Scottish Hospitals Inquiry
Supplementary Witness Statement of
Dr Jairam Sastry

PERSONAL DETAILS

1. My name is Jairam Sastry. I am a Consultant Paediatric Oncologist at the Royal Hospital for Children (RHC) at the Queen Elizabeth University Hospital (QEUH) in Glasgow. I am employed by Greater Glasgow and Clyde (GGC) Health Board within the NHS.

2. I have previously provided a statement to the Inquiry.

OVERVIEW

3. In this statement I will provide answers to the clarification points raised following my initial statement to the Inquiry.

ISSUES RELATING TO WATER SYSTEMS

4. I have been asked by the Inquiry if I was told why access to water was being limited; if I was aware of what patients and families were being told about the reasons why access to water was restricted; and if I received any instructions about what I could and could not tell patients and families about the water supply, or any other aspect of concern about infections.

5. I did not attend many of the IMTs in 2018 when the water issues were being raised as I was not invited. I believe it was primarily my consultant colleagues, Dr Dermot Murphy and Professor Brenda Gibson who attended the IMTs at this time. They were feeding back to the consultants and other clinical staff in the team what they had been told in these meetings, rather than us hearing this directly from the IMT. We were being told that we should not be using the water for washing our hands as the water samples from Ward 2A had grown multiple organisms. I cannot expand on this as I did not receive the minutes

from these meetings due to not being a member of the IMT team. I do not recall what was told to the families or if there were any specific instructions given to staff about what to tell the families.

6. Within paragraph 112 of my initial statement I stated that staff felt that to some extent the environmental situation within the unit was underplayed to the patients and parents. I have been asked to expand on this. This original response related to 2018 as by 2019 the parents and patients were aware that the built environment was a problem. My colleagues and I within the unit felt that in 2018 the environment was being underplayed but that was a subjective feeling. The environmental situation related to contaminated water and issues with the drainage. The staff within the unit, including me, felt that what was being decided at the IMTs was not being communicated to parents who were unaware at that time that there were issues with the environment. I was not aware of any specific person directing that approach.

CLOSURE AND MOVEMENT OF WARDS

7. Within paragraph 129 of my initial statement I use the term 'management' several times and I have been asked who I mean by "management". Jamie Redfern and Jen Rodgers were the individuals representing management in the IMT meetings in 2018, prior to our move to Ward 6A. They were relaying to us that we should carry on treating patients on the Ward as there was no connection between the infections we were seeing and the environment, and that any issues with the environment were being addressed. In effect they were saying the environment was safe. My clinical colleagues and I were not happy with this due to the unusual types and increased numbers of infections we were seeing. Whilst the IMT suggested remedial action such as enhanced cleaning, bottled water and treatment to the drains it did not seem to be working. We were telling Jamie Redfern and Jen Rodgers that we did not want to continue treating patients in the Ward and asking where else we could move our patients instead.

INFECTIONS WITHIN THE HOSPITAL WARDS

8. Within paragraph 151 of my initial statement I highlight the decrease and increase of infections within Wards 6A and 4B in 2019. The reference to 2019 is correct. Whilst we were based in Ward 2A, the number of infections never decreased. In September 2018, we moved to Wards 6A and 4B. It was only then that we saw a decrease in the number of infections in our patients, temporarily, before it started to increase again.

INFECTION CONTROL MANAGEMENT WITHIN THE HOSPITAL WARD

9. Within paragraphs 163 to 173 of my initial statement I use the term IPC and state that I felt that their main intention was to tell us that the infections were nothing to do with the environment and that what we were seeing was a change in pattern of gram-negative infections. I have been asked by the Inquiry who the IPC are, and who was the individual intent on trying to disprove the link between infections and environment. The IPC is the Infection Prevention and Control Team for the Hospital. In 2019 the IPC lead had changed to Professor Alistair Leonard and the IMT Chair changed to Emilia Crighton. My recollection is that when Professor Leonard took over as IPC lead, he tried to take one organism at a time and show us that these strains were different/unconnected and unrelated to the infections we were seeing in our patients and those organisms growing from the environment. At that time it felt as though the IMT and IPC were trying to disprove there was a link between the infections and the environment.

10. Within paragraph 167 of my initial statement I said that in 2018 and 2019, in the context of the IMT meetings, clinicians were told that there was "absolutely no link" between the environment and infections. The Inquiry has asked me if I know who was responsible for telling clinicians this and if I can be more specific on the timeframe of this. As I have already stated, I did not attend many of the IMTs in 2018, it was primarily my consultant colleagues, Dr Dermot Murphy, and Professor Brenda Gibson who relayed the IMT

discussions to staff. Towards the latter half of 2019, I was often present at the IMT meetings and that is when I heard this information directly from the IPC lead, Professor Alistair Leonard, and the IMT Chair, Emilia Crighton.

USE OF PROPHYLACTIC MEDICATION

11. Within paragraph 187 of my initial statement where I discuss the use of prophylaxis, I gave my view that we should not be giving antifungal/antibiotic prophylaxis just because we have to continue to treat patients in an environment that is not suitable. The Inquiry has asked me to clarify if I believed prophylaxis was being prescribed because and only because of concerns about the built environment.

12. Most of our patients were receiving antibiotic or antifungal prophylaxis due to the treatment they were undergoing and provision of that was directed by their cancer treatment protocols and national guidelines. However in specific instances such as during the cladding works to the Hospital or when there were Cryptococcus concerns in Wards 6A and 4B in January 2019 the IMT asked us to prescribe antifungal prophylaxis to patients (in addition to those patients who required it as a result of the treatment they were undergoing). Whether patients were prescribed prophylaxis depended on the particular concerns at that time and was directed by microbiology through the IMT.

COMMUNICATION BETWEEN GGC HEALTH BOARD, CLINICAL STAFF AND PATIENTS ON INFECTIONS IN THE WARDS

13. Within paragraph 201 of my initial statement I stated that many of the IMT members probably still believe that there is no connection between the environment and the infections, which we clinicians do not agree with. My clinical colleagues and I believe that the number and type of infections we saw were unusual and that there was no compelling alternative explanation other than a connection to the built environment. In the face of what was

grown from water, drainage, condensation on the wall etc., we suspect the environment may have contributed to these infections.

MINUTES OF SPECIFIC IMT MEETINGS

14. Within paragraph 209 of my initial statement I use the term IPC and discuss a particular IMT meeting where the IPC told me that it was not standard practice to check for the organism Mycobacterium chelonae in water. Dr Teresa Inkster was still the Chair of the IMT at this point.

15. The Inquiry has asked me for clarification of paragraph 219 in my initial statement where I discuss the minutes of a particular IMT meeting. I state that on page four of those minutes it says, "This case has been classed as an HCAI as not an in-patient at the time of the sample." I think that must be a typo (not classified as HCAI) as that is not what they were saying in the meeting. The patient was an in-patient at the time so that is the opposite of what they were saying. It must have been an HCAI. There is some confusion about what was said at this IMT. My recollection is that the IMT did not consider this particular case to be a healthcare associated infection (HCAI), however I understand there has been a mistake in the way this was minuted. We, the consultants, were saying it should be an HCAI.

16. I have been asked by the Inquiry if I believed the culture was such that employees did not feel able to speak up about concerns. Whilst we had been able to express our views and these were taken account of in 2018, as matters moved on and we progressed into 2019, the IMT became less interested in clinicians' views. They plainly wanted to believe that they had found a solution to these issues or that the infections were not linked to the environment.

DOCUMENTS

17. I have been asked for my views/opinions on documents submitted to the Inquiry.

18. In respect of the document 'Briefings dated March 2018', Bundle 5, pages 108 and 109, the Inquiry have asked me for my views on the level of information provided in this briefing. I have been asked whether clinicians had been provided with any more information than is shown in these briefings. I had not seen this briefing before. The communications directed to patients and parents were not usually circulated to clinicians. It was usually the nurse in charge who would hand these communications out to patients. The clinicians were only told that the IMT was investigating a possible link between the infections in patients and the environment.

19. In respect of the document 'Series of media statements issued by GGC updating the media on the water incident,' Bundle 5, pages 136 to 139, the Inquiry have asked if I recall whether staff or patients and families were provided with a similar update. I do not recall any similar updates being distributed to staff or families in 2018 (at least in writing). The only information clinicians would receive from the IMT at that time was through our colleagues who attended these meetings. A consultant meeting would be arranged thereafter so our colleagues who attended the IMT could relay the discussions from the IMT.

20. In respect of the document 'A patient briefing dated 7 June 2018', Bundle 5, page 142, the Inquiry have asked my views on the level of information provided in this briefing and whether I recall if patients and families were told why these IPC steps were being taken. I do not recall what was told to the patients and families at this time. One of the issues was that only those who were inpatients at that time seemed to be receiving information. After the IMTs, somebody such as Jamie Redfern or Jen Rodgers would visit the ward, usually with Professor Gibson, to discuss the outcome of these meetings with

parents/carers. We became aware that those who were outpatients at that time were not getting the same information.

21. In respect of the document 'Press briefing dated 13 June 2018', Bundle 5, page 145, the Inquiry have asked if staff, patients, and families appreciated the distinction between the issues with the water supply and the drains. I have been asked what the state of awareness about the water supply was at this time. My recollection is that we were told that the water was safe as they had carried out Chlorine treatment and put filters on the taps. The staff understood the new issue to be the drains. I am not sure what the patients were told or understood to be the situation at that time.

22. In respect of the document 'Press briefing', Bundle 5, page 278, the Inquiry have asked to what extent I agreed with the statement made in January 2019 that '*our infection rates are lower than the Scottish average*'? I disagree with this statement made in January 2019 because at that time, as clinicians, we were seeing a higher number of unusual organisms in our patients. I suspect they were possibly referring to the Health Protection Scotland report dated December 2018 ('Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHS Scotland') around the incidence of infection but as clinicians that was not our experience and we were concerned about the rates and nature of infection we were seeing.

23. In respect of the document 'Press briefings,' Bundle 5, pages 279 to 280, and page 346, I have been asked by the Inquiry of my understanding as to whether patients could drink or use tap water in early 2019; whether there was clear communication about the safety of the water for Schiehallion patients; and whether those concerns about water were allayed at any stage.

24. In early 2019, we were being told that the patients could use tap water to wash their hands or shower. Filters had been added to taps and distilled water

and bottled water was given to patients for drinking. Water coolers/dispensers had been removed from most of the hospital premises including from wards, corridors, and canteens. Water coolers/dispensers were never intended for patient use, they were used by parents and staff. That is because in 2018 management knew the water was contaminated.

25. The water coolers/dispensers have not been returned and we still supply bottled water to our patients now. The filters on taps have been removed from all other areas except in areas for immunocompromised patients including Schiehallion. I understand from what the management is saying that in terms of the water quality levels the number of microbials growing in the water is now much lower than it should be so it is actually safe to drink (albeit they have not removed the tap filters).

26. In respect of the document 'GGC Press release about Mycobacterium Chelonae (21 June 2019), Bundle 5, page 319, the Inquiry have asked if I have any comment on the accuracy of GGC's response to the questions about Mycobacterium Chelonae and its source. I do not agree with the accuracy of that response as children with exposed central lines were having showers in contaminated water. My clinical colleagues agreed at the time. At some point in June 2019, the IMT advised that Mycobacterium chelonae had been identified in three showerheads on Ward 6A (although I do not know whether they understood that the strain of Mycobacteria identified from the water and from the patient were the same at the time of this press release).

27. In respect of the document 'Email from Professor Gibson to Jennifer Armstrong dated 8 January 2019 [22:16]', Bundle 6, page 43, the Inquiry have asked if I was aware that these concerns were being raised with Dr Armstrong at that time and whether these were the concerns of the combined 'consultant body'. I can confirm that I was aware these concerns were being raised with Dr Armstrong at that time and these were concerns of the combined consultant body.

28. Within that document/email Professor Gibson asks, "*Are all new patients to be told that the environment carries a risk to their child which will require prophylaxis, and that in itself may carry a risk...we are prophylaxing children without any agreement on what information should be given to the parents*." The Inquiry have asked if I shared these same concerns, and I confirm that I did. As clinicians we come together and Professor Gibson was writing on the clinicians' behalf as the lead clinician. I shared the concerns in the email as did my other clinical colleagues.

29. The Inquiry have asked what patients and parents were being told about the environment and the use of prophylaxis at the time. To my knowledge IMT members were meeting the parents at that time. I only attended these meetings with the parents a few times when one of my patients' parents was being spoken to. Parents were told prophylactic antibiotic was given to their child only as a precaution due to environmental concerns although they have found no link between the environment and infection seen in patients. I do not think these concerns were resolved at the time.

30. In respect of the document 'SBAR prepared by Mr Jamie Redfern dated 14 November 2019', Bundle 4, page 202, the Inquiry have asked if I saw this document in 2019; and whether I was asked for any input to it. I do not recollect seeing this document however I do not agree with the footnotes which state there was no impact on PHOS day care, that transplant services continued as normal, and that the enterobacter infections were not linked to the hospital. Moving to Ward 6A had a significant impact on day care, inpatient care, space for staff and facilities for children on the Ward (like the playroom, school room and lack of waiting areas etc).

31. The Inquiry have asked me my views on the conclusion that none of the infections were linked to the environment and the reference to Professor Leonard's report. It was technologically fascinating to see Professor Leonard's work. However, as clinicians we were not satisfied with his findings as we did

not feel the report explained the increase in infections or demonstrated a lack of evidence that there was a link between the infections and the environment. We were used to seeing some infections in our patients from time to time, but not the number of infections or particular organisms we were dealing with here. As I had not seen the document before it was provided by the Inquiry I was not given an opportunity to raise any concerns. In any event, there was a significant drop in the number of infections on Ward 6A from the end of September 2019 which we, as clinicians, were happy with.

32. In respect of the document 'SBAR prepared by Mr Andrew Murray dated 12 December 2019', Bundle 6, page 12, the SBAR records *"Haemato-oncologists have provided confirmation that they are reassured regarding the safety of the water and the environment in 6A, based on evidence from a range of sources and the longstanding improvement approach to Infection Control" I have been* asked whether I was satisfied about the safety of the water system and environment in ward 6A? There was a significant drop in the number of infections on Ward 6A from the end of September 2019. The clinicians were happy with this. All the actions laid out by the IMT had been implemented on Ward 6A.

33. In respect of the above SBAR the Inquiry has asked me if I was asked for my views on these matters. I do not recall attending any meetings with Mr Murray to discuss the issues raised.

34. I have also been asked by the Inquiry if I was satisfied with the decision to cease prescribing Ciprofloxacin as a prophylactic antibiotic. Clinicians were only prescribing Ciprofloxacin on the recommendation of IMT/microbiology. It was therefore something we took advice on. We were not prescribing ciprofloxacin all the time; we were giving it to patients until the IMT/microbiology told us we could stop. It took a long time for them to say that, as unusual infections were still being seen and we had no explanation for that. I believe they told us to continue with the prescription until around September 2019 when infections significantly dropped. The clinicians were

happy to stop the prophylaxis because we were no longer seeing the same level of infection and we could see a justification for this advice.

35. In respect of the document 'IMT 14 August 2019 - A36591626 – IMT Gram Negative Blood Ward 6A', Bundle 1, page 343 which records an exchange about whether patterns of infections were different amongst this group of patients from the pattern previously experienced. I am asked whether I agreed with the views expressed by Teresa Inkster and Christine Peters who are noted to have emphasised that it was the nature of the infections that was the key concern. My colleagues and I were seeing unusual types of organisms at that time, different to the types we were used to seeing in our patients and I suspect that is what Teresa and Christine were referring to when they emphasised it was the nature of the infections (i.e., the nature of the bacteria) that was the key concern. If so, I held the same views at that time.

36. In respect of the document 'IMT 6 September 2019', Bundle 1, page 354, the Inquiry have asked whether I felt the message being given to patients or to the media fully reflected the concerns clinicians had at that time. The clinicians were concerned that we were seeing unusual infections which had increased in number and concerned that these may be linked to the hospital environment. The difficulty was that we as clinicians were not sure of the information being given to the media or patients as we did not see everything that was passed on to them. During the odd occasion when I saw patients and their families with management (for example, in cases of infections involving my own patients), I felt that the information given by management was vague and did not reflect everything discussed at the IMTs. For example, I do not recall them explaining how rare or unusual these organisms were or that the Board was considering a possible link between the infections and environment. They were suggesting that they did not know where the infection had come from but that they were investigating this.

37. In respect of the document 'SBAR 6A 7 October 2019', Bundle 4, page 180, I have been asked by the Inquiry whether I had sight of this document at the

time and whether I feel that the views set out in the SBAR were adequately dealt with. I am also asked whether I have identified any basis for rejecting the views of the microbiologists set out in the SBAR.

38. I had sight of this SBAR at the time as Teresa Inkster and Christine Peters provided the consultants in the Haematology and Oncology Unit with a copy of this during one of the IMT meetings. I cannot say that the IMT did not make attempts to deal with these concerns. There were hypotheses in 2018 and 2019 and the IMT did try to address these issues through remedial action, but it did not improve the type of bacteria or infection rate in our patient population.

39. I agree completely with the views set out by the microbiologists in the SBAR. Their findings had been backed up with evidence and the clinicians held the same views. The microbiologists recommended that the IMT investigate and also consider changing the criteria for HAI and what is classified as environmental bacteria, but I do not feel that the IMT ever acknowledged or addressed these concerns.

40. In respect of the document 'IMT 8 October 2019', Bundle 1, page 373, the Inquiry have asked whether I attended this IMT and whether the peer review of the microbiology data was ever obtained. The Haemato-oncologists asked the IMT to arrange for an external body to come in and investigate the infections, to see if there was something fundamental that we were missing. However, to my knowledge, the only review carried out was by Health Protection Scotland (HPS). I do not know the source of the data considered or whether this was ever peer reviewed.

41. Whilst the Haemato-oncologists thought it more appropriate that an independent body out with Scotland carried out the review, we could only make suggestions. I was disappointed that a review by a body external to Scotland was not instructed as I think it would have been helpful for somebody with no previous knowledge of the problems to carry out a review. I

do not know what the usual practice or process was in this kind of situation and the decisions around instructing reviews were the responsibility of management.

42. At this IMT I raised the point that there had been numerous incidents every week since moving to Ward 6A. The Inquiry have asked what I meant by that and whether my concerns were addressed.

43. My reference to the numerous incidents every week refers to problems with the building and estates such as mould in patient rooms, condensation on chilled beams, leaks, or problems with the drainage system. My concern was that it felt as though the building was falling apart and that there was a new issue on the ward every day, which meant moving patients from room to room. Estates were attending to these issues, trying to fix them, but these problems persisted and came up in other rooms. However I do feel that my concerns have now been met since moving to the newly furbished ward. We have not experienced the same sorts of problems since we moved back to Ward 2A.

44. In respect of the document 'SBAR 6A 10 October 2019', Bundle 4, page 193, the Inquiry have asked whether I had had sight of this SBAR. I am also asked whether I felt that it dealt adequately with the point made about the unusual nature of the infections. I have previously had sight of this SBAR. The comment made in the SBAR about the current number of unusual infections being consistent with historical figures over time is applicable to September and October 2019 only when there was a significant decrease in the number of infections seen in our patients.

45. I have been asked by the Inquiry for my thoughts on reliance being placed on there being no identified link between infections and the environment. I personally felt that the IMT were trying to prove there was not a link, but the organisms grown in the water, drains, leaks etc. were similar to those being seen in our patients.

46. I have also been asked to clarify whether I was comfortable with the question of the existence of a link or risk being approached in this way. I was not comfortable with the approach to the link between the environment and the infections in patients, namely using genomic sequencing of one type of infection. I do not know whether genomic sequencing is a standard approach for proving or disproving links elsewhere in the world but we as clinicians did not know if this was a robust or evidence-based technique and we were not qualified to comment on this.

47. The IMT were producing hypotheses about how the environment may have contributed to the infections seen in our patients. They were suggesting remedial action as a result of these hypotheses. My concerns were that the organisms grown in the water, drains, condensation, leaks etc. were similar to those seen in our patients which is why I had concerns around whether there was a sufficient basis for saying there was no link between the infections and the built environment. However I do not have the relevant expertise in IPC to be able comment on whether the hypotheses and remedial action were suitably robust.

The Reopening of Ward 6A

48. I have been asked by the Inquiry if I was satisfied that it was safe to reopen Ward 6A to new patients and if so on what basis was I satisfied. From September/October 2019, the number of infections we were seeing had significantly reduced, even compared with national standards. I was therefore satisfied that it was safe to reopen Ward 6A to new patients.

49. I believe that the facts stated in this witness statement are true, that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.