might expect to see, or are higher than expected.

The review, commissioned by the Chief Nursing Officer, Scottish Government, and undertaken by Health Protection Scotland, has now been completed. This has confirmed that since the move to Ward 6A and 4B in September 2018, infection rates have been within expected levels and similar to other Scottish paediatric units.

The review also showed for a particular group of infections, known as gram positive infections, the rates have been lower than elsewhere in Scotland.

Health Protection Scotland have also established that there was no 'single point of exposure' to infection.

This was in keeping with the findings from detailed investigations by our Incident Management Team. We have fully tested the water supply and ward surfaces in Ward 6A. All of the tests have come back showing no traces of the particular types of bacteria present in the cases investigated.

We have also reviewed individual infections and found no links between individual infections and no source of infections in the ward.

Health Protection Scotland has concluded there is no evidence to support the continued restriction of new admissions to Ward 6A at the Queen Elizabeth University Hospital.

Health Protection Scotland have also confirmed that they are content with the actions that have been taken by the Incident Management Team to investigate individual cases, that they have reviewed evidence of effective implementation of the actions they recommended and are assured that appropriate arrangements are in place for ongoing monitoring of infections, including triggers for detailed scrutiny going forward.

On the basis of the IMT investigation's findings and the results from the Health Protection Scotland review, a recommendation to re-open the ward has been accepted.

Restrictions have therefore now been lifted and the ward has re-opened to new patient admissions today.

We want to assure you of our absolute commitment to ensuring our environment remains safe for our patients.

To support the re-opening, a number of ward enhancements have been introduced including new parent and staff facilities, installation of HEPA filters in shower rooms and enhanced maintenance and cleaning of the air heating and cooling system.

We continue to closely monitor the quality of the water supply to ensure it remains safe. Sampling of the water system is carried out by an external specialist water hygiene company and analysed in their laboratory. This independent water expert has confirmed that it is 'wholesome', which is an industry term meaning it is safe to use.

As a further assurance we carry out our own sampling of the water supply by our own laboratory staff. The results of water sampling are reported and considered by the laboratory team and a group within NHS Greater Glasgow and Clyde called the 'Water Technical Group' – this has representatives from infection control, external advisors and local technical staff.

The on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide added to keep it clean and safe.

Any patient cared for high risk areas has point of use water filters in place as an extra precaution.

We understand that there may have been confusion because of the signs at the sinks within the single bed rooms, which advise patients that they are for hand washing use only.

Although the water is safe to drink, water from basins in patient rooms should not be used, as they are for handwashing only; this is advice from infection prevention and control colleagues.

Alongside ongoing routine monitoring and surveillance of infections, we have also established a Clinical Management Group to maintain vigilance on issues of infection control. At the request of the Cabinet Secretary, external experts from the National Service Network for Children and Young People with Cancer will join this group.

We completely understand this has been a distressing time for families and staff. There will always be a small number of patients who develop infections because of the seriousness of their illness. There are clearly lessons for us to learn in how we communicate with families during these periods. We welcome the opportunity to work with parents and Professor Craig White, who has been appointed by the Cabinet Secretary for Health, to consider how we can improve our information flow.

We would like to thank you for your understanding throughout this difficult time. If you have any further questions please speak to a member of staff who will be able to help or will refer the matter on to an appropriate person.

Yours sincerely

[redacted]

**Jane Grant**
**Chief Executive**
**NHS Greater Glasgow and Clyde**

**Greater Glasgow and Clyde NHS Board**

[redacted]

[redacted]

www.nhsggc.org.uk

Date: 21st November 2019
Our Ref: JG/LLPAE

Enquiries to: Jane Grant
[redacted]

Dear Parents/Carers

You will all be aware that over the past few months we have been investigating a number of cases of infection in Ward 6A to identify if there are any links between those infections and the ward environment.

As part of this, an independent review of the unit's infection rates was carried out. The purpose was to examine whether infection rates within Ward 6A are what we might expect to see, or are higher than expected.

The review, commissioned by the Chief Nursing Officer, Scottish Government, and undertaken by Health Protection Scotland, has now been completed.

Health Protection Scotland has concluded there is no evidence to support the continued restriction of new admissions to Ward 6A at the Queen Elizabeth University Hospital.

Health Protection Scotland have also confirmed that they are content with the actions that have been taken by the Incident Management Team (IMT) to investigate individual cases, that they have reviewed evidence of effective implementation of the actions they recommended and are assured that appropriate arrangements are in place for ongoing monitoring of infections, including triggers for detailed scrutiny going forward.

On the basis of the IMT investigation's findings and the results from the Health Protection Scotland review, a recommendation to re-open the ward has been accepted. We anticipate that the Health Protection Scotland report will be published shortly.

Restrictions have therefore now been lifted and the ward has re-opened to new patient admissions today. We want to assure you of our absolute commitment to ensuring our environment remains safe for our patients.

To support the re-opening, a number of ward enhancements have been introduced including new parent and staff facilities, installation of HEPA filters in shower rooms and enhanced maintenance and cleaning of the air heating and cooling system.

We continue to closely monitor the quality of the water supply to ensure it remains safe. Sampling of the water system is carried out by an external specialist water hygiene company and analysed in their laboratory. This independent water expert has confirmed that it is 'wholesome', which is an industry term meaning it is safe to use.

As a further assurance we carry out our own sampling of the water supply by our own laboratory staff. The results of water sampling are reported and considered by the laboratory team and a group

within NHS Greater Glasgow and Clyde called the 'Water Technical Group' – this has representatives from infection control, external advisors and local technical staff.

The on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide added to keep it clean and safe.

Any patient cared for high risk areas has point of use water filters in place as an extra precaution.

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We would like to thank you for your understanding throughout this difficult time. If you have any further questions please speak to a member of staff who will be able to help or will refer the matter on to an appropriate person.

Yours sincerely

[redacted]

**Jane Grant**
**Chief Executive**
**NHS Greater Glasgow and Clyde**


Friday, November 21, 2019

In response to escalation steps announcement:

## NHS GREATER GLASGOW AND CLYDE STATEMENT

“We welcome the additional support offered and are committed to working closely with the Scottish Government to implement any recommended additional changes and enhancements across infection control and associated engagement.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

[redacted] **The Times**

Newspapers are saying today up to 150 patients may have been affected by the water supply contamination issues in wards 2A/2B

Please could you clarify the figures for me. As I understand it 150 patients were treated on the wards between 2016 and their closure last year.

What is the total number of patients where there is evidence they may have been affected by the water supply issue?

**NHSGGC MEDIA STATEMENT**

At this stage, the information we have to show a potential link between the water supply and infections are the findings from Health Protection Scotland's report from February 2019 which investigated the period from 29th of January until 26th of September 2018.

This report showed 23 cases of bloodstream infections potentially linked to contaminated water.

**ENDS**

**NHS GREATER GLASOW AND CLYDE STATEMENT**

**Ward 6A has re-opened to new patient admissions following a detailed investigation by the Incident Management Team and a review by Health Protection Scotland. We are writing to all parents and carers to confirm this decision and the letter from our Chief Executive Jane Grant is shared here. If you have any questions then please get in touch with us or with Professor Craig White.**

Dear Parents/Carers

You will all be aware that over the past few months we have been investigating a number of cases of infection in Ward 6A to identify if there are any links between those infections and the ward environment.

As part of this, an independent review of the unit's infection rates was carried out. The purpose was to examine whether infection rates within Ward 6A are what we might expect to see, or are higher than expected.

The review, commissioned by the Chief Nursing Officer, Scottish Government, and undertaken by Health Protection Scotland, has now been completed.

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To support the re-opening, a number of ward enhancements have been introduced including new parent and staff facilities, installation of HEPA filters in shower rooms and enhanced maintenance and cleaning of the air heating and cooling system.

We continue to closely monitor the quality of the water supply to ensure it remains safe. Sampling of the water system is carried out by an external specialist water hygiene company and analysed in their laboratory. This independent water expert has confirmed that it is 'wholesome', which is an industry term meaning it is safe to use.

As a further assurance we carry out our own sampling of the water supply by our own laboratory staff. The results of water sampling are reported and considered by the laboratory team and a group within NHS Greater Glasgow and Clyde called the 'Water Technical Group' – this has representatives from infection control, external advisors and local technical staff.

The on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide added to keep it clean and safe.

Any patient cared for high risk areas has point of use water filters in place as an extra precaution.

We understand that there may have been confusion because of the signs at the sinks within the single bed rooms, which advise patients that they are for hand washing use only.

Although the water is safe to drink, water from basins in patient rooms should not be used, as they are for handwashing only; this is advice from infection prevention and control colleagues.

Alongside ongoing routine monitoring and surveillance of infections, we have also established a Clinical Management Group to maintain vigilance on issues of infection control. At the request of the Cabinet Secretary, external experts from the National Service Network for Children and Young People with Cancer will join this group.

We completely understand this has been a distressing time for families and staff. There will always be a small number of patients who develop infections because of the seriousness of their illness. There are clearly lessons for us to learn in how we communicate with families during these periods. We welcome the opportunity to work with parents and Professor Craig White, who has been appointed by the Cabinet Secretary for Health, to consider how we can improve our information flow.

We would like to thank you for your understanding throughout this difficult time. If you have any further questions please speak to a member of staff who will be able to help or will refer the matter on to an appropriate person.

[redacted] **– Mail on Sunday**

We have learned this afternoon of a third case which is being investigated by your board and would appreciate an urgent response for our deadline tonight of 7pm.
We have been speaking to the parent of a young child who recently contracted an infection linked to the water borne bug serratia mercescens. She has confirmed the health board are officially investigating the case as part of the wider investigation and has expressed outrage at the lack of communication from officials on the matter. Specifically, she says it's her right as a parent to know what happened to her child in the QEUH.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

We have been in contact with this parent and offered to meet them when they are next in the hospital this week. We have made arrangements for the family to meet a clinician and an infection control expert to discuss their child's care.

The investigation into a number of unusual infections in ward 6A has been ongoing for a number of weeks. We have kept parents and carers with children in Ward 6A informed of our investigations. Senior managers and senior nurses are on the ward regularly updating the families of patients directly affected and we have also provided them with written updates on the investigation.

This investigation has found no links between the individual infections and no link between the infections and the ward environment.

An independent review into infection rates, commissioned by the Chief Nursing Officer, Scottish Government, and undertaken by Health Protection Scotland, has also been carried out.

Health Protection Scotland has concluded there is no evidence to support the continued restriction of new admissions to Ward 6A at the Queen Elizabeth University Hospital.

Health Protection Scotland have also confirmed that they are content with the actions that have been taken by the Incident Management Team (IMT) to investigate individual cases, that they have reviewed evidence of effective implementation of the actions they recommended and are assured that appropriate arrangements are in place for ongoing monitoring of infections, including triggers for detailed scrutiny going forward.

On the basis of the IMT investigation's findings and the results from the Health Protection Scotland review, a recommendation to re-open the ward has been accepted.

The ward has now re-opened to new patient admissions.

Jane Grant, Chief Executive said: "We are extremely sorry that this parent does not feel they have had the answers to the questions about their child and we understand how distressing this is. We have made arrangements to meet the family on Tuesday and they are also in communication with Professor Craig White.

"We are all fully committed to ensuring that questions are answered fully and truthfully and parents reassured."

**ENDS**

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

We have been in contact with this parent and offered to meet them when they are next in the hospital this week. We have made arrangements for the family to meet a clinician and an infection control expert to discuss their child's care.

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"We are all fully committed to ensuring that questions are answered fully and truthfully and parents reassured."

**ENDS**

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

The water is safe to use.

We continue to closely monitor the quality of the water supply to ensure it remains safe.

Sampling of the water system is carried out by an external specialist water hygiene company and analysed in their laboratory. The independent water expert has confirmed that it is 'wholesome' meaning it is safe to use.

As a further assurance we carry out our own sampling of the water supply by NHS laboratory staff. Currently we are taking up to 140 samples every month. The results are closely monitored by our infection control and technical experts.

Any patient cared for in high risk areas has point of use filters in place as an extra precaution.

We understand there may have been confusion because of the signs at the sinks within the single bedrooms, which advise patients that they are for hand washing only.

Although the water is safe to drink, water from basins in patient rooms should not be used as they are for hand washing only. This is advice from infection prevention and control staff.

Tap water for drinking is available from kitchens in wards.

ENDS

[redacted] **– HealthandCare.scot**

I'm looking for a response from the board for a story about pressures on paediatric services at the Royal Hospital for Children. We've been told that there were:

- No beds left for children over this weekend.
- Some children have been put up in nearby hotels.
- All elective lists for paediatric surgery have been cancelled.

I'd appreciate it if your response could include clarification on how many children have been placed in hotels as a result of bed shortages and when elective paediatric surgery will resume. My deadline is 4pm today.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

No patient requiring hospital admission has been 'put up in nearby hotels'.

If a child is coming for treatment from outwith the area it is standard procedure that we will provide a hotel stay for the family the night before the child is due to be admitted for their treatment. This saves the family having to travel on the morning of the child's procedure.

Over the last week we have seen a significant rise in the number of patients attending the Royal Hospital for Children with respiratory illnesses which reflects the increased number of respiratory illnesses within the community.

This has resulted in the hospital having a high level of bed occupancy due to medical emergencies.

We do our best not to postpone any planned procedures but, as with every other board across Scotland, when we are experiencing a high demand for emergency medical care we have, unfortunately, to reschedule a very small number non-urgent planned inpatient procedures. This week we have had to reschedule seven non-urgent planned procedures.

We are making arrangements to re-book these patients as soon as possible at a date that suits them.

**ENDS**

[redacted] **– Herald on Sunday**

I am looking at your review of NHSGGC paediatric haemato-oncology data report which came out this week. I notice figures 8 and 9 are redacted. I understand this is probably because the types of bacteria, along with the year they were recorded, could compromise patient confidentiality. Can you please provide me with a list of the bacteria for the total time period, without breaking it down by year, to avoid such confidentiality issues?

Children are still receiving prophylactic medication while being treated at the QEUH for cancer. Why?

Hi [redacted],

You would need to direct the first question to HPS. This was not our report.

Here is our statement for your last question. Please let me know you have it.

Best wishes

Claire

## NHS GREATER GLASGOW AND CLYDE RESPONSE

This is a clinical decision and patients are receiving prophylaxis on a case by case basis.

**ENDS**


Monday, 2 December 2019

[redacted], **Daily Record**

As discussed, we have been told that staff at the Royal Hospital for Sick Children, Glasgow, are handing out bottled water to patients/inpatients.

Can you confirm if this is the case please?

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

All inpatients in the Royal Hospital for Children are offered tap water, milk or juice to drink. Our tap water is perfectly safe to drink.

Children in our Bone Marrow Transplant (BMT) Unit will receive specialist sterile water as part of their treatment. This in common with other paediatric BMT units in the UK.

In our Outpatients department, as there is no easy access to a kitchen area, when children would like a drink, our staff have bottled water to hand to offer.

**ENDS**

For further information either telephone [redacted] or email [redacted]


Monday, December 2, 2019

## NHS GREATER GLASGOW AND CLYDE STATEMENT ON PRESCRIBING OF PROPHYLACTIC ANTIBIOTICS

Some children in this group are routinely prescribed prophylactic antibiotics at certain times as part of their clinical treatment plan.

As a precautionary measure, in August an Incident Management Team recommended that prophylaxis be prescribed to patients in Ward 6A while we undertook environmental testing of the ward.

This testing has concluded and there is no link to the ward environment or the infections being investigated. Therefore, the prophylaxis that was offered to children as a precaution while we were investigating the incident will now be reviewed.

As some children will require prophylaxis associated with their illness rather than the ward environment, it is important that their doctor has the opportunity to have a full conversation with the family before making a decision that is best for the child.

We would encourage any parents to speak to their child's clinical team if they have any questions specific to any medicine that has been prescribed for their child.

**ENDS**

For further information either telephone [redacted] or email [redacted]


**4th December 2019**

**NHS GREATER GLASGOW AND CLYDE STATEMENT**

The tap water at the Queen Elizabeth University Hospital and at the Royal Hospital for Children is safe to drink and has been internally and externally verified as such. Furthermore, there are robust processes in place which allow for ongoing monitoring of the system to ensure the water remains wholesome.

Any increase of people drinking bottled water at the QEUH may be due to the recent removal of bottled water coolers from the site due to risk of contamination. This was in response to the potential for bacteria to grow in the nozzle and the water bottle if not routinely used, which could pose an infection risk to vulnerable patients.

All patients and staff have access to safe drinking water on wards and this information was shared with them on 14 August. While we are not aware of any questions raised in relation to the water supply, we want to provide absolute reassurance and alleviate any concerns on this matter. We would urge staff with questions to speak to a senior member of facilities management.

ENDS

For further information either telephone [redacted] or email [redacted]


Friday, December 6, 2019 (LD)

[redacted] **Herald on Sunday** - whether the [redacted] has been investigated in terms of if the infection was linked to their death, and also where the infection came from.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

NHSGGC is committed to acting and responding compassionately and sensitively to the needs, questions and concerns of all families following any death.

We understand that the family have asked that their privacy be respected at this time.

We appreciate the wider public interest in our response to infection prevention and control and can confirm there is no suggestion of linked cases of infection with the one you have asked about.

**ENDS**

**Background note**
It is important to make clear that we are not investigating the death of a patient.

For further information either telephone [redacted] or email [redacted]


Friday, December 27, 2019

## NHSGGC STATEMENT ON HSE IMPROVEMENT NOTICE

As part of our ongoing commitment to providing a safe environment for our patients and staff, we have been working with the Health and Safety Executive (HSE) over the past few months to look at governance and processes relating to the Queen Elizabeth University Hospital and the Royal Hospital for Children on areas highlighted in the March 2019 Healthcare Improvement Scotland Report.

On 24th December our Chief Executive received notification from the HSE that they were serving an Improvement Notice in relation to Ward 4C as part of these investigations.

In the interests of openness and transparency and building public confidence in NHSGGC, we are today publishing the Improvement Notice on our website.
This notice requires us to carry out a verification of the ventilation system for Ward 4C.

Ward 4C is a renal transplant/haemato-oncology ward and neither of the groups of patients cared for in this ward require specialist ventilation.

Any ‘at risk’ haemato-oncology patients are cared for in Ward 4B which is a fully HEPA-filtered ward.

We have also confirmed with other UK centres who care for renal transplant patients they similarly treat these patients in a general ward environment.

As an additional precaution, however, to further safeguard our patients, we installed mobile HEPA filters in Ward 4C in January 2019 as part of our control measures when we were investigating infections at that time.

Under Scottish health technical memoranda, general wards do not require to undergo the critical system verification that has been required in the Ward 4C Improvement Notice.

In view of this, and the additional safeguards that we have already implemented, we have asked for an early meeting with HSE to discuss the content of the Improvement Notice in more detail.

This meeting will take place in the first week in January.

Jane Grant, Chief Executive, said: “We are sorry for the distress that patients and their families have experienced by the current issues and want to assure them and the public that we are working with the Scottish Government to do everything necessary to remedy the situation.

“I also want to thank our staff for the commitment and professionalism they have demonstrated throughout this time, ensuring that our patients continue to receive the safe, high quality healthcare they deserve.

“Patients who require specialist ventilation are cared for in Ward 4B which is a fully HEPA-filtered ward.  As a further precaution we introduced mobile HEPA filters in Ward 4C in January as part of our control measures when we were investigating infections at that time.

“We welcome the opportunity to discuss these actions with the Health and Safety Executive when we meet them in the New Year.”

**ENDS**

Link to Improvement Notice: https://www.nhsggc.org.uk/media/257740/improvement-notice-kwqeuhdec1901.pdf


Wednesday, January 15, 2020 (LD)

[redacted] **Daily Mail** - ward 6A web resource - question raised by parents

## NHS GREATER GLASGOW AND CLYDE STATEMENT

Jane Grant, Chief Executive, said: "We are fully committed to providing high quality care for all of our patients in a safe, person centred environment. We realise how important it is to ensure parents and carers are kept fully informed about the current situation in Ward 6A and for us to be open and transparent with families and with the public on these issues.

"To help re-build trust and confidence in NHS Greater Glasgow and Clyde, we have now launched a dedicated web resource on Ward 6A and this includes answers to a range of questions from families. These questions were asked by parents who met the Cabinet Secretary for Health and Sport in October and we have since sought to reassure parents that these issues have been fully investigated and action taken as appropriate.

"We are grateful to parents and to Professor Craig White and colleagues who have worked with us to deliver the web resource. We welcome any feedback from families on how this can be improved and encourage any family with any question or concern to speak to a member of staff so that this can be responded to personally.

"On the specific questions raised by families, we can advise:

***Facilities***:
"We constantly look to improve our services and we have worked with the families to make enhancements to the ward facilities, including a parents' kitchen and social space for families. This area is a dedicated space where they can make tea and coffee or warm up food in the microwave. We have also introduced a dedicated play area and encourage parents to feedback to ward staff any further areas that we can make improvements.

"Our person-centred care team have recently begun a process of in-depth conversations with patients and families in the unit to produce feedback on further areas for improvement. To date, this feedback has been extremely positive with particular praise for communication within the unit and respect and dignity."

***Cleanliness***:

“Patient safety is a key priority and our ongoing regular audits demonstrate that we routinely achieve a high level of cleanliness in the unit. Ward 6A has its own domestic staff and a domestic supervisor to ensure standards of cleanliness are maintained. There is a daily meeting between clinical and domestic staff to monitor cleaning levels.

“In addition, a complete review of the ward environment, involving infection prevention and control staff, ward senior charge nurses, the domestic services manager and estates and facilities staff, takes place every week to monitor cleanliness and the general estates environment. If any issues are identified, then these are quickly remedied.
Wastewater treatment

“We are sorry that families have complained about the smell from the nearby waste water treatment site but would wish to allay any concerns that smell alone can pose a health risk. The Independent Review team have also looked into this issue as part of their independent review of the hospitals. They point out that: “A number of hospitals have been sited close to major wastewater treatment sites across Scotland over the years. This includes the former Southern General Hospital on which the QEUH now sits. The Shieldhall wastewater treatment site dates back to 1901.”

***Equipment***:
“Any equipment defects or failures, if reported, are repaired as quickly as possible through routine maintenance. There is a dedicated estates officer to respond to any issue and the team are also involved in the weekly walk round and a weekly clinical meeting to address any issues.”

**ENDS**

For further information either telephone [redacted] or email [redacted]


Tuesday, 28 Jan 2020

## NHS GREATER GLASGOW AND CLYDE STATEMENT

**Jane Grant, Chief Executive at NHS Greater Glasgow and Clyde, said:**

“We welcome the Cabinet Secretary’s update today, which gives more detail about the review team and the timescales involved.

“Our Board and senior leadership team are entirely focused on delivering safe, person-centred care for the people of Greater Glasgow and Clyde.

“It is right that patients and families are at the centre of everything we do and we recognise it is absolutely critical that they have the information they need and are supported properly.

“We continue to work with Professor Marion Bain in the area of infection control and we welcome the opportunity now to work with Professor Mike Stevens and Gaynor Evans to address these issues and go on to rebuild the confidence of the public.

“We make strenuous efforts to ensure all statements are issued in a timely and accurate manner and we will work with Professor Bain to address the concerns others have raised with her.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

**Statement on Legal Proceedings**

NHS Greater Glasgow and Clyde has served a summons on Multiplex, Capita Property and Infrastructure Ltd and Currie and Brown UK Limited for losses and damages incurred due to a number of technical issues within the Queen Elizabeth University Hospital and the Royal Hospital for Children.

Given the public interest in the hospitals and legal proceedings, the summons is being published today (26 February 2020).

The summons sets out where the requirements of NHSGGC were not met in either design, commissioning or building stages in eleven specific areas.

The legal action is being taken following a review commissioned by NHSGGC to consider how these technical issues arose and any further actions required.

Specific issues have also been the subject of a further external review. An independent review by Health Protection Scotland (HPS) into the water supply confirmed contamination of the water system in 2018.

The independent review by HPS, which was commissioned by NHSGGC, was established to investigate a number of probable linked cases of infection associated with the water supply.

HPS agreed with the measures proposed by NHSGGC to address the water system issues – and these actions have been taken.

The report and the remedial work carried out by NHSGGC have been shared with families, the public and other stakeholders.

Jane Grant, Chief Executive, said: “We would assure patients and their families that patient safety is paramount and that patient care at the two hospitals is of a high standard.

“Our staff strive at all times to provide high quality care and I would like to thank them for their continued professionalism and dedication during this time.

“Whilst we are now taking legal action on a number of design and installation issues, it is important to stress that the hospitals continue to provide safe and effective care.

“A significant amount of work has already taken place including the remedial action on the water supply and the ventilation.

“We know that patients, families and staff have been caused concern as the issues have emerged and I am sorry for any distress caused.

“As the matters are now the subject of court proceedings, we are not in a position to comment further.”

**ENDS**

**Summons**
https://www.nhsggc.org.uk/media/258718/2020-01-22-qeuh-finalised-summons.pdf
**Precis**
https://www.nhsggc.org.uk/media/258719/note-re-proceedings-raised-against-mpx.pdf

**Background**
The current estimation of damages and losses is approximately £73m, which include the costs incurred to date and an estimate of future anticipated costs.

It should be noted that because this sum is an estimate it may be subject to change. In total, the summons covers eleven technical issues. Action taken to address the issues is as follows:

**Issue 1 Water System - Action Taken**
When issues with the water system were identified in Wards 2A and 2B at the RHC in March 2018, steps were taken to investigate and put in place improvements and control measures including fitting point of use filters on water outlets.

When bacteria were subsequently identified in the drains of these wards in June 2018, drain cleaning was initiated in high risk areas.

In mid-September, we made the decision to transfer the patients to Ward 6A of the neighbouring QEUH. This allowed our technical staff to carry out more detailed examinations of the overall environment of the two wards.

We subsequently installed a continuous Chlorine Dioxide dosing plant in RHC (December 2018) and QEUH (March 2019) and installed further point of use filters in all clinical areas where the haemato-oncology patients are likely to attend. These solutions were endorsed by Health Protection Scotland and Health Facilities Scotland.

We continue to monitor water hygiene closely. The water is ‘potable’ meaning it conforms to drinking water standards.

**Issue 2, 3 and 4 Ventilation – Action Taken**
Work was carried out on the adult BMT unit in 2017 to improve the air quality and provide HEPA filtration to all patient bedrooms and ancillary areas. We continue to monitor the air quality in this unit.

Seven negative pressure rooms have been upgraded and this was complete by May 2019.

The ventilation system in Ward 2A and 2B of the RHC is currently being upgraded to provide optimal, state of the art facilities for all our young haemato-oncology patients. This work will conclude in summer 2020.

**Issue 5: Plant and building service capacity**
Further design investigation required.

**Issue 6 Toughened glazing – Action Taken**
A protective canopy is being installed, and is currently under construction, to mitigate the risk of the impact of fractured glass.

**Issue 7 Doors – Action Taken**
The door frames are not as required in the contract and replacement and repairs are having to be carried out more often than expected. However, it must be stressed that fire safety has not been compromised as this does not affect the integrity or functionality of the doors.

**Issue 8: Heating system**
The energy plant continues not to achieve the required efficiency.

**Issue 9 Atrium roof – Action Taken**
The section of the roof that was damaged has since been replaced.

**Issue 10: Internal fabric moisture ingress – Action Taken**
Previous media reports have covered the issues relating to the design and materials used in the construction of the en-suite bathrooms. A programme of repair or replacement is underway.

**Issue 11: Pneumatic transport system – Action Taken**
The hospitals continue to operate with alternative transportation and portering arrangements as a backup.

For further media information either telephone [redacted] or email [redacted]

[redacted]

**From:** NHS Greater Glasgow and Clyde [redacted]
**Sent:** 15 June 2020 17:06
**To:** Best, Jonathan
**Subject:** [BlockedURL][ExternaltoGGC][MARKETING] NHSGGC response to the Independent Review of the QEUH campus

NHSGGC News Update

NHS Greater Glasgow and Clyde

**NHSGGC response to the Independent Review of the QEUH campus**

The report from the Independent Review of the QEUH campus has been published today. Below is our statement in response to the Report, a video from the report authors and a link to the report.

**NHSGGC statement**

Questions around the safety of the hospitals on the QEUH campus have persisted for some time, causing distress to a number of families and a great degree of public concern. We are very sorry that this situation has arisen and for the anxiety this caused.

The independent review by Dr Fraser and Dr Montgomery provides a

comprehensive assessment of issues that arose with the QEUH and the RHC in relation to their design, build, commissioning and maintenance and we welcome the publication of their report.

Today's report highlights a number of shortcomings by the Board, its contractors and its advisors at various stages of the design, build, commissioning and maintenance of the QEUH and RHC. It also recognises that since the hospitals opened, we have taken remedial action to resolve a wide range of issues, some of which are now subject to legal action against the contractors and the advisors.

The report also concludes that there is no sound evidential basis for avoidable deaths having resulted from failures identified with the design, build and maintenance of the QEUH campus, including the water system and that the link between air changes and infection risk has not been established. Furthermore, it finds no sound evidence linking the instances of Cryptococcus infection to the presence of pigeons on the campus.

The report finds that our hospitals are delivering high quality healthcare, supported by modern safety systems and features. It recognises the significant efforts of our infection control teams, along with clinical colleagues, to ensure patient safety and to reduce infection rates in our hospitals.

We hope that today's report provides some comfort to families who have had unanswered questions about factors contributing to the death of their loved one and helps restore public confidence in the safety of the hospitals. We would like to apologise again to those families that these issues have arisen and for the time taken to resolve them.

Welcoming the report, Jane Grant, Chief Executive said: "This has been a very difficult period for our patients, their families and our staff for which we apologise.

"The findings highlight several areas of learning for NHSGGC. We remain fully committed to applying the learning from this experience. We also remain

focused on remedying any ongoing consequences of decisions and actions taken when designing, building and commissioning of the hospitals and in their maintenance.

“The report highlights issues concerning previous ways of working in one area of the Board with regard to Infection Prevention and Control. We recognise that there are still issues to be addressed concerning the organisation’s culture.

“We would like to thank Professor Marion Bain and Professor Angela Wallace for their work on behalf of the Scottish Government to support the team to develop a more supportive and inclusive culture in this area.

“Whistleblowing is an important factor in better understanding issues and promoting a culture of openness where staff feel confident to raise concerns. We are committed to supporting whistleblowers within our organisation and thank those who came forward with their concerns about the hospitals.”

Professor John Brown CBE, Chairman, added: “We hope that this report, and the lessons from it, can enable the Health Board to move forward, to restore public confidence in the QEUH and the RHC and to help re-build the reputation of these hospitals to one based on the high quality, person centred care being provided by our hard working and committed staff rather than on the problems we experienced with the design and construction of the buildings.”

**Video from the Independent Review report authors, produced by 3x1 agency:**

**You can read the report here:** BLOCKEDqueenelizabethhospitalreview[.]scot/queen-elizabeth-university-hospital-review-review-report/BLOCKED

**ENDS**


Tuesday 28 July (NM)

I wondered what the latest date for opening of wards 2A/2B?

We understand from media reports, the last date was Spring 2020, do you have a new date?

We are planning to do something either today or tomorrow that will be looking ahead to the start of the Public Inquiry. We're interviewing one of the families whose child has had an infection that is being investigated in the case note review.

I'll know in the next couple of hours whether the piece will run today or later in the week so will come back to you as soon as that is confirmed. But I would need to get an answer by later this afternoon.

Will also come back if there are any other specific questions that come out of the interview but for now it was to find out if there was a new date for the opening of the wards.

## NHS GREATER GLASGOW AND CLYDE STATEMENT

“Work continues on the ventilation upgrade on Ward 2A and 2B. This multimillion investment is to ensure we are taking every possible measure to reduce the likelihood of infection for this group of patients. We are confident this will be one of the safest environments within the UK.

"The schedule for Wards 2A and 2B has been affected by COVID-19. Whilst the project was deemed an essential NHS build and therefore enabled to continue throughout the pandemic, works were and continue to be affected by social distancing regulations and by delays in the supply chain. We are currently assessing the impact of this on the timescales for the programme. We are sorry for the delay and will confirm the planned opening date as soon as it is available.”

**ENDS**

For further information either telephone [redacted] or email [redacted]

NHS Greater Glasgow and Clyde

# Core brief

Friday, 22 February 2019

**Introduction**

This issue provides information on an HPS report on the water at the Royal Hospital for Children and the Queen Elizabeth University Hospital.

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A Health Protection Scotland (HPS) report on the water at the Royal Hospital for Children and the Queen Elizabeth University Hospital was issued today - click on the following link for the full report: https://www.gov.scot/publications/qe-university-hospital-royal-hospital-children-water-incident/

NHSGGC statement on water report below:

There have been no cases of infection associated with water since September 2018.

Our engineering teams have installed a water treatment system within the Royal Hospital for Children and are working on the new system for the adult hospital. This will be completed in March.

In the meantime, filters remain in place and we continue to monitor the quality of water with very encouraging results.

Over the past few months, whilst our investigations continued, our overriding priority has always been the safety of our patients.

We are sorry that a number of young patients in our care suffered an infection and also apologise for the inconvenience and worry that the families in wards 2A and B in particular will have experienced.

Since the report, written in December 2018, the Cabinet Secretary for Health and Sport has announced a review into the design, commissioning and construction of the Queen Elizabeth University Hospital and the Royal Hospital for Children.

Earlier this week our Board also approved a further three reviews into the hospital to provide assurance to the public and address recent concerns.

Our teams will be supported in these reviews by national experts including Health Protection Scotland and Healthcare Facilities Scotland.

NHSGGC statement on water report

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## NHS GREATER GLASGOW AND CLYDE STATEMENT

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Our statement on report below:

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**From:** Cook, Claire
**Sent:** 22 February 2019 13:14
**To:** Office, Press
**Subject:** Report into water contamination incident

**From:** Mark Taylor [redacted]
**Sent:** 22 February 2019 13:11
**To:** Office, Press
**Subject:** [BlockedURL][ExternaltoGGC]Report into water contamination incident

22/02/19 12:37

# Report into water contamination incident

Responding to Health Protection Scotland's report into last year's water contamination incident at Queen Elizabeth University Hospital, which was published today, Health Secretary Jeane Freeman said:

"The report makes a number of important recommendations for NHS Greater Glasgow and Clyde, as well as all NHS boards, Health Protection Scotland and Health Facilities Scotland. It is vital that these recommendations are addressed.

"NHS Greater Glasgow and Clyde continue to take the necessary actions and I will continue to seek regular updates on these actions to ensure full accountability of the board. I will also ensure that work is taken forward on the wider recommendations to ensure key lessons can be learned Scotland-wide to

prevent similar issues arising in the future and ensure our healthcare facilities support the delivery of world class health care.

“This report will be provided to the independent review into the Queen Elizabeth University Hospital. As I have previously stated to Parliament, it is vital that we all understand what the issues are, why they have arisen, and that the recommendations will be taken forward.”

**Background:**

The full report can be read here.

## Contacts

**Mark Taylor**

Senior Media Manager

[redacted]

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# Media Statement

NHS Greater Glasgow and Clyde

Friday, February 22, 2019 (LD)

[redacted] **Daily Mail** - water report

**NHSGGC STATEMENT ON WATER REPORT**

There have been no cases of infection associated with water since September 2018.

Our engineering teams have installed a water treatment system within the Royal Hospital for Children and are working on the new system for the adult hospital. This will be completed in March.

In the meantime, filters remain in place and we continue to monitor the quality of water with very encouraging results.

Over the past few months, whilst our investigations continued, our overriding priority has always been the safety of our patients

We are sorry that a number of young patients in our care suffered an infection and also apologise for the inconvenience and worry that the families in wards 2A and B in particular will have experienced.

Since the report, written in December 2018, the Cabinet Secretary for Health and Sport has announced a review into the design, commissioning and construction of the Queen Elizabeth University Hospital and the Royal Hospital for Children.

Earlier this week our Board also approved a further three reviews into the hospital to provide assurance to the public and address recent concerns.

Our teams will be supported in these reviews by national experts including Health Protection Scotland and Healthcare Facilities Scotland.

**ENDS**

For further information either telephone [redacted] or email [redacted]

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** Stv.tv (Web)
**Date:** 22 February 2019
**Page:** N/A
**Reach:** 134501
**Value:** 3610

## Review of water system ordered after infection outbreak

HPS wants to avoid a repeat of an infectious outbreak at a children's hospital.A health watchdog will carry out a national review of the water systems at all healthcare facilities in Scotland built since 2013 to avoid a repeat of an infection outbreak at a children's hospital.

Health Protection Scotland (HPS) launched an investigation after patients in wards for those with compromised immune systems at the Royal Hospital for Children (RHC) in Glasgow were found to have infections.

An HPS investigation report states the first child was infected in 2016, with a total of 25 cases found by September 2018, when the patients were moved out of the wards 2A/B and into the neighbouring Queen Elizabeth University Hospital (QEUH).

No patients died as a result of the outbreak, but a number of children required "additional intervention" and there were delays to chemotherapy treatments.

Tests found "widespread contamination of the water system that serves both QEUH and RHC".

This included contamination on taps and drains in the affected wards, and the system there was sanitised, with water filters put in place, and drains were decontaminated prior to the patients being moved.

Now, as part of a series of recommendations, HPS plans to "undertake an urgent national water review of all healthcare premises built since 2013 to provide assurance that a similar incident has not and is not likely to occur elsewhere".

The report said the most likely cause is thought to be a possible combination of existing contamination at the installation and/or commissioning of the water system and contamination at taps spreading backwards.

Water samples showed indicators of contamination prior to handover and the contractor sanitised the system but there were some indications there may still have been areas with higher than acceptable levels of the contamination indicator.

Part of a water treatment system installed involves continual dosing with chlorine dioxide which the report said may take up to two years to be effective throughout the system.

A spokeswoman for the health board said: "There have been no cases of infection associated with water since September 2018.

"Our engineering teams have installed a water treatment system within the Royal Hospital for Children and are working on the new system for the adult hospital. This will be completed in March.

"In the meantime, filters remain in place and we continue to monitor the quality of water with very encouraging results.

"Over the past few months, whilst our investigations continued, our overriding priority has always been the safety of our patients.

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**Value:** 3610

"We are sorry that a number of young patients in our care suffered an infection and also apologise for the inconvenience and worry that the families in wards 2A and B in particular will have experienced."

She added that four reviews into the hospital have been announced since the report was written in December 2018.

Health Secretary Jeane Freeman said: "The report makes a number of important recommendations for NHS Greater Glasgow and Clyde, as well as all NHS boards, Health Protection Scotland and Health Facilities Scotland.

"It is vital that these recommendations are addressed.

"NHS Greater Glasgow and Clyde continue to take the necessary actions and I will continue to seek regular updates on these actions to ensure full accountability of the board.

"I will also ensure that work is taken forward on the wider recommendations to ensure key lessons can be learned Scotland-wide to prevent similar issues arising in the future and ensure our healthcare facilities support the delivery of world-class health care."

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Unattributed[sourcelink]https://stv.tv/news/west-central/1435757-review-of-water-system-ordered-after-infection-outbreak/[/sourcelink]

The Herald

Date 23 February 2019
Page 1,3

Precise.

# Tests found water supply was contaminated before hospital was opened

HELEN MCARDLE

TESTS exposed widespread bacterial contamination of the water supply at Glasgow's superhospital even before it opened, a new report has revealed.

The contractor responsible for building the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) was forced to sanitise the entire system, before handing it over to the health board after sampling detected "hygiene issues with the water supply" and signs of unusually high microbial contamination.

In spite of efforts to cleanse the hospitals' water supply, Health Protection Scotland said that "there are a number of reports which indicate that there may still have been a number of areas with higher than normally acceptable levels of [microbes]".

The new hospitals opened in May 2015, but just a few months later – in February 2016 – a child with cancer developed a bloodstream infection caused by Cupriavidus pauculus, a rare water-borne bacteria. The patient was being treated in Ward 2A at the children's hospital and

Continued on Page 3

The Herald

Date 23 February 2019
Page 1,3



# New hospital's water supply was contaminated before it opened

Continued from Page 1

subsequent tests traced the source to a tap from a wash-hand basin in the pharmacy department where artificial nutrition was prepared. The sink was subsequently removed.

A second paediatric cancer patient fell ill with the same bug in September 2017, but the source was found to be a different wash-hand basin.

Then, between January 29 and September 20 2018, a further 21 children in wards 2A and 2 B – known as the Schiehallion unit – developed a range of blood infections caused by 12 separate types of bacteria and fungi.

These included Serratia marascens, which was previously the cause of an outbreak at the Princess Royal Maternity Hospital in 2011 and resulted in one infant dying and 11 others sickened.

The Health Protection Scotland report reveals that all cases were linked to the water supply or drains. It also found that tests as far back as March 2018 highlighted risks of infection at the adjacent adult hospital.

THE TIMES

Date 23 February 2019
Page 7

Precise.

# Widespread water contamination found at Glasgow hospitals

Laura Paterson

Health inspectors found widespread contamination of the water system during a nine-month investigation at one of Scotland's largest health boards.

A national review will now be carried out at all healthcare facilities built in Scotland since 2013 in an attempt to avoid a repeat of the outbreak of infection at the Royal Hospital for Children [RHC] in Glasgow.

Patients in wards for those with compromised immune systems were found to have infections.

A report on the investigation by Health Protection Scotland [HPS] said that the first child had been infected in 2016, with a total of 25 cases found by last September, when the patients were moved out of wards 2A and 2B and into the neighbouring Queen Elizabeth University Hospital.

No patients died as a result of the outbreak but a number of children required "additional intervention" and there were delays to chemotherapy treatments.

Tests found widespread contamination of the water system that serves both the Queen Elizabeth and RHC. This included contamination in taps and drains in the affected wards. The system was sanitised, with water filters installed and drains decontaminated before the patients were moved.

As part of a series of recommendations, HPS plans an urgent review of all healthcare premises built since 2013 "to provide assurance that a similar incident has not and is not likely to occur elsewhere".

The report said that the most likely cause was a contamination at the installation or commissioning of the water system, combined with contamination at taps spreading backwards.

Water samples showed indicators of contamination prior to handover. The contractor sanitised the system but there may have been areas with higher than acceptable levels of contamination, the report said. Part of the treatment involves dosing the water with chlorine dioxide, which the report said may take up to two years to be effective throughout the system.

A spokeswoman for the health board said: "There have been no cases of infection associated with water since September 2018. Our engineering teams have installed a water treatment system within the Royal Hospital for Children and are working on the new system for the adult hospital. This will be completed in March.

"In the meantime, filters remain in place and we continue to monitor the quality of water with very encouraging results. We are sorry that a number of young patients in our care suffered an infection and also apologise for the inconvenience and worry that the families in wards 2A and B in particular will have experienced."

Jeane Freeman, the health secretary, said it was vital that recommendations in the report were addressed. "NHS Greater Glasgow and Clyde continue to take the necessary actions and I will continue to seek regular updates on these actions to ensure full accountability of the board," she said, adding that key lessons must "be learnt Scotland-wide".

**Client:** NHS Greater Glasgow and Clyde Media Coverage
**Source:** The National (Scotland) (Main)
**Date:** 23 February 2019
**Page:** 2
**Reach:** 10380
**Size:** 153cm2
**Value:** 166.77

# Review set to prevent infection outbreaks

**BY LAURA WEBSTER**

A REVIEW into water systems at Scotland's newest healthcare facilities will be carried out to avoid a repeat of a 2016 infection outbreak at a children's hospital.

The watchdog Health Protection Scotland (HPS) launched an investigation after patients in wards for those with compromised immune systems at Glasgow's Royal Hospital for Children (RHC) were found to have infections.

The HPS investigation report states 25 cases were found from 2016 to September 2018.

No patients died as a result of the outbreak, but a number of children required "additional intervention" and there were delays to chemotherapy treatments.

Tests found "widespread contamination of the water system that serves both QEUH and RHC".

Contamination was found on taps and drains in the affected wards, and the system was sanitised.

Now, as part of a series of recommendations, HPS plans to "undertake an urgent national water review of all healthcare premises built since 2013 to provide assurance that a similar incident has not and is not likely to occur elsewhere".

A spokeswoman for the Glasgow health board said: "There have been no cases of infection associated with water since September 2018.

"Our engineering teams have installed a water treatment system within the Royal Hospital for Children and are working on the new system for the adult hospital. This will be completed in March.

"In the meantime, filters remain in place and we continue to monitor the quality of water with very encouraging results.

"Over the past few months, whilst our investigations continued, our overriding priority has always been the safety of our patients.

"We are sorry that a number of young patients in our care suffered an infection and also apologise for the inconvenience and worry that the families in wards 2A and B in particular will have experienced."

The Daily Telegraph

Date 23 February 2019
Page 7

Precise.

# NHS to check tainted water

NHS boards across Scotland were yesterday ordered to test hospital water supplies after widespread contamination at two hospitals.

Health Protection Scotland launched an investigation after patients with compromised immune systems at the Royal Hospital for Children in Glasgow were found to have infections. A total of 25 cases had been found by September 2018 when patients were moved to Queen Elizabeth University Hospital. No patients died but a number of children required "additional intervention".

Tests found contamination of the water system that serves both of the hospitals. Samples showed contamination in taps and drains prior to the building being handed over by the contractor.

An NHS Greater Glasgow and Clyde spokesman said: "There have been no cases of infection associated with water since September 2018."

DAILY STAR OF SCOTLAND

Date 23 February 2019
Page 2

Precise.

A PROBE into the water supply at Glasgow's Queen Elizabeth University Hospital in Glasgow found "widespread contamination".

The probe began after an infection outbreak in two cancer wards at the nearby Royal Hospital for Children last year.

A report by Health Protection Scotland said contamination was in taps and drains at both hospitals.

Scottish Daily Mail

Date 23 February 2019
Page 23

Precise.

# NHS demands bug probe at every hospital in the country

By **Kate Foster**
Scottish Health Editor

AN urgent review of Scotland's hospital water systems has been ordered after a probe found 'widespread contamination' at a 'superhospital'.

The findings have emerged after 23 children were infected with a range of bacteria that was traced back to taps in a cancer unit.

New water treatment systems are being installed at the £842million Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children in Glasgow – costing £1million – less than four years after the facility was built.

But inspectors have ordered an 'urgent' review of the water supplies of all healthcare premises in Scotland built in the past few years, to make sure 'a similar incident is not likely elsewhere'.

A separate investigation is taking place into the death of two patients infected with a fungus linked to pigeons at the QEUH.

The 'most likely cause' of the water problems is that the taps were contaminated when they were installed during the hospital's construction, and the bacteria spread throughout the water system, the investigation by Health Protection Scotland found.

The first infection was detected in 2016 in the children's haemato-oncology unit, the Schiehallion ward, which houses the National Bone Marrow Transplant Unit.

Last year, children were moved to the adult hospital while the cancer unit's water supply was upgraded.

A spokesman for NHS Greater Glasgow and Clyde said: 'There have been no cases of infection associated with water since September 2018.

'We continue to monitor the quality of water with very encouraging results.'

All hospitals in Scotland built since 2013 will be investigated to see if they have similar problems.

Scottish Conservative health spokesman Miles Briggs said: 'For families and staff, the water contamination incident has been both distressing and concerning.

'The revelation that the problem might have been caused during construction and affects the whole site raises real questions about the construction of the hospital.'

Scottish Labour health spokesman Monica Lennon said: 'Labour supports an urgent national water review. However, there are serious questions for the health board and the Government to answer on how this was handled.'

Health Secretary Jeane Freeman said: 'NHS Greater Glasgow and Clyde continues to take the necessary actions and I will continue to seek regular updates on these actions.

'I will also ensure work is taken forward to ensure key lessons can be learned to

Scottish Daily Mail

Date 23 February 2019
Page 23

Precise.

prevent similar issues arising in the future.'

## Scotland has most 'avoidable deaths'

SCOTLAND has the highest rate of 'avoidable deaths' in the UK caused by drinking, smoking and unhealthy food.

An Office for National Statistics report found that in 2017 the rate of avoidable deaths was higher in Scotland than the rest of the UK, at 363 per 100,000 population of men. That compared with 268 in England.

The figure for Scots women was 229 per 100,000 population, compared with 165 in England.

The report said: 'Avoidable mortality rates for males and females are consistently highest in Scotland and lowest in England.'

## Massive failure of waiting time law

THE SNP'S flagship NHS waiting time law has been broken more than 170,000 times since it came into force in 2012.

Almost one in ten patients are not being seen within the Treatment Time Guarantee of 12 weeks after being referred by a doctor.

Scottish Labour revealed the number of patients seen is 1,835,139, of whom 171,480 waited more than 12 weeks.

A Scottish Government spokesman said: 'We recognise that people are waiting too long, which is why the Health Secretary published our £850million Waiting Times Improvement Plan in October last year.'

### 'Distressing and concerning'

Raises questions: Miles Briggs

SCOTTISH DAILY EXPRESS

Date 23 February 2019
Page 20

Precise.

# Hospital water 'badly infected'

A PROBE into the water supply at Glasgow's Queen Elizabeth University Hospital in Glasgow has found "widespread contamination".

The probe was launched after an infection outbreak in wards at the neighbouring Royal Hospital for Children (RHC) last year.

Health Protection Scotland (HPS) said contamination was found in taps and drains at both hospitals.

A total of 23 children contracted bloodstream infections in the cancer wards between January and September last year, thought to be linked to bacteria in the water supply.

HPS said work to fix the problem was ongoing and water testing had identified widespread contamination across the hospital campus.

But it said there had been no further infections since the closure of wards 2A and 2B – which house the National Bone Marrow Transplant Unit at the children's hospital.

Daily Record

Date 27 February 2019
Page 5

Precise.

# Public were 'shaken' by NHS troubles

PUBLIC confidence in the NHS was "shaken" by the recent outbreak of hospital infections, Health Secretary Jeane Freeman admitted yesterday.

It emerged last month that two babies died after contracting an extremely rare strain of staphylococcus aureus.

And two patients caught an infection linked to pigeon droppings at Queen Elizabeth University Hospital in Glasgow.

Freeman insisted progress has been made since an outbreak of C.Difficile at Vale of Leven Hospital a decade ago but told MSPs: "I understand that public confidence has been shaken."

Dear Parent / Carer

We appreciate that this is a difficult time and are sorry for any distress that has been experienced by you during this time.

We have been committed to keeping you up to date on the work we have been doing to enhance the ward environment.

We are continuing to make positive progress towards reopening the ward to new patients

We are extremely grateful to you for your continued co-operation and support and want to ensure you have ready access to information and new developments.

To help keep you informed we have established a closed group on Facebook.

The page can be access through https://www.facebook.com/groups/515596955925791/ or by searching for *NHS GGC Haemato-Oncology Closed Facebook Group*

You can join by requesting to be a member of the group and we will add you.

In addition, our clinical, nursing and infection control and senior management staff are also available to discuss anything further.

Regards

9 October 2019

**Parent update on Incident Management Team**

Dear Parent / Carer

We have committed to updating you on our investigations into a number of unusual infections in the ward. Whilst these infections are uncommon the overall number of infections on the ward remain within accepted limits.

Our infection control, clinical, nursing staff and facilities teams along with senior management and national experts from Health Protection Scotland (HPS) continue to work together to investigate the current incident.

We have undertaken extensive testing of the ward environment and at this stage no link has been detected between the infections and the ward environment or our infection control practices.

In one previous case, we found the type of bacteria to be widespread in the general domestic water supply and in the water supply to public buildings. The investigation into this one case has now been closed.

A further Incident Management Team meeting took place on Tuesday evening and it was agreed that ongoing environmental sampling and testing will continue.

We are also continuing to divert a small number of new admissions and high risk patients. All other inpatients and day cases continue to be treated on the ward as do outpatients who are being seen and treated as normal.

A review of all the data relating to the number and nature of the infections is being carried out by HPS and this is ongoing.

The ward staff kitchen is currently out of use. This is the result of a leak from the sink tap. The cause of the leak has been identified as a faulty tap connector on a recently fitted tap. The leak has been repaired and work is being undertaken to re-open the staff kitchen next week.

We appreciate and understand how difficult things are currently and are sorry for any distress caused during this time. We are extremely grateful to you for your continued co-operation and support and want to ensure you have access to information updates.

To help keep you informed we have established a closed group on Facebook.

The page can be access through https://www.facebook.com/groups/515596955925791/ or by searching for *NHSGGC Haemato-Oncology Closed Facebook Group*

You can join by requesting to be a member of the group, once you have answered the two questions we will add you.

In addition, our Chief Executive and Chairman will be writing to every parent and carer to offer an opportunity to meet. Our clinical, nursing and infection control and senior management staff are also available to discuss anything further.

NHS Greater Glasgow and Clyde

# Want to keep up-to-date with what's happening in and around **wards 6A** and **4B**?


We've created an area on our website dedicated to **paediatric haemato-oncology services**.

Find it at: **www.nhsggc.org.uk/ward6a-and-4b**

There's also a closed Facebook page just for you, the parents and carers of children being treated here. It's easy to join.

Visit: **www.nhsggc.org.uk/facebookPHO**

Please let us know if there's anything you'd like to be included in these platforms.

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**Questions put forward by the Disclosure Programme**

We will be looking at the stories of a number of families who have questions about treatment.
In particular [redacted] mum [redacted] has questions about the infection that her daughter contracted. We'd like to address those and what action was taken by the heath board to test for Stenotrophomonas.

Also the family of a patient who died after contracting Cryptococcus have questions about their care.
We'd like to ask specifically about the investigation into Cryto and why the plant room has now been ruled out as a source. What is the health boards position on where it came from?

We also have spoken other families who are worried about infection risk to the care of their children even now in the hospital. We'd like to ask about the care they are receiving.

We have expert opinion on the water and ventilation systems. They have questions about decision making at the time of opening, and also about the prominence of infection control during the building and design phase and beyond.

We'd like to ask about efforts to address the issues identified in the water system, whether in addition to the pipe work; taps and shower heads could have contributed to an increase in infections. And we'd like to discuss when issues with the ventilation system were identified and what action was taken as a result.

We will also be looking into whether a culture of bullying and a lack of transparency impacted on patient safety.

Not all of these issues were identified in the recent Independent Review and so we would really like to get an on camera response from the Health Board that will address these concerns.

**NHS Greater Glasgow and Clyde Statement for BBC Disclosure Scotland programme**

**22/06/20**

We are grateful for the opportunity to comment and welcome the findings of the Independent Review recently published into the QEUH/RHC by Dr Andrew Fraser and Dr Brian Montgomery.

We are truly sorry that, following the Independent Review, families who have lost a loved one have questions remaining about the circumstances of their death. We have offered to meet families and remain committed to supporting them in any way we can.

The Independent Review of The Queen Elizabeth University Hospital and Royal Hospital for Children found that the hospitals have "modern safety features and systems that we would expect of a hospital of this type. The general population of patients, staff and visitors can have confidence that the QEUH and RHC offer a setting for high quality healthcare."

The Reviewers were impressed with the staff working in the hospitals whom they praised for their professionalism and for their focus on effective and high quality care with the opportunities and advantages of modern hospital facilities.

The Independent Review into QEUH/RHC is one of a number of reviews into the QEUH/RHC that have taken place since the hospitals opened. We have also held our own internal review, which involved independent experts, and we have invited external scrutiny of the issues by Health Protection Scotland and Health Facilities Scotland.

Various allegations made to this programme have been investigated independently in various forums and have not been substantiated through any of these independent investigations.

In particular, the Independent Review has found no avoidable deaths linked to shortcomings in the design, build, commissioning, and maintenance of the hospitals.

It judged the 'link between pigeons and air inlets in the vicinity providing contaminated air through high quality filters towards the patients involved' not to be a 'sound theory'. More than 3000 air samples have been taken from the hospitals' environment. Cryptococcus neoformans has never been found in any of the air samples.

We remain fully committed to learning from this experience. We welcome the forthcoming Public Inquiry and are committed to fully participating in that process and implementing any lessons learned from any of these processes as necessary and appropriate.

**Ends.**

**NHS Greater Glasgow and Clyde Statement for BBC Disclosure Scotland programme**

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We remain fully committed to learning from this experience. We welcome the forthcoming Public Inquiry and are committed to fully participating in that process and implementing any lessons learned from any of these processes as necessary and appropriate.

Ends.

Responses to questions

1. That the family of [redacted] believes the stenotrophomonas which infected her [redacted] and contributed to [redacted] death, was contracted through contaminated water at the hospital.

**The death of any child is a tragedy. In relevant cases we have investigated the circumstances of the death and shared our findings with the child's family. We have also referred cases to the**

**Procurator Fiscal, which will also be examined through the independent case note review and may be addressed by the Public Inquiry. For these reasons, we will not comment upon individual cases.**

2. That when the hospital tested for stenotrophomonas from tap outlets in September 2017, it tested water from 10 taps and one shower head from ward 2A. The other water samples were taken from other wards.

**An infection control doctor investigating possible sources asked the specialist laboratory in August 2017 if it would be possible to set up a test for Stenotrophomonas. The laboratory established the processes to do so and tested 118 samples in September 2017.**

**39 samples were taken from Ward 2A and 118 from across the campus – all of which were negative.**

3. Did hospital treat or dose the water, with the aim of removing stenotrophomonas in the water, in the children's hospital between June and September 2017?

**No. Routine water testing is carried out in our hospitals in line with national guidance as well as specific testing at the request of Infection Control Doctors. At no time in 2017 was stenotrophomonas found in the water. Treatment using chlorine dioxide was commenced in December 2018 in response to our investigations with Health Protection Scotland and Health Facilities Scotland into a number of unusual infections.**

4. That there has been a cover up at the board level of the extent of the water contamination and faulty ventilation in the hospital.

**This is untrue and in our view entirely unsubstantiated.**

**There has been significant scrutiny of the ventilation and the water supply for the hospitals.**

**We have fully investigated these issues and have called upon external expert advice to assist us with this.**

**We have also fully participated in the recently published Independent Review into the QEUH/RHC and water and ventilation issues are covered by the Terms of Reference of the upcoming Public Inquiry.**

5. That there is a culture of bullying, and that staff were told "not to put things in writing" because of the potential of these being picked up later during inquiries.

**This is untrue and not accepted. These issues have been the subject of intensive scrutiny by the Independent Review. We would refer you to their report for an independent assessment of the culture of NHSGGC.**

**The Independent Review found 'no evidence of institutionalised bullying in NHSGG&C'.**

6. That the ventilation and water systems were substandard and that this has been linked to an increase in infections and possible deaths of patients and that this put patients, particularly children, at risk.

**This has been scrutinised by the Independent Review. We would refer you to their report. The Independent Review found that no avoidable deaths have resulted from failures in the design, build, commissioning or maintenance of the QEUH and RHC.**

7. That infection control doctors were not given water risk assessments which they repeatedly asked to see from 2015.

**We have not seen any evidence to support these allegations.**

8. Were the water risk assessments of 2015 and 2018 escalated to board level at the time?

**The 2015 and 2017 DMA reports were escalated to senior management in 2018, when action was taken to address the issues identified.**

**This has been scrutinised by the Independent Review. We would refer you to their report.**

9. That the opening of the hospital should have been delayed because of the contamination risk.

**These matters are currently the subject of ongoing legal action and we are therefore not in a positon to comment further at this time.**

10. That taps with flow straighteners were not removed from high risk areas of the hospital, nor were flow straighteners removed, after the hospital was told that these were a risk to patients.,

**This has been scrutinised by the Independent Review. We would refer you to their report.**

**The Independent Review found: "These design and specification issues around taps and basins were considered acceptable and in line with NHS design guidance at the time. The example of the taps illustrates an important point about constant change in knowledge and lessons from experience of IP&C risks with the built environment elsewhere that drives change and has practical impact on building projects in progress. So whilst the Review discusses problems and ideal solutions with the benefit of hindsight, most of the decisions on taps at the design stage would have been in line with guidance and considered normal practice at the time."**

11. That the health board took the decision to keep the taps because it was under pressure to deliver the hospital on time and budget and replacing the tap inserts or the taps would increase costs and cause a delay.

**These allegations are unfounded and inaccurate. The decision to accept the taps was taken in June 2014 by an expert group involving Health Protection Scotland, Health Facilities Scotland, NHSGGC and Public Health England.**

12. That children were and are being given strong antibiotics to protect them against possible infections derived from the flawed water and ventilation systems at the hospital.

**Antifungal treatment is given according to a clinical protocol approved by a multi-disciplinary team based upon evidence from a range of sources and a long standing proven approach to infection control.**

13. That the hospital stated infection rates were low, despite 15 recorded HIATS reported to HPS between 2016 and 2019.

**The latest independent national survey of hospital infection rates showed that infection rates at the Royal Hospital for Children are lower than the other comparable paediatric hospitals in Scotland at 3.6%.**

**The Independent Review also found that: "The general profile of infection control in terms of recorded incidence of key infections and outbreaks in the 'New Build' hospital complex was as good as, or better than other comparable data, both in other hospitals and compared with the hospitals that QEUH/RHC replaced and also when compared with other hospitals across Scotland."**

14. That the ventilation system in the children's ward was not fit for purpose, did not comply with regulations and could be putting vulnerable children at additional risk.

**This has been scrutinised by the Independent Review. We would refer you to their report.**

**Ventilation is also covered by the Terms of Reference of the upcoming Public Inquiry.**

**The Independent Review has recognised the measures taken by NHSGGC and in its second main finding states: "The QEUH and RHC combined now have in place the modern safety features and systems that we would expect of a hospital of this type. The general population of patients, staff and visitors can have confidence that the QEUH and RHC offers a setting for high quality healthcare."**

15. That there is insufficient evidence to rule out the presence of pigeons and their droppings in and around the hospital, in air vents, plant rooms, the ventilation system and on roofs, as a source of Cryptococcus neoformans in two patients.

**The Independent Review scrutinised this issue. We would refer you to their report.**

> **They state: "In the specific instance of the pigeon and excrement found in the hospital near an air inlet, we understand that where the pigeon remains were found does not match the air systems supplying specific parts of the hospital where certain patients affected by one microorganism (Cryptococcus) spent much of their in-patient care.**
>
> **"The presence of pigeons within or in the vicinity of the hospital, or defects on the building that would allow the entry of a pigeon or other bird carrying a specific organism capable of causing a serious infection in a vulnerable person are not sufficient to establish a strong association or causative link.**
>
> **"On the reports we have reviewed and advice we have heard, therefore, we judge that the link between pigeons, pigeon guano or excrement, and air inlets in the vicinity of these**

**finds providing contaminated air through high quality filters towards the patients involved, is not a sound theory on its own."**

**The specific microorganism in question, Cryptococcus Neoformans, has never been isolated on that site.**

16. That Cryptococcus contributed to the death of [redacted]. [redacted] family are firmly of the view [redacted] would not have deteriorated so rapidly had [redacted] not acquired this infection in hospital.

**We are unable to comment on individual cases. Our sympathies remain with the family of this [redacted].**

17. That you were provided with a report from an independent haematologist commissioned by the procurator fiscal, which says that Cryptococcus was a contributory factor in [redacted] death.

**We are unable to comment on individual cases. Our sympathies remain with the family of this [redacted].**

18. That the way the hospital has been managed in dealing with the above issues could be argued to have been negligent.

**This is untrue and in our view entirely unsubstantiated.**

19. That infection control doctors raised issues about the ventilation and water systems as far back as the year it opened, with senior members of the board, including the past and present chief executives.

**The Independent Review scrutinised this issue. We would refer you to their report.**

20. That three other children died with water borne infections in PICU.

**The death of any child is a tragedy. In relevant cases we have investigated the circumstances of the death and shared our findings with the child's family. Relevant cases will also be examined through the independent case note review and may be addressed by the Public Inquiry. For these reasons, we will not comment upon individual cases.**

SCOTTISH HOSPITALS INQUIRY

**Bundle of Documents for the Oral Hearing**
**Commencing 12 June 2023**
**Bundle 5 – Communications Documents**