SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
12 June 2023

Day 3
Wednesday, 14 June 2023
Emma Somerville

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10:00

THE CHAIR: Good morning, everyone. Now, this morning, and possibly this afternoon, Ms Arnott will be conducting questioning. I think our first witness is Emma Somerville.

MS ARNOTT: That is correct, my Lord.

THE CHAIR: Right, thank you. Ms Somerville, please. Good morning, Ms Somerville.

THE WITNESS: Morning.

THE CHAIR: As you will have gathered, I am the chair of the Inquiry, Philip Brodie, and you are about to be asked questions by Ms Arnott, who is one of the counsel to the Inquiry. You provided us with a statement, and I do not anticipate you are going to be asked everything in the statement by any means, but Ms Arnott will probably concentrate on what she thinks is important. First of all, I understand you are prepared to take the oath.

THE WITNESS: Yes, I am.

Ms Emma Somerville
Sworn

THE CHAIR: Thank you very much, Ms Somerville.

THE WITNESS: Thank you.

THE CHAIR: Now, I would anticipate that we will take a break for coffee about half past eleven, but can I just emphasise this? I think it is important that the witness is in control of the timetable in this sense.

THE WITNESS: Okay.

THE CHAIR: If at any stage for any reason you wish to take a short break, just give me an indication, and we will take a break. So, you are in control.

THE WITNESS: Okay, thank you.

THE CHAIR: Ms Arnott.

MS ARNOTT: Thank you, My Lord.

Questioned by Ms Arnott

Q Good morning, Ms Somerville.

A Good morning.

Q I am going to begin by taking you through a few formal questions. Could you please confirm your full name?

A Yeah, it's Emma Catherine Somerville.

Q Thank you, and you are currently a senior charge nurse working in Ward 2A of the Royal Hospital for Children in Glasgow. Is that right?

A Yeah, that's correct.

Q You have provided a

statement to the Inquiry, and I understand you are content for that statement to form part of your evidence to the Scottish Hospitals Inquiry. Is that correct?

A Yes, that is.

Q Ms Somerville do you have a hard copy of your statements in front of you?

A Yes, I do.

Q If you want to look at your statement at any stage to refresh your memory, please, just go ahead and do so.

A Okay.

Q Now, before we come on to talk about the issues at the hospital, I am going to begin by asking you a few questions about your career as a nurse. You qualified as a registered nurse in paediatrics in 2002. Is that right?

A Yeah, that's correct.

Q Since then you have gone on to obtain a number of other qualifications. Is that right?

A Yes.

Q I wonder if you could tell me a bit about those.

A So, I went back to university and completed a degree and that was in pain management and palliative care. I also attended Open University Robert Gordon, and I

completed a course in chemotherapy administration, and then I went back to Glasgow Caledonian University where I completed my non-medical prescribing course, and that was a few years ago.

Q Okay, thank you. In your statement you say that your first job, I think, was on the Schiehallion Ward in Yorkhill. Is that correct?

A Yeah, that's correct.

Q Does that mean you have worked on the Schiehallion Unit for your entire career?

A Yes, I have.

Q Over 20 years?

A Yeah, over 20 years.

Q Thank you. Now, I am going to ask you some questions now, just some general questions about the Schiehallion Unit at the RHC. Could you begin by telling me a little bit about what kind of patients are cared for in the Schiehallion Unit?

A So, we care for haematology or oncology patients, any patient with a blood condition, transplant patients. We've also got an MIBG suite which is a radiation suite, and we treat patients with neuroblastoma in that suite too, and that's a relatively new process that we've started doing as well.

Q Okay, thank you. What

sort of age range of patients will you see in the Schiehallion?

A We'll see from babies right up to 18.

Q Am I right in thinking that many of these patients will receive treatment in and out of the hospital over a period of months or even years?

A Yeah, that's correct. It's a long journey for most of our patients. So, they would be seen as an inpatient and as an outpatient in our Day Care Unit.

Q Okay, that actually takes me on to my next question. I understand the unit is split into two, so we have got Ward 2A and 2B. I wonder if you could just give me an overview of the difference between those two units.

A So 2A, it's a 23-bedded unit. So, when the patients are in getting treatment, they would be in 2A. If the patients were receiving day care, they would go to Ward 2B. When the patients are starting chemotherapy, they would come up to Ward 2B and then they would transfer over to Ward 2A when there's a bed. If patients are unwell, they maybe come in through CDU day care and then come to Ward 2A. Transplant patients would be in Ward 2A because we are the

Transplant Unit so they would receive their care as an inpatient.

Q And am I right in thinking you work mainly on Ward 2A?

A Yes, I do. I also am part of the Hospital Coordination Team. That's the responsibility of the senior charge nurses. So, I do have experience of other wards but I've mainly always been in 2A.

Q We are going to hear from your colleague Ms Howat, the senior charge nurse for Ward 2B later on today. I will focus my questions for you on Ward 2A, but would I be right in thinking that Wards 2A and 2B work closely together for the reasons you have just described?

A Yeah, that's correct. We would work over the one floor, and I've got a close working relationship with Ms Howat.

Q Thank you. Now, in your statement you helpfully described the layout of the unit, and I do not think I need to go there with you today. What I would like to do now is ask you a few questions about your role as a senior charge nurse in Ward 2A. I wonder if you could begin just by outlining your responsibilities.

A So, I'm the line manager for the nursing staff within the Schiehallion Ward. I'm responsible for

making sure that patient care is delivered to a high standard, ensuring that the patients are safe. I obviously give emotional support to the patients and their families. I attend safety huddles and report any issues in the ward to the lead nurse. I'm part of the MDT. I would attend meetings, child protection hearings, and I also deliver clinical care as well.

Q Okay, thank you. Now, in your statement you quite helpfully set out, I think, what a typical day looks like for you. I wonder if you could just begin by explaining from the start of your day, what are the sort of meetings and things that happen from there?

A So, our shift starts at half seven in the morning. The nurse in charge of the night shift will hand over any issues overnight, they'll go through all the patients and what's expected for that day. That's in a kind of SBAR form and then at eight o'clock I would join the safety huddle for the hospital. I would report patient numbers, admissions, discharges, staffing levels, high dependency patients, constant cares, anything that's happening in the ward that day – maybe a patient's getting a high-risk infusion – to any patients going to the Beatson for treatment, and I would also report if

the staffing levels for the shift were safe. At this point if there's anything else that's happened that I need to escalate to the lead nurse or the hospital coordinator then that's what I would do at that time.

Then at nine o'clock there's the ward handover. I generally don't attend that. The band 6 nurses will be in charge of the shift. They will work with the medics and consultants and attend the ward round, but if there was anything from the safety huddle that I had to pass over to the medics, I would let my band 6 nurse know, and they would do that at the nine o'clock handover. If there was patients in other wards or if there's patients in CDU awaiting to be admitted, this would be the time to communicate it back to the doctors or the consultants.

Q Thank you. Sorry, carry on.

A I was just going to then tell you the rest. We've got another safety huddle at three o'clock and again that would replicate what we've reported in the morning and that would again be staffing levels for the night shift and anything else that you needed to escalate at that point in the day.

Q Okay, thank you. When you talk about the safety huddle, are

you talking about safety in terms of delivering patient treatment and care?

A So, it's an escalation to the hospital coordinator and the lead nurse attends. After that, the lead nurse then goes to a touchpoint meeting and that's where the rest of the senior management team for the hospital. So, at that point, again, staffing levels or patient activity, patient numbers, bed pressures, anything like that is discussed at that time, and then that's a link for the lead nurse to take back to the senior management team.

Q Thank you. So, all of the huddles and meetings that you have just described that take place in the morning of your typical day, these are all means for an exchange of information to, I suppose, to come to ward level and also to be escalated up from ward level. Is that right?

A Yeah, that's correct.

Q Okay, now you mentioned the ward round in your statement. Is the ward round something you participate in?

A Back in 2A, pre-move, I would have carried out ward rounds then but a lot of my role now is managerial or attending meetings so generally my band 6s would cover the ward round with the consultants and

the medics, and if need be then I can pop in and out from whatever I'm doing.

Q On a typical day, or a typical week even, do you have fairly regular contact with patients and families on the ward?

A Yes.

Q Now, in your statement, and from what you have just said, you indicate having some responsibility for day-to-day safety on the ward in terms of delivering care to children and their families. You have mentioned staff resourcing as part of that. In your statement, you also mentioned reporting issues to Estates when that needs to happen. I wonder if you could just explain that process to us.

A So, for instance, if there's a fault in a room or a blocked sink, blocked toilet, we've got an FM system, so that's facilities management. It's an electronic system, and then Estates would pick that up. Generally, if it's something that I would want escalated urgently, I would follow up the FM number with an email but, again, at the safety huddles that I attend at eight in the morning and three at the hospital. Safety huddles-- one of the things the hospital coordinator will ask at that time does anybody need anything

escalated to Estates, and they would ask for the FM number. So, I can escalate it myself or I can escalate it through the hospital coordinator.

Q Okay, thank you. Ms Callaghan, I think it would be helpful just to turn up paragraph 22 of Ms Somerville's statement and that is at page 76 of the statement bundle. That is fine. Can you read that, Ms Somerville? Is it big enough for you on the screen?

A Yes, thank you.

Q If you just take a moment to familiarise yourself with that paragraph, you do not need to read it all in detail. I am just going to ask you a couple of questions about the risk register.

A Yeah, that's fine. I can answer.

Q Thank you. Now, you mentioned in this paragraph, again, you are talking about health and safety matters on the ward.

A Okay.

Q You mentioned, I think, a local risk register. Can you tell me what that is? Is it a physical document? Is it an electronic system?

A It's an electronic document. I am the health and safety holder for the manager's manual. So, at the time myself and Ms Howat

would complete the risk register together. That was any risks that were in the ward, and anything we were doing to mitigate the risks. We would then send it out to our quality manager for comment with the rest of the team and then then it would go to Dr Sastry, who is the lead consultant for clinical governance. We have clinical governance meetings bi-monthly. At that point, if anybody from the team wants to discuss the risk register, then that's an opportunity to do so.

Q Thank you. What kind of thing would be put on the risk register?

A So, anything that was a risk to the ward. So, we would have had at the time COVID as a risk because, obviously, that was a risk to our patient group. A way to mitigate risks was making sure that staff had PCR screening, that staff were wearing PPE. We obviously had some issues with the water, so that was on the risk register. Mitigation for that would be point-of-use filters were in situ, water testing was carried out, staff were completing hand hygiene. Those kind of things.

Q So, all of that information would be included on the risk register. Now, you may not remember this but I am just going to ask, do you remember when issues with the water were

placed on the risk register?

A I think the first time I thought about the water was March 2018, so probably placed on the risk register after that time.

Q Okay. In paragraph 22, you give another example of something that would be placed on the risk register, and we will come on to this later on, but you talk about concerns about staffing levels between Wards 6A and 4B. Can you remember when that would have been put on the risk register? Would that have happened just at the time of the decant or some time after that?

A So, that would be September 2018 when we moved to 6A and 4B. So, that would have then been added to the risk register after September.

Q Okay. In that paragraph, again, you mention something called a corporate risk register, is that a document you ever have cause to see?

A No, when I share the risk register with our clinical governance consultant, I believe that he then forwards that on to the clinical service manager, and at that level, it would then go to the senior management team and be put on the corporate risk register.

Q So that is a separate document.

A Yeah, I'm not aware of that.

Q Okay. Thank you, Ms Callaghan, we can put that that paragraph away now. In your statement, you also say that as part of your role you have some responsibility for resolving complaints from families. I wonder if you could just tell me what you mean by that? What kind of complaints were you dealing with?

A So, any feedback from the families, whether it be positive or negative. Maybe one of the families wanted to speak to one of the consultants or their doctors, they would maybe feed that back to me and then I would arrange that, or in things like the quality of the foods. If we get any complaints that maybe the food wasn't great, I would then feed back to catering. I would ask them to come and speak to the family and see what we could do to help the family. So, basically, anything that they are not happy with, I would try and resolve at my level.

Q If it is something that you are unable to resolve at the ward level you would then escalate?

A I would escalate, yeah. If it's a medical problem I would usually

speak to the family's consultant. If it was something I couldn't resolve, I would then escalate to the lead nurse.

Q Okay, thank you. Now, given everything you have said about your role would it be accurate to say that you are on the front line of the ward on a day-to-day basis?

A Yeah, that's correct.

Q Does that also mean that you are in daily contact both with your nursing staff, and the patients and families on the ward daily?

A Yes, that's correct.

Q The Inquiry has already heard evidence about the types of illnesses and treatments that children on the Schiehallion Unit encounter and the challenges they face, and in that context, I am going to ask you a few questions about the nature of care provided by nurses on the Schiehallion Unit. Now, could you begin by telling me if nurses on the unit are specially trained?

A Yes, they are. We've got quite a robust training package. So, when a nurse starts in Schiehallion Ward, they work with our nurse educator, and they'll complete an induction package. If it's a newly qualified nurse, we would send them on a course to administer intravenous medication. There is also a course for

before they give chemotherapy, and currently, our nursing staff attend Edinburgh. Then it's a passport document, it's called, and that's sign off for giving chemotherapy. They have to be supervised administering chemotherapy so many times before they're deemed competent to do that, and then that would be a sign off by either one of the senior nurses or the nurse educator.

They also have radiation nurses. Again, that's separate training. Then you would have a radiation badge, sign off and then you can work in the MIBG room. We also have training for bone marrow transplant in patients, again, you have to be skilled to be able to look after transplant patients, and that would be a sign off as well before they are allowed to look after them on their own.

Q Okay, thank you. As part of that special training, would nurses on Schiehallion receive special or particular training in line care?

A Yes. So, we've got a CLABSI group. So that's trying to deliver best care and again, the nurse educator would watch-- or observe practice before a nurse carried out a dressing change or taking bloods from a central line. So, again, there would be training in place before anyone

could work with central lines.

Q Now, you also mentioned in your statement particular special local protocols for the Schiehallion Unit. I wonder if you could just tell me a bit about why the Schiehallion Unit needs particular protocols for care?

A I think because it's such a specialised patient group. Patients are in our ward for months or years. Leukaemia patients, three years. So everything is specialised to their treatment. We have a quality manager, and she's excellent at making sure that all the SOPs are signed off and up to date. We have got really good practice. Sorry, I lost my train of thought.

Q No, that is absolutely fine. I will try and be a bit more specific as well. Is one of the reasons that you have those particular protocols because of the particular vulnerabilities of the patients of Schiehallion? So, I am thinking, for example, in relation to susceptibility to infection.

A Yes.

Q Okay, so are some of the protocols designed to mitigate that risk?

A Yes, so there'll be protocols for giving antibiotics and,

again, it's just so that you've got a robust system that you can follow when looking after the patients.

Q Okay, and do protocols follow patients if, for example, they have to go to another ward for a different type of treatment or because capacity is restricted in Schiehallion?

A Yeah, they should be able to access them. So, if a patient comes into CDU and they're going to be admitted up to the ward and they're having their first dose of antibiotics, down in the Clinical Decisions Unit-- the medical staff down there should be able to access the policies that we follow.

Q And are they held electronically?

A Yes.

Q Thank you. Now, the Inquiry heard some evidence from families who perceived that protocols did not always follow when their children were housed on other wards. Do you think it is possible that sometimes there were slips from the protocols on other wards?

A There shouldn't be, so I don't think so.

Q Okay and, in your experience, do patients and families prefer to be housed on Schiehallion?

A Yeah, I think they do.

Our ward has maybe got some nicer facilities. There's a parents' room. We've now got three rooms for the children or young people. We have a playroom, we have a tween room and we have a TCT Lounge. So we have got more facilities than some of the other wards.

Q Okay, and do you think, generally, families feel safer on Schiehallion partly because of the specialist training that the nurses have and partly because of the facilities and the environment that they're in?

A I'd like to think the families would feel safe in any ward. I think what happens is, because the children and families are in for such a long time they build a relationship, so they know the core group of nurses, they trust us. So I think maybe when they go to other wards, they don't know the nurses as well. So I think it's to do with the relationship and then, obviously, we've got a parents' room and playroom, so maybe the other wards don't have-- I don't want to say "as good facilities," but we've got slightly improved facilities.

Q And maybe slightly more tailored given the duration----

A Yes, for the patient group, and I think as well because some of the patients that go to the

other wards are maybe only in for a couple of days or maybe not as long-term patients, and ours is obviously tailored for long-term patients.

Q Okay. I think that takes me onto the last question that I was going to ask you just on this topic. From everything you've said, nursing on the Schiehallion Unit sounds like it is probably an incredibly challenging job but, in your experience, what is it you think attracts nurses to this particular area of work?

A I think it's the fact that you do get to build up a relationship with the children and the families. They're in for a long time. It's a really rewarding job. Most children do get better, and to see the children or young people coming through their cancer journey and at the end and ringing the bell once they're finished, it is really rewarding. Our role, we do give a lot of emotional support, so I think if that's the type of nursing that you like-- most-- every nurse is caring, but even more so for patients with cancer or blood conditions, yeah.

Q Okay, thank you. Now, in your statement, you also talk about the importance of infection control on the ward. Now, I just want to ask you a few questions about that from a nursing perspective. I think you have

already told us why infection control is important on Ward A, because of the type of patient that you are treating. What is the role of nurses in helping to ensure good infection control practices?

A Well, we would make sure that the environment's clean, that the patient's clean, trying to reduce patients getting infections. We would do that by delivering good line care; ensuring the IV giving sets are changed appropriately; that the correct medication is administered; wearing PPE; ensuring, if any of the patients have to go into isolation, that that's handed over; care planning; correct documentation; we've got maintenance bundles for lines; peripheral cannulas, again, we've got maintenance bundles. So, just quite a lot of patient safety aspects and audits that we deliver.

Q Now, in your statement you mention the monitoring of infection control on the ward and how that is done, and the Inquiry has not had much evidence about that yet, so I want to just ask you a few questions about what those things are that you mention in your statement. Now, I do not think we need to turn up your statement itself, but I will give paragraph references just for those

following along. Now, in paragraph 23 of your statement, you mention something called the "Care Assurance system," or "LanQIP." I am probably pronouncing that wrongly, but what is the purpose of that?

A So, that's documentation. Care Assurance is our SIPs audits, so that is infection control, audits of the environment that we would carry out locally. So, the data would then be submitted into care assurance. Hand hygiene would be submitted into that as well. We do local hand hygiene checks, and the LanQIP is where we would put the information for central line audits and also peripheral cannulas.

Q Okay. At paragraph 24, you mention your SIP audits, which I think you've just mentioned there. Could you tell me what involved in that kind of audit?

A Yeah, so you would be checking the environment, checking hand hygiene usage within your staff group. You would be checking the linen-- is linen segregated correctly, that there's correct domestic waste, clinical waste, sharps boxes, are they closed, they're not overfilled, is the waste bags tied correctly? I'm trying to think what else is on it. Basically, infection control, control of the

environment and assuring that staff are carrying out procedures correctly.

Q Is that carried out on a room-by-room basis or a ward basis or?

A Yeah, so we would do spot checks of rooms.

Q Okay. In paragraph 25, you mention peer audits. Now, it might seem obvious, but could you just explain to us what a peer audit is?

A So, peer audits would be maybe nurses from other areas coming in and they would carry out an infection control audit or practice development. Nurses would come into the ward and spot check line care, staff administer IV, intravenous medication. So, generally, your peers are coming into your unit and would audit you from another clinical area.

Q And are all of these things that you've just mentioned a regular part of infection control on the wards?

A On our ward, yes.

Q On Schiehallion?

A Yeah.

Q Now, in paragraph 40 of your statement you mention something called "enhanced supervision." Could you tell us what that is?

A So enhanced supervision, during the issues that we were having with the water, this was something that Infection Control commenced. The ward still is under enhanced supervision every six weeks. There's either a lead nurse or senior nurse from Infection Control, a lead nurse from the hospital, someone from Estates, someone from Facilities and either myself or one of the other senior charge nurses or band 6 nurses would then attend. There is a template that Infection Control follow. They would spot check four rooms. Now the four rooms would be empty rooms because, after COVID, to reduce footfall in the patient rooms, we don't go into occupied patient rooms. They would check central line care plans, make sure all the documentation has been carried out, check control of the environment. Is there any Estates issues? Is there any cracked flooring? Was there any cleaning issues? If there was any domestic cleaning issues, that would be fed back to Facilities, and just a general inspection of the clinical area to make sure it's safe.

Q And, prior to COVID, would that have involved going in and out of patient rooms to spot check them?

A Yes, it would've.

Q Okay. Now, in your

statement you mention that in around about May 2017 there was an increase in central line infections and that a quality improvement group was set up, and I think you have already mentioned that this morning. That is the CLABSI quality improvement group. Is that right?

A Yes, that's right.

Q Okay. Now, we're going to hear more detailed evidence about the response to that concern from others, but I wonder if you could tell me what the quality improvement group involved from the nursing perspective? So, what kind of line care improvements were made?

A So, we benchmarked Cincinnati Hospital. They were seen as gold standard for line care. At the time, we changed our practice to aseptic non-touch technique. Other centres were using that. I believe Great Ormond Street had been using that for several years before we changed, and that's what nursing is about – following best practice, continually auditing your practice – so we changed to ANTT. We used to change the central lines every 48 hours after-- so if a patient went to theatre, we would change the dressing after 48 hours. We changed that to 7 days and, again, that was seen as best

practice to let the skin settle. We started using Biopatches there, chlorhexidine-impregnated dressings. Again, we just used to use them for-- until the first dressing change. We now keep them on for at least three weeks, and some patients actually like to keep them on all the time now, and that's fine. So that was the kind of things we changed over. Disinfectant caps, I'm not sure which hospital used them, but certainly that was something for keeping the end of the lines clean at all times, and that still works well. We used to have Curos caps, but they weren't the best fit, so we now have changed to a company called BD, and that's working well. So every patient that has a central line or port now has a disinfectant cap on their line when it's not in use.

Q Can I check-- one of the caps that you have mentioned-- what we have heard about in the Inquiry is a green cap that was put on the line.

A Yeah, so green is Curos, blue is BD.

Q Okay. So it was during the Quality Improvement project that the green caps were put on the lines?

A Yeah, that's correct.

Q Okay, and did you see positive results from the Quality Improvement project?

A I'm not sure because then, after that, we had the issue of the water and I think----

Q So it was not that long after it started that----

A I think so. I can't remember the full timeframe, but the group started, and then we continued with the group, and then it got to March, and then obviously there was some things found in the water.

Q We are about to come onto that in a few minutes, but one thing I just want to ask you about: we heard evidence on Monday from Professor Gibson and she said her assessment of the standard of line care in the Schiehallion is extremely high. Would you agree with that assessment?

A Yeah, it's excellent.

Q Thank you. Now, I am about to come onto the events that you have just referenced that started in March 2018 but, before I do that, I just want to ask a couple of questions about some of the standalone building issues that are mentioned in your statement, and I think you will be aware that these were concerns that were raised by patients and families in 2021. We do not need to turn up your statement, but the paragraph reference for those who want it is 46.

Now, the first issue I want to mention is the temperature of the room. I think some evidence was heard that the temperature of the rooms could be quite hot, and the rooms could be humid. Is that right?

A Yes, that's correct.

Q Okay, and I think you say in your statement that is no longer a problem in the newly refurbished Schiehallion Unit.

A Yeah, that's correct.

Q Okay. Also mentioned were issues about shower rooms flooding into bedrooms. Do you recall that?

A Yeah, that's no longer an issue.

Q Okay, so that has also been resolved? Okay. Now, we also heard evidence from both families and staff about the odour thought to be linked to the nearby sewage works. Can you recall if that affected patients on the ward?

A Yeah, I remember one father asked to speak to me about it. His daughter was in getting chemotherapy, and she was very nauseated, and the smell was making her nausea worse. So, at that point, I asked my ward clerkess to put it on the FM system – they have access to that as well – and I escalated it to Estates.

The Estates colleagues came up. They checked the ward. They checked the vents. They checked the plant rooms, but nothing could be found, and that was since we moved back. That was last summer. So, we moved back to the ward last March, so that was over the summer months. I haven't had any feedback so far this year, however certainly last year when we had moved back it was an issue over the summer months.

Q So just to be clear, the odour issue persists on the refurbished ward or at least it did last year?

A It did. We've not had any issues over the winter months. However----

Q What about in the recent heat that we've had the last couple of weeks?

A Yeah, so nothing so far, and if there is, again, I will escalate it.

Q Have you noticed the odour in the ward yourself?

A Yes.

Q Since the unit has been refurbished?

A Yes.

Q Okay, thank you. I am going to take you now to events in March 2018, and we are going to just begin a chronological walkthrough of what happened. Now, you say in your statement there was a time around March 2018 when there was a concern about the type of infections you were seeing in the ward and the possibility that they came from the water supply. Now, thinking back to the start of March 2018, could you explain how you first became aware of these concerns?

A Yes. It was either a Thursday or a Friday night. Infection Control phoned the nurse in charge phone – it was late afternoon, early evening – and advised that there was something found in the water and could I advise the families not to use the water until further notice. So, I went round, and I updated the families, and I handed them two small bottles of water and asked not to use the water until further notice. That was for, obviously, washing, teeth brushing, anything like that, and I believe that was the same instruction for all weekend until the start of the next week when we had an IMT, but we were advising the families, young children, teenagers to use wipes and bottled water.

Q And can you recall what you were able to tell them about what the concern was?

A I think I just said Infection Control have advised not to use the

water at present, but I think that was as much as I said.

Q Okay, and you say in your statement that the call from Infection Control effectively gave you an immediate instruction, so it seemed to be an urgent issue at the time.

A Yeah.

Q How did you feel at that point?

A I think I was quite anxious because Infection Control were anxious and, obviously, to have something in the water system, especially when we had been having infections, I was concerned for the patients.

Q And what was the reaction of patients and families when you gave them the instruction not to use the water at that point?

A That evening they were okay. They trust either myself or nursing colleagues, and they acted on the instructions. As time went on, I think they got upset. They wanted to wash their children. Some of the teenagers wanted to have showers. We were giving them no access to water except bottled water or wipes.

Q Okay, we will come on just to focus in on some of what you have just said, but you have indicated that shortly after this initial immediate

instruction was given, an IMT was called, and my understanding of an IMT is that its purpose is to investigate the infections and the possible cause of infections. Is that your understanding of what an IMT does?

A Yeah.

Q And I think we can see from the papers that you attended a number of IMT meetings over the course of the next 18 months/2 years. Is that right?

A Yes, I did.

Q Can I just pause there to ask what your role would be at the IMT?

A I think I was a link for the patients and the families. I would feedback any concerns that the families had, and also so I was updated. Obviously, I'm responsible for the day-to-day running of the ward, so I think it was to keep me involved.

Q So it kept you updated, and then you were able to relay whatever information you could to the patients and families?

A No, I would have to wait on official communication before I updated staff or families.

Q An official communication from the IMT?

A Well, the Comms team. Someone from Comms would attend

the IMTs.

Q Would patients and families be aware that you were going off to IMT meetings? Would that be obvious from the ward?

A Maybe they wouldn't know the term IMT, but I would say, "I'm going to a meeting to get updated," but maybe wouldn't know the name being IMT.

Q And so when you came back from the meeting that had taken you off the ward, would patients and families expect an update or be looking to you for an update?

A Yes.

Q But you were not always able to give them that straight away?

A Yes.

Q Okay. Before March 2018, were IMT meetings a regular feature of your job?

A No.

Q Had you ever been to any before March 2018?

A I don't think so, not that I can recall.

Q Did that change?

A Yes, I was there quite frequently after that.

Q Okay. Now, we know from the papers there were a number of IMT meetings in March 2018, and I think it might be helpful just to illustrate

the type of thing that is discussed at that meeting if we look at one of the minutes. So, Ms Callaghan, could you bring up-- it is the minute of the IMT meeting on 21 March 2018. It is at bundle 1, page 75. That is great. If we can maybe just enlarge that slightly. That is great. Ms Somerville, can you see that?

A Yes.

Q Could we just scroll back down to the top again? Ms Somerville, do you see your name on the list of attendees there?

A Yes.

Q So it looks like you were at this meeting. Right, okay. It was about three weeks into the water incident, so it was 21 March.

A Okay.

Q Ms Callaghan, could we scroll down to page 76, please, and maybe just enlarge the paragraph under "RHC Water Report"? You might be able to read that, Ms Somerville, but I do not know if others might struggle. I know my eyesight is not great. That is much better, thank you. So, if you just scroll down so we can see that full section under "RHC Water Report." Great, thank you very much. If you just take a moment to look at that, Ms Somerville, and let me know when you have done. It is really

just the first two paragraphs of that we are looking at.

A Yeah, I've read it.

Q Now, was it your understanding from what was said at the IMT that water outlets in Ward 2A had tested positive for some kind of bacteria?

A Yes.

Q Okay. Looking at the minute we can see three bacteria have been found, and I'm sure I'll pronounce these incorrectly, but we've got Cupriavidus, Stenotrophomonas and Pseudomonas. Is that right?

A Yes.

Q Now, were those findings concerning to you?

A Yes.

Q Why was that?

A Because they are infections that our patient group may have, and I don't think that they should be in the water.

Q And were these particular bacteria familiar to you? Had you seen them before?

A Stenotrophomonas and Pseudomonas, yes. I don't think I had heard of Cupriavidus before.

Q Okay, and just reading down to the second paragraph under that heading, does this minute indicate that bacteria were found in water

outlets on other wards within the RHC? So, we see reference to Ward 2B and 3C there.

A Yeah, that's what it says in the minute, yeah.

Q Yes, okay, and so was it your understanding that concern about the water extended beyond just Ward 2A?

A Yes.

Q Okay, and if I ask you to read down just to the next heading – perhaps we could just scroll down slightly, Ms Callaghan – do we see there an indication that, in fact, the concern about the water extended to the adult hospital?

A Yes.

Q And that's referenced to Ward 4B, which I believe is the bone marrow transplant unit in the adult hospital?

A For adults, yes.

Q Right, okay, and do we see reference there to two positive results of Cupriavidus in Ward 4B?

A Yes.

Q Ms Callaghan, could we scroll down to page 77, please? There is a heading, "Current Infection Control Measures." I would like to look at that paragraph. That is great, thank you. Ms Somerville, again, if you could just take a moment to familiarise yourself

with the first part of that section.

A Yeah, that's correct.

Q Yes. Do you recall those control measures being put in place?

A Yeah, I do.

Q Okay. So, in effect, would it be accurate to say that all contact with water was to be limited----

A Yes.

Q -- for immunocompromised patients? And if we read down to the next line, there is a note there that says, "Please note that sterile water should be used if it's a bone marrow transplant patient." Is that something different from the use of bottled water?

A Yes, sterile water is different from bottled water. We use Cow & Gate sterile water, but the transplant patients generally don't like the taste of it, but that's what we advise to use.

Q Okay, and if we read on slightly, you'll see the next paragraph refers to a twice-daily Actichlor clean. What does that involve?

A Actichlor is a chlorine-based cleaner, so the rooms were getting cleaned twice per day with the chlorine. Normally, it would be once a day, unless it's a source isolation room; they're always cleaned twice per day.

Q Okay, so that was a step up in cleaning?

A Yes.

Q Okay. The next paragraph we see relates to hand hygiene. Just have a look at that. Does that represent a change to the usual hand hygiene practice?

A Yes, so normally you would use one or the other. If your hands are visibly dirty, then you can wash them. If they're not, you can gel them, but we were advised to do both.

Q So it was a belt-and-braces approach?

A Also, Sterillium is not a hand gel that you would normally use. That's an added step.

Q Okay.

A I believe they use it in theatre.

Q Okay. Ms Callaghan, could we scroll onto the next page, please, and just enlarge the top section-- top paragraph? We see at the very top of the page there there's reference to ciprofloxacin. Is that a prophylactic medication?

A Yes.

Q Okay, and finally if we just look to the next paragraph there, we see your name and you raising a concern that some patients in Ward 2A are getting frustrated at not being

allowed to shower for a number of days. I wonder if you could just tell us a bit more about that.

A Well, some of the patients and families were obviously getting upset. We advise to prevent infection that you wash every day and have a shower, and now we were advising against that and to, obviously, use bottled water or wipes. Obviously, bottled water isn't warm.

Q So they were left facing a situation where they did not know whether it was safer to clean or not to clean using the showers?

A Yeah.

Q Okay. Ms Callaghan, could you scroll down slightly just so we see the paragraph that begins "Water control measures"? Now, Ms Somerville, I am not going to ask you to go through all of that. We can see quite a long paragraph that outlines various water control measures, but if you just look at the first paragraph, you can see reference to tap and shower filters being fitted on various wards, including Ward 2A. Is that right?

A Yes.

Q Were the filters something that had to be replaced frequently?

A Yes.

Q And do you recall how often?

A I think at the start it was seven days, and then we went onto monthly. The date's usually on the filter. The company come in and fit them.

Q I was going to ask next whether the replacement was done by Estates or an external company. Are you indicating it was an external company came in to fit the filters?

A Now it is. At the time, I'm sure it was DMA.

Q DMA Canyon?

A Yeah.

Q So they were involved in fitting the filters back in 2018?

A I believe so.

Q Okay, and now is it your own Estates team that does it now?

A DMA still come in. They do water testing, and they run taps, and they change filters.

Q What does the actual process of changing the filters involve? Does it involve people from the external company coming in and going into patient rooms?

A Yes.

Q Okay. Is it quite a disruptive process?

A Not really. The DMA would come and speak to either myself or one of the band 6 nurses and ask is

there any room that they shouldn't go into in case a child was unwell that morning and then they would come back in the afternoon. They are good at checking in with us. Basically, the filter comes off the tap and a new one clips on and, again, the shower head, kind of, unscrews off and a new one goes on. So, it's not too disruptive but, obviously, it's an added person going into your room.

Q Okay. Thank you, Ms Callaghan, we can put that minute away now. Now, in your statement you also refer to a point in time, I think in March 2018, where the water was turned off altogether. Can you describe the impact of having no water at all on a hospital ward?

A Well, obviously, when you're training to be a nurse the first thing you learn about is hand hygiene and washing hands, so it seemed a bit strange not to have any water. Also, the toilets can't flush because you need water to flush the toilets. Again, when patients come in, we're saying the importance of keeping your child clean or the young people, "You need to make sure you're showering, you're keeping yourself clean," and then we don't have any access to water.

Q So it caused concern both for staff and for the patients and families?

A Yeah.

Q Okay. Was this situation out of the ordinary to you? Had you ever experienced anything like it in your career before?

A No, I've never experienced anything like it.

Q Okay. Now, in your statement you also talk about the introduction of additional infection control measures, I think, around about this time, and we can see reference to those in the IMT minutes. I think it is, perhaps, around this time that enhanced supervision is introduced to the ward. Is that right?

A Yeah.

Q Okay. Could you possibly give us an overview of the changes that were made to infection control practices as a result of these concerns about the water?

A So, there was point-of-use filters. There was shower-- obviously, the shower heads were changed, enhanced supervision, just checking-- continually checking the environment. We would have an external hand hygiene auditor. He would review nursing and medical practice and then feed back. Infection control during hand supervision would be spot checking the care

maintenance bundle for central lines and also for peripheral cannulas. They would also observe staff administering IV medication and observe staff – both nursing and medical staff – the usage of PPE.

Q You mentioned in your statement at one point-- I am not sure, to be fair, if it relates to events in March or slightly later in 2018 in May, but you mentioned a time where you were, effectively, having to go into patient rooms and give families instructions about infection control and what they should and should not be doing. Is that right?

A Yes, that's correct.

Q What kind of things were you instructing them to do?

A So, to make sure the rooms are clutter free, but you have to be careful because clutter is patient belongings, so that's a patient's home from home. So as long as the domestic and our healthcare support workers can get access for cleaning, I would ask families to work with us. Parent beds, if they could be up during the day, again, to allow domestics access for cleaning the floor, and no items to be around the sinks. That was something that we, kind of, stepped up on throughout the summer months.

Q Do you think this having to give instructions to the families strained the relationship at all between the nursing staff and the families on the ward?

A Yeah. I felt like I was continually on at them.

Q Okay. I think you also say in your statement though that, to some extent, they were reassured by the fact that there were infection control measures happening. So, was it a bit of a balance? On the one hand they were reassured, but on the other hand they were frustrated by----

A Yes. It was trying to get a balance. Some families were more upset than others. Again, some families were in right through, maybe, other families went home or went to day care. So, I suppose every family's experience was different.

Q Okay, thank you. Now, we are going to come back to talk about communication towards the end of your evidence, but just thinking back to March 2018, could you describe how communication around these events was handled, firstly, maybe, with staff?

A So, the IMTs would finish, we would wait on the official communication. At that point, it was either myself or Professor Gibson that

would update staff and families. As that went on then the chief nurse and general manager would come and help. I think as things continued there was a lot more things then going on, and they would have a presence in the ward.

Q We will come back to talk a bit more about that later on.

A Okay.

Q In the early stages of this instance, so thinking back to March 2018, do you think patients and families understood why these measures were being put in place on the ward?

A I'm not sure. I think because we didn't really know-- I mean, everything from the IMT was a hypothesis, and then things continued. So sometimes we didn't really know why we were getting infections, and these were, obviously, control measures. I would try and make it clear but, obviously, I would have to give out the official communication. So, whatever was on the communication brief, that would be what I delivered to the families.

Q I am going to move forward now to events in May and June 2018. You say in your statement that you did not attend any IMTs, I think, between around about the end

of March and the beginning of June. Did you think that whatever the problem had been, had been resolved?

A I don't-- I think so. There was additional water testing, the control measures were still in place. I think so.

Q So, did you have some uncertainty about what the situation was then?

A Yeah.

Q Okay. We know from the documents that the IMT meetings started up again around the end of May 2018. Can you recall the circumstances that led up to this second period of concern?

A I think there was a spike in infections. Again, I don't know the number off the top of my head but there was a concern that the amount of children with central line infections had increased.

Q Were these-- do you know what type of infections these were? I am not looking for specifics but were they Gram positive, Gram negative?

A Gram negatives.

Q Gram negatives. From your perspective as a nurse, are gram negative infections concerning?

A Yeah. Our patient group

do get Gram negatives, but I hadn't seen the volume of children affected before, so that was concerning. Also, Infection Control and Microbiology were concerned.

Q So, are you indicating that even in your time in Yorkhill you had not seen the same sort of pattern of these-- this type of infection?

A I don't recall ever seen as many at the one time.

Q Do you know what the IMT's hypothesis was, at this stage, for the spike in infections?

A I believe it was from the drains.

Q Okay. Now, you mention in your statement somebody observing black sludge in the drains. Is that right?

A Yeah, it was one of the families. It was in one of the trough sinks. They asked to see me or their nurse looking after them. Obviously, they escalated it to someone, and I checked, and there was black matter in the sink and contacted the consultant microbiologist. She came to the ward and carried out a sink inspection. There was concerns about one of the trough sinks in the BMT rooms and also the treatment room where we prepared the IV medication-- intravenous medication was bubbling.

Maybe that's not the right description, but that's what it looked like. So, she was concerned about the two sinks at that time.

Q Can you remember if it was thought that this was a continuation of what had happened in March in relation to the water supply or perhaps something different?

A I think it was separate.

Q Okay. Can you describe the infection control measures that were put in place in response to this particular concern?

A Yes. So, there was a drain cleaning program introduced.

Q Was there also something called HPV cleaning?

A Yes, hydrogen peroxide vapour.

Q Could you tell me what that involves?

A So, at that time-- I think it's different HPV cleaning now, but then it's an external company came in. So, there was drain cleaning and there was-- we had to move the patients because it's a brush cleaning and there could be spray and then there was something poured down. I think we then started changing taps or drains again. I can't recall the actual timing of events. At the back of that, we then carried out an HPV clean. So,

we would have to help the company move the patients, give access to rooms. They would spray hydrogen peroxide in the room on all the items. We had to then wait for a few hours, and then the room could be used again. There was some issues. A lot of the rooms were humid, and they had-- the company had to put in a de-humidifier to get the levels of humidity down before they could continue the HPV cleaning.

Q So, what you have just described, this sounds as though it might have been quite a disruptive process on the day-to-day running of the ward. Is that accurate?

A Yes, and also for the healthcare support workers it was a lot of additional work because they were trying to help me coordinate it and move patients from rooms.

Q What is the role of a healthcare support worker on the ward?

A They support nursing staff. They're not registered nurses, but they are nurse supports. They look after the children the same as a registered nurse and help with basic care and a lot of the additional tasks of room moves, cleans. They helped do all that.

Q So they are physically

involved in the logistics of this?

A Yeah, they are.

Q Okay. Am I right in thinking that the impacts of the HPV cleaning impacted the entire ward?

A Yeah, that's correct.

Q Okay. Am I also right in thinking that at some point around this time the ward was closed to new admissions for a time?

A Yes. I think because of the disruption it wouldn't have been fair to bring a new diagnosis patient into-- obviously, all the room moves and infections. We didn't really know what was going on. The ward did have a high Estates presence at that time and Infection Control.

Q Okay. A high Estates presence?

A Yeah.

Q Did all of that have an additional burden on staff?

A Yeah, the uncertainty of why there was infections, the additional workload, moving patients, families were anxious. What was causing the infections? We were asking to move rooms often. So, yeah, it was a stressful environment to work in at the time.

Q Can I take it from what you have just said that this took you and other nursing staff away from

patient care at times?

A Yes it did.

Q Okay. During this time, you personally are also attending IMT meetings quite frequently. Is that right?

A Yes.

Q Okay. Now, in your statement you indicate that around this time there had been some delayed transplants as a result of the ward issues, and I think that links to the closure of the ward to new admissions that you have just mentioned and the disruption. Could you tell us a bit more about that?

A So, the transplant patients, we try-- we've got a bed planning meeting. We try and not bring two transplant patients in at the one time. Transplant patients become pretty unwell. They also require one-to-one nursing as per our JACIE standards. So we try and spread the transplant patients out by two weeks if donor availability lets us do so. That's just to do with acuity on the ward so that we can safely-- safe staffing levels, but due to the ward being closed and donor availability we had to then transplant at the same time.

Q Okay. I think we might come on and ask Ms Howat some more questions about that this

afternoon because I think she was involved in gathering some data about the impacts there. Aside from the practical implications that you have described on the ward, how would you describe the impact on staff at this time, in terms of their concerns about the safety of the ward?

A The morale was really low. Some staff went to their union. As part of the NMC code of conduct, one of the things that we do is to ensure patient safety, and all nurses know that. The nurses in the ward were not confident that patient safety was being adhered to.

Q Okay. Do you think staff were worried that the problems had not been resolved----

A Yes.

Q -- despite the control measures that had been put in place? Okay. Do you think that patients and families during this time had a clear understanding what the IMT hypothesis was?

Q I would like to think so, but I think there were so many IMTs, and we had so many issues and room changes for various reasons that would have probably been easy to get confused.

Q So, just thinking about the situation overall in the ward in

around about June 2018 – so during the second period of concern – how would you describe the atmosphere on the ward?

A So, some staff reported to me that Schiehallion had lost its soul.

THE CHAIR: Sorry, I did not just-- Schiehallion had lost----

A Its soul.

THE CHAIR: Its soul. Thank you.

MS ALNOTT: Okay, thank you. I am going to just turn back to some communication questions from around this time, and there is one document I would like to show to you. It is just a briefing that was issued to parents and families. So, Ms Callahan, could you bring this up? It is briefing dated 13 June 2018. It is bundle 5, page 144. You might need to blow that up a bit, I think. Great, thank you. Now, Ms Somerville if you just take a moment just to familiarise yourself with that.

A Okay.

Q Okay, thank you. Now, you are not the author of this document. Is that right?

A No.

Q This is the kind of briefing that would have been passed to you to hand out following IMT meetings. Is that right?

A Yes, it's from our comms team.

Q Yes, great, okay. So that is as per the process that you described to us earlier on in your evidence?

A Yes.

Q Okay. Now, do you see it is headed information for parents about cleaning in Ward 2A?

A Yes.

Q Then it begins by referring to a new cleaning method to be used in Ward 2A, and it goes on to describe the process involved in HPV cleaning. Would you agree it provides quite a good explanation of the HPV cleaning process, quite a full explanation of that?

A Yeah, it explains the process and what will happen.

Q Now, do you see anything in that briefing that explains why there is a new cleaning method?

A No.

Q Do you see anything in there about bacteria or environmental testing?

A No.

Q Do you see anything about the IMT or concern about infection?

A No.

Q Okay. Now, in your view, is there any acknowledgement of the

level of concern about risks posed by the environment at this time?

A No.

Q Okay. Do you recall if patients and families still had more questions when you handed out this briefing?

A I can't recall, but if they did, I would then escalate to the lead nurse or chief nurse and, at that point, the chief nurse or general manager used to come to the ward. I wouldn't answer anything that I couldn't answer. I would escalate it and ask the lead nurse or chief nurse to come and speak to the families if they had some concerns and, again, that was never an issue. They would come down.

Q Okay. So, that was Ms Rodgers?

A Yes, she was chief nurse at that time.

Q Do you think families were aware at this time that the HPV cleaning and the drain cleaning and the disruption in the ward that you have described was in response to infection concerns? Do you think they had that awareness?

A I think so.

Q How would they have been aware of that if not from the briefing?

A I think from previous

briefings, infection was mentioned.

Q So, this would, effectively, be a continuation of the explanation of control measures. What about nursing staff at this time? Do you think nursing staff had a clear idea of what was going on?

A I think everyone was getting confused because it was water then it was drains and, yeah, all the additional checks and moving rooms and cleaning. Obviously, you're trying to do your job as well, maybe not got time to-- obviously, for me I was at the IMT, so I probably knew the background, so if this was the official communication that nursing staff were getting as well, it maybe wasn't as clear.

Q Okay. This question, perhaps, links to what you have just said but, in your view, did communication with staff and patients and families at this time – so this is back in the middle of 2018 – help to manage concerns about safety on the ward?

A I think so. I think it got better. Sometimes it was slow because by the finish of the IMT then Comms would draft the information, then it would have to be checked by someone, then by the time it got to ward level, you could be late

afternoon, early evening.

Q But still usually on the same day as the IMT meeting had taken place?

A Yeah.

Q Okay. As I said, we are going to come back to some more communication questions later on, but for now I would like to just move forward in time again if that is okay. So, we are going to look now at what happened in September 2018. I think, again, you indicate in your statement that after June 2018 the next IMT you attend is in September. I wonder if you could tell us about the circumstances leading up to the convening of the IMT in September 2018?

A So, that was pre-move. The reason we moved was because Estates, obviously, needed access. I think they were cleaning drains, changing taps, and infections were still high. So, there was IMTs. The plan was to move for a short period of time, and that would let Estates and Infection Control do all their checks, carry out all the Estates work that we were trying to do as well as look after children and run a busy ward. At that point, we started planning to decant.

Q Okay. So, was this the third time in 2018 that there had been some concern about infections?

A I just recall there had been concerns probably throughout 2018.

Q Okay. By this point, then, you and the ward had been through six months of IMT's investigations control measures, and yet the problem did not seem to be resolved.

A Yes.

Q Ms Callaghan, I wonder if we could turn up paragraph 136 of the Somerville's statement, please. Yes, that is it. Great, thank you. Sorry, I should have given you the bundle reference. So, it is 136. So, if you just scroll up a bit, that'd be great. Thank you. Now, Ms Somerville, you mentioned a few moments ago in your evidence about staff going to the unions, I wonder if – given what you see in this paragraph – it was actually in September 2018 that you became aware of that happening?

A Yeah, that would be correct.

Q So, just take a moment to look at that paragraph.

A That's fine.

Q Great, thank you. Now, I am not asking you what advice was received from the union. I wonder if, though, you could tell us whether that

indicates-- the fact that staff had gone to their union indicates a particular level of concern among nursing staff on the ward at that time?

A Yeah, they were concerned for patient safety.

Q Why do you think they had to go to their unions at that time?

A I think they were concerned that we continued to look after the children in an unsafe environment, and they wanted some advice. Again, it was in case we were breaking the NMC code of conduct.

Q Did they have to go to their unions for any particular reason? Was there not something they could do internally to escalate the issue?

A I think the advice was always that the unit was safe, and I think it was an external opinion.

Q Okay, thank you, and I will just ask again, thinking back to what was happening in September 2018 and nursing staff having to go to their unions to ask whether they could continue to treat patients in a building in this situation, have you ever been in a situation like this before?

A Never.

Q So, you were in a brand-new hospital building, and you and your nursing staff were concerned it was not a safe place to care for

patients. Is that right?

A Yes.

Q It may seem obvious, but could you describe the impact of this situation on the nursing staff at this time?

A So, working in the Schiehallion Ward, as I've said, obviously, a lot of emotional support. You're building up relationship with your patients and families. So, you know, it's a stressful environment to work and to have all the additional pressures of nursing staff being monitored, peer audits, Infection Control presence, Estates presence, staff were concerned that this was not normal for a ward and again, they have good relationship-- trusting relationships with children, young people and families, so this was then a breakdown of relationships.

Q Are you indicating that the impact on staff at this time also had an impact on their relationship with patients and families at this time?

A Yeah, as I said, you know, we were in checking and, "Make sure there's no items at the sink. Can you keep your room clutter free." We, obviously, didn't know-- we just didn't really know where the infections were coming from. Nothing was getting better. The control measures were put

in place, and we continued to see infections.

Q Was it a consequence of the fact that you did not know what was going on that you could not reassure patients and families?

A Well, obviously, there was hypothesis, but I don't think anything was ever confirmed.

Q Okay, thank you. Now, you explain in your statement, and you have just mentioned a few moments ago that in September 2018 a decision was made to close Wards 2A and 2B and to move the unit towards Wards 6A and 4B. Now, you talk about the decant itself in your statement and we are going to hear more about that from others, so I do not propose to turn that up or to go to that with you for now, but I would like to ask you about your views on Ward 6A itself and the impact of the decant on staff and patients and families. I wonder if we could start by asking you to describe the impact of being in Ward 6A and 4B on patients and families.

A So, obviously, 6A/4B was in in the adult hospital, so there wasn't really any child or young person friendly playrooms or TCT lounge. Obviously, in-patients and out-patients were in together. There were some issues that the children were having to

share the lifts with adults. Sometimes, adults were going out for cigarettes and families would complain about the smell. That was resolved. There was eventually a lift closed off for transferring of patients up to 6A. Personally, 6A, I like the layout because you could see all the rooms at the one time, so it was easier visibility for nursing. However, I know the families didn't really like it. There was no parent room. I believe that some of the families felt quite isolated.

Q Yes. We heard evidence from some of the families that – I think through the loss of the facilities that you'd had on 2A – they felt that in effect they lost their support network. Would you recognise that?

A Yes.

Q And we also heard evidence, I think particularly from some of the teenage patients, that they felt institutionalised on Ward 6A. I think through the loss of the TCT and those facilities. Do you recognise that impact?

A So I was with one of the teenagers when we moved back. She was interviewed by TCT when we moved back to 2A, and that was what she said. She really struggled with her mental health being in 6A. She did feel isolated, whereas now she feels a

lot more supported being back in 2A, so that was nice to hear from her point of view.

Q Okay, thank you. Could you describe the impacts of being on Ward 6A and 4B on your nursing staff? You refer to this in your statement, but was there an impact on the practicalities of nursing between two wards?

A Yeah, so obviously we were nursing over two floors. Transplant patients should have one nurse for one patient, but in 4B if there was one patient then there had to be two nurses because you need-- paediatric nursing, you always need two nurses to check chemotherapy IV drugs. So that would then mean that there was one less staff member in 6A. So it was always tight over the two floors, and you would have to send another nurse down for break relief. So that was challenging as well, and sometimes the staff did say they felt less supported in 4B. That was our sickest patients down there, transplant patients, and they did feel a bit vulnerable looking after the patients when they were two floors down. I did try and go down every day but, again, it's challenging when you're trying to manage 6A as well as 4B.

Q And you mentioned, right

back at the beginning of your evidence, that this concern about staffing was actually something that reached the stage of being placed onto the local risk register. Is that right?

A Yeah, we added it to the risk register because it was a risk at that time.

Q Okay, and how long did you think the decant was going to be for when you first moved?

A I thought four weeks.

Q A short period of time?

A Yeah.

Q Okay, and did you think Ward 6A and Ward 4B were suitable, at least for a temporary relocation?

A I thought temporarily because looking after the children in Schiehallion at that point was becoming challenging, moving rooms, giving access for Estates and Infection Control. So to leave for four weeks, get everything done that needed to be done and then move back, I thought that was the safest thing to do.

Q Okay, and do you think you would have a greater concern if you'd known it would be for three and a half years?

A Yes.

Q Now, at some point after the decant, did you become aware of a delay in the date for moving back?

A Yeah, I believe there was going to be an upgrade in the ventilation system.

Q An upgrade?

A An upgrade.

Q To the ventilation system in 2A?

A Yes.

Q Were you told at that point what the issue with the ventilation in 2A was?

A I think perhaps it was discussed at an IMT, but I wasn't there, so I can't remember being told.

Q Do you know now what the issue was?

A I believe that the rooms weren't spec'd right.

Q In terms of the ventilation?

A Yeah.

THE CHAIR: Sorry, I just missed the word you used there. You believe the rooms----

A Spec'd. Specification.

THE CHAIR: Specification, thank you.

MS ARNOTT: Would I be right I thinking that, after the decant, there was a period of time where things settled down and everyone got used to life on 6A and 4B, at least for a few weeks or months?

A Yes.

Q Okay. Now I am going to ask you some questions about what happened at the end of 2018 and the beginning of 2019, but I just wanted to be clear that I am not asking you about individual infections or patients at this time. Now, was there a point in time where-- or when concerns about safety of the ward arose on 6A?

A Yes. The lead nurse and chief nurse asked me to hand out comms that was printed about increased fungus over the Queen Elizabeth campus and, as a control measure, we were going to be using mobile HEPA filters. I hadn't been to any IMTs at that point, so I don't think at that time I was aware of any issues behind the scenes.

Q And when you were given this briefing to hand out, were you aware of what the fungus referred to was?

A No.

Q Are you now aware what it was?

A Yes.

Q And what was it? You can tell me that.

A Cryptococcus.

Q Okay, and had you heard of Cryptococcus before?

A No.

Q Did it cause you

concern?

A Well, I didn't really know what it was, so I think fungus and immunocompromised patient can be concerning, but I don't think I was overly concerned. I didn't have a knowledge of it.

Q Okay, and you mentioned at that time that portable HEPA filters were put in place-- or around about that time.

A Yes.

Q Can you tell us a bit about those and where they were and what sort of impact they had on the ward?

A So, they were placed in the patient rooms, in their bedrooms, and they were also in the corridors. They had to be plugged in, so they were next to power supply. Families complained that they were noisy. So, at that point they were up at level six, so we turned them down to level four so it wasn't as noisy, but in the corridors they were at the full level, and they were placed everywhere in 6A. 4B already used them, I think. I don't know why, but I would imagine because that's the transplant unit. So I had seen them before, but we started using them in 6A.

Q Okay, and do you know what the purpose of the portable

HEPA filters was?

A I think to reduce air particles, to clean the air.

MS ARNOTT: My Lord, I am conscious of the time, and I wonder if that might be a good time to take the morning break.

THE CHAIR: Yes, it would appear to be a precise time to take a break. Ms Arnott, as I said, we will take a break for coffee, so I think we could be back for 10 to 12. Mrs Brown will take you to the witness room.

THE WITNESS: Okay, thanks.

THE CHAIR: We will try and sit again at ten to twelve.

(Short break)

THE CHAIR: Ms Arnott.

MS ARNOTT: Thank you, my Lord. Ms Somerville, before the break we were talking about events around about the start of 2019 and you told us that there had been concerns about an unusual fungus across the campus, portable HEPA filters had been brought in. Now, around that time was there another concern about air quality on the ward that arose?

A There was air sampling being carried out, but I can't remember if it found anything else.

Q And was there a link

between the air sampling and something to do with shower rooms-- seals in the shower rooms?

A Yes. One of my colleagues had found a kind of gap in the shower seals and I believe that Estates had to have access to all the rooms to carry out a repair of the seals in the shower.

Q And, in order to do that, was it necessary to leave Ward 6A and decant to another ward?

A Yes, so we tried to give Estates access whilst we continued to work in 6A and 4B at that time, but then Infection Control advised that, because of the nature of the patients and obviously a lot of disruption, we would then further decant to the Clinical Decisions Unit.

Q And could you perhaps just remind us what the Clinical Decisions Unit is and where it is?

A So, it's back in the children's hospital. It's on the ground floor, it's adjacent to the emergency department, and that's where children would go and await an assessment to find out if they're getting admitted into one of the wards or if they maybe just need some hours to review and then they would be discharged.

Q And where did the patients from the CDU go when the

patients from Ward 6A moved in there?

A They decanted into Schiehallion.

Q Okay, so there was a general reshuffling of patients to accommodate this decant back to CDU?

A Yes.

Q Okay. What assurance were you provided with that the environment in CDU, which was back in the children's hospital, would be safe for the Schiehallion patients?

A Infection Control advised that it would be safe. I believe point-of-use filters in the drain cleaning program were carried out. It was difficult because, as we left 6A, CDU were just moving out, so they were kind of cleaning at the back as we were arriving.

Q And were you once again involved in planning and implementing the logistics of all of this?

A Yeah, I was involved in the move from 6A to CDU and then, at that time, I had to go back to 2A because, when we'd left 2A, obviously we thought at that point it was for four weeks, didn't expect then another ward to be using our facilities, and we had maybe left some equipment and everything out. So then I went back to

2A to try and make sure that it was fit for another ward to receive, as well as checking on the nursing staff in 4B, decanting the patients from 6A to CDU, and then having to work in between CDU and 4B.

Q From everything that you've just said, was this quite a challenging time for you personally?

A Yeah, I was extremely stressed.

Q Yes. Were you provided with any support in doing all of this?

A I was taken off the hospital cover rota because at that point my role would obviously—it had been still part of the hospital coordination team. So, at that point, the lead nurse advised that I shouldn't be doing that role as well and just focusing on the ward at that particular time.

Q Okay, and how long did the decant to CDU last for?

A I think it was a couple of months.

Q I wonder if we might just pause there and take the temperature of the situation on the ward at this time. So the decant to CDU comes only four months or so after the closure of Ward 2A and 2B because of concerns about the safety of the ward, and then you have to leave what

should have been the safe haven in Ward 6A because of further concerns about the safety of that ward. Could you describe the level of concern among the patients and families at that time?

A So, the families were then really worried. We obviously assured them that we were moving to 6A for a short period of time and that area was safe, and now we had concerns about the area we had moved to and we were then now moving back into the children's hospital, to another area, and obviously when we gave the family instructions, we were only going to be staying for a short period of time in ward 6A. The time had now then passed and then we were going back into the children's, to CDU, and then going back to 6A. So, I think it was probably a lot for the families to take in.

Q Okay, thank you. Do you think they had a clear understanding about the state of safety of the building at that point?

A So, there would have been comms given out, but I think there's just probably quite a lot of confusion because there's so much change and obviously the families are concerned about their children.

They're going through a cancer diagnosis, so then to have been pressured with moving wards and trying to obtain and digest information that we were giving them, I can understand why it was a difficult time for them.

Q And just thinking back again to just taking the temperature of the ward at this point in time, could you just describe the level of concern among staff?

A Again, staff were really concerned. They thought that 6A was a safe place as they had obviously escalated their concerns in September, before we moved, and now we were moving again. It is quite difficult to pack up a ward and move, logistically, planning where the patients are going to go and stock and medication, and obviously we still had our patients in 4B, so they were in a separate hospital.

Q So at that time you were actually nursing across 4B, CDU and you were also doing something at 2A?

A I was back in 2A trying to coordinate some of the equipment and furniture that we had left because at that point then another ward was moving into 2A and they needed access to the doctor's room and my office and things like that. So, I had

left them some things. Again, I only thought we were moving for four weeks, so I was just trying to make sure that all the belongings were packed away so that CDU then had the facilities of Ward 2A, Schiehallion.

Q At this time did you sense that there was a feeling of control over this situation?

A I didn't feel in control.

Q And do you think anyone felt in control of what was going on?

A Not sure. I can't really answer for everyone else, but certainly myself and nursing staff probably didn't feel in control.

Q Okay. I am going to ask you a few questions now about the remainder of 2019. Now, we have got other witnesses who will give us a bit more detail about that, so it will just be a few questions. So, I think you moved back from Ward 6A, or certainly we have heard evidence that the move back to 6A from CDU was in around about February, and at that point when you moved back to 6A from CDU, did you have confidence at that point that 6A was going to be a safe environment?

A We were assured from Infection Control and Estates that all the work was completed. So, I trust my colleagues that, if they advise

that's the best place to look after patients, it was a safe environment to do so.

Q And when you moved back to 6A – so, just thinking through the rest of 2019 – did you have ongoing control measures during this time?

A So the HEPA filters stayed in place, the filters would have been on the taps, the drain cleaning programme continues – it still continues just now – filters on showers, and I believe that air sampling was being carried out.

Q Did you still have enhanced supervision during this time?

A Yes, we did.

Q In your statement you mention some additional cleaning around about something called a "chilled beam." Do you recall what that was?

A Yeah, so we had some chilled beams that were leaking water. I think chilled beams is the ventilation system that's in the rooms and we had some concerns that they were leaking water or condensation. So, I think they were cleaned every three months and then that was increased to either four or six weekly. So, again, the room had to be emptied to allow Estates access

to clean the chilled beam, so therefore the patients had to move out and we had to close rooms.

Q So you had to close rooms as a result of the chilled beam cleaning?

A Yes.

Q Now, we do not need to turn it up, but in your statement, and it is at paragraph 184, you sum up the situation on Ward 6A and just say there is a lot of building disruption on 6A. Is that what you remember your time, and certainly in 2019, on 6A as being like?

A Yeah. Again, we had just left 2A, Schiehallion, because there had been a lot of building work estates presence and again it seemed that it was happening again in 6A.

Q And at this point in time, so in 2019 onwards, 6A, to your knowledge, was the water supply safe to use at this time?

A So the filters were still on the taps and showers. I can't recall, but at some point there was a chlorine dioxide or a cleaning of tanks and the water had to go off at some point.

Q And were families still using bottled water on 6A?

A No, on 6A, when we moved, we had advised that families and patients could shower or wash

hands. I can't remember if we were still drinking bottled water. Certainly, at one point, when we were advised the water was wholesome, we changed to jugs of tap water and that was filtered tap water. That was from the kitchen.

Q And that is tap water that has passed through the point-of-use filters that you have described on the taps?

A Yeah, that's correct.

Q Do you think that patients and families on the ward had a clear idea of whether the water supply was safe at that time?

A I would hope that the comms explained that, but I'm not sure. Again, there probably could have been some confusion because there was so much going on in 6A again.

Q Do you think there was some form of ongoing anxiety about the environment in 6A among the families?

A Yes.

Q Were you aware of any further concerns about infection during the rest of 2019 on Ward 6A?

A Some of the children were started back on prophylactic ciprofloxacin, so I think something was found in the water but, again, I get

mixed up. I can't remember.

Q Okay. Did there come a point in 2019 where the ward was closed to new admissions again?

A Yes.

Q And do you remember why that happened?

A I don't recall when it was but, again I think it was to do with an increase in infections.

Q But at some point it reopened to new admissions?

A Yes.

Q Okay. Ms Somerville, I want to jump forward in time now to when you moved back to the new 2A and 2B. So, I think that was in around about March 2022. Is that right?

A Yes.

Q Okay. What has changed in the unit?

A So we have better facilities, we have the TCT Lounge. Obviously we had that before but that's-- the teenagers can use it again. We have a tween room. Two of our former patients, they identified there was a gap between the playroom and teenage room. There wasn't any facilities for the kind of 8 to 12 children, so we now have that and that's really well used. Parents' kitchen is back open, so the parents can make themselves tea or coffee, have some

time away. We have an interview room, so if any of the consultants or medics would like to speak to families, they've got an actual room that they can use. There is a pharmacy room now. We didn't have that before. Probably better office space for the medical staff. The Outreach Team; paediatric oncology nurses are now in the ward as well and they have got a hot-desk space. Yeah, it's just generally a better environment than it was in 6A.

Q And do you know what, if anything, has changed about the ventilation system?

A So I believe they're all positive-pressure ventilation rooms or lobbies. There is one room that has negative pressure and that would house any infectious patients, COVID, and that was on a recommendation from Infection Control when the ward was being upgraded. And I worked with Estates before we moved back. One of the capital planning managers, he explained about how the ventilation system works and I believe it's one of the best ventilation systems that is in the hospital.

Q And have you been provided with assurances about the safety of the ward now?

A Yes.

Q Do you have any ongoing concern about the building system, so the water, drainage, ventilation?

A Not now.

Q You do not have any doubts about the safety of the ward now?

A No.

Q Do you drink the water on the ward now?

A Yes.

Q Is it filtered still?

A Yes, I use the filtered taps either from the parents' kitchen or the pantry.

Q Okay. Now, you indicate in your statement that there are still control measures in place on the new ward. What is your understanding as to why those are still there?

A I think it's to give added assurance. We still have filters on taps, showers, enhanced supervision. Now, instead of four weekly, it's six weekly, and we carry out ventilation cleaning. There's an external company who come in, Correctair, and they work with us and we give them access to the rooms, and then there's a domestic clean after that and then the rooms are signed off. So there are still additional checks and cleans that we continue to do.

Q What is it that is cleaned in terms of the ventilation now?

A Estates would be able to clarify, but I believe that they cleaned for dust.

Q And, as far as you're aware, these measures are in place really as a belt and braces? Is that what you mean by "added assurance"?

A I think so.

Q I think you mentioned in your statement there is still some form of HPV cleaning goes on, but it is slightly different from the HPV cleaning before.

A Yes, a company come in now and the person kind of sprays locally. It's not a machine, so it's easier than before. It still is a task because you have to move patients. We carry it out every six months. It was last carried out in March, and we work with the company to give them access to the patient room so that it can be HPV cleaned. Again, we'll plan round that because you don't want to do it on the same day that there's a bone marrow transplant, or you're moving rooms. So, again, it does require a bit of coordination.

Q And do you think that is something that is going to carry on happening? Is it now a fixed feature of infection control on the ward?

A Yeah, I was advised by the clinical service manager that we will be carrying that out every six months.

Q Okay. Just thinking about what you said earlier about infection patterns and levels that you observed, do you have any ongoing concerns about that on the new ward?

A Not at the minute. We do continue to get patients that have infections and a root cause analysis would be carried out from the Infection Control team. That's a template that they would complete. They look at the patient pathway, antibiotics that the patient has been on and, if they had any concerns, they would advise us, but Infection Control lead on that.

Q But as far as you're aware, there are no concerns at the moment?

A No.

Q Thank you. Ms Somerville, I just want to pause there and reflect on the impacts of this whole experience. Now, you have told us about a very difficult period over around about 18 months, during which the ward experienced huge disruption. You did not know if you were caring for patients in a safe environment. Your nurses did not know if they were caring for patients in a safe environment.

You were in and out of IMT meetings. You were helping to manage control measures and you were dealing with heightened infection control scrutiny and, throughout this time, you were also on the frontline of dealing with anxious and stressed staff and extremely concerned families. Now, you have worked in paediatric nursing for over 20 years. Have you ever experienced anything like this in your career?

A No, I haven't.

Q How would you sum up the overall impact, firstly on patients and families, of this experience?

A It was just really stressful for the families, upsetting. They were worried about their children. Families are worried about children getting infections anyway, but this was obviously added pressure from the environment. We were moving wards, we were moving rooms, we were checking on the families. Families should be able to chat to nursing staff and we would offer emotional support, but we were obviously in, checking on the rooms, so I imagine that the patients' and families' journey could have been better.

Q How would you describe the overall impact on your nursing staff?

A Again, they were really demotivated, stressed, I had staff off sick, and everyone-- I think we're still recovering from it just now.

Q And why do you say you are "still recovering"?

A I think it was, again, pretty stressful and just taking a long time for anxieties to settle.

Q Do you feel that that process is progressing?

A Yeah. The ward now, as I said, it's really good. The nursing team, medical team are great. It's just taking a bit of time to get over.

Q How would you describe the impact on you of all of this?

A Yeah, I was really stressed. It took me away from my day-to-day role. I had not long went into, well, a senior charge nurse role and this all happened. So I had some plans for other things and I just didn't have the time to do them, so I'm hoping now that things have settled I can get to do my job properly.

Q Other things in terms of improving the ward and developing it----

A Yeah, kind of like team building and then obviously we've got the Schiehallion family day coming up. We've just started some of the parents' groups again. A lot of the things were

paused during COVID as well so, although we moved, then we had COVID as well which stopped things. So hopefully now time to do the things and make the world better for the patients, families and staff.

Q Okay, thank you. Now, the final topic I want to ask you about is communication. Now, we have touched on that through your evidence already to some extent and you have told us about the impacts of this experience. I would be interested in exploring your views on whether communication with staff and with patients and families helped to manage the situation as it was ongoing, and I would be particularly interested in hearing about the communication challenges that you faced during this time. I will just wait until you have got your water. Now, thinking firstly about communication with staff, you indicate in your statement that communication from the health board itself to staff is via a document called the core brief. Is that right?

A Yes.

Q Okay. Could you explain what that is?

A So the core brief is sent out in an email. We are asked, as line managers, if there's any staff that don't

have access to the email, then we could give them a paper copy. If there's anything from the core brief, we would maybe add it to the safety brief. However, not all nursing staff have access to their emails outwith work time. Senior nurses will have access, remote access, so they will receive emails if they're not at work. However, nursing staff would not have remote access and also, when they're in the ward, they're not-- they don't have an office. They're not always at a desk. We would advise staff to check their emails, but patient care comes first so, if they are in with patients, it might be later in the day before they get a chance to settle down and look at their emails.

Q And is there a range of information that can be contained in the core brief? Different types of information?

A Yeah, updates on COVID, immunisations, board-wide issues, positive feedback, if there's been any awards, and I think probably just anything that-- communication for GGC staff that they have to be made aware of.

Q Do you think it is an effective means of communicating information about the hospital building, infections, control measures, that kind

of thing?

A Probably for consultants, doctors and senior nurses, because we would have access to our emails, and also remotely, but not always for maybe ward-level nurses.

Q In your view, is there a better way that might be done?

A Maybe like a text message to personal mobile numbers. Most people have a mobile phone, so maybe a link to-- via text message.

Q Okay, thank you. Now, thinking about communication with patients and families, you have already told us a bit about that, and I think you say in your statement that there were sometimes delays in information being provided to staff to enable them to then communicate with patients and families. Could you tell me a bit more about that sort of challenge?

A Yeah, if we come out of the IMT, the families and staff would be wanting an update. So if there was a delay, I think that would then increase anxiety because we're not saying anything, you're waiting on your official communication, and although I would say that, "We're waiting on official communication," I think then sometimes the delay-- because you're not giving an update, they start worrying. "Oh, is there something else

going on?" But I understand there is a process that the communication team have to make sure that everything goes out as accurate.

Q Okay, and from what you recall, were concerns raised by patients and families about communication?

A Yeah, sometimes, and I would escalate that to lead nurse/chief nurse. The chief nurse and general manager would come up and speak to families if there was any issues.

Q And what type of concerns would they raise?

A Maybe about confusion and worries about infection and those types of things.

Q Okay. So, would you say that sometimes they were looking for a bit more information than they had?

A Yes.

Q Okay. Now, in your statement you also say that communication improved over time as a result of feedback from patients and families. I wonder if you could describe what has changed and how it has improved?

A Well, since we've moved back to 2A, Schiehallion, we've not really had any issues. There is now a closed Facebook group for the families, and if there's any information

it can be shared on the Facebook, but since we've moved back we've not really had to update any of the concerns like we had before.

Q So would you say it is untested at this point?

A Yes.

Q Okay. Now, you say in your statement that you were provided in support in communicating with patients and families from the chief nurse, the general manager and, I think, Dr Inkster, who is a microbiologist, but is it right to say that a lot of the day-to-day communication with patients and families fell to you and to your nursing staff?

A Yes.

Q Okay. Do you think it should be the job of nurses to tell patients and families about potential risks posed by building systems?

A Maybe not to this extent.

Q Do you think there is a better use for your time?

A Yes.

Q And did you feel that sometimes being the messenger for this sort of information caused a strain with the patients and families?

A Yeah because the families would sometimes get upset and I would try and give them reassurance. I think when

Microbiology came to speak, there was one time when we moved over to 6A, there was like a parent meeting and infection control-- not infection control, microbiology consultant. She led that and the families fed back that they found that really beneficial. So that was perhaps something that worked well.

Q Do you think that is because someone with a bit more knowledge about the actual issues was able to speak to them directly----

A Yeah.

Q -- at that point? Okay. Now, just overall, on reflection, do you think there was a clear communication strategy for communicating with patients and families at the beginning of all of this?

A So I would be advised at the IMT to update and myself and Professor Gibson would carry out that role and then, as time went on, there was official communication and documents, and then obviously the chief nurse and general manager would be on site as well. But if a family wanted more information, then I would feed that back to lead nurse/chief nurse, and they would arrange someone else to come down and chat to the families. I know Professor Gibson and consultant

microbiologists spent a lot of time with families as well, updating them.

Q Okay, so there was some support for you, in terms of communicating with the patients and families, if you needed it----

A If I needed it, yeah.

Q -- and if you wanted more information? Okay. Ms Somerville, we are just about to come to the end of your evidence, and I just want to ask you this. Do you have any unanswered questions about what happened during 2018 and 2019?

A I think a lot of it was a hypothesis. There wasn't always confirmation that there was direct links. So, yeah, maybe some questions were never answered, but I'm not sure if there was ever, you know, a black and white answer. So I don't know if these questions could be answered.

Q Have you ever been told whether or not there was in fact a risk posed either by the water, drains, or ventilation?

A Again, I think it was a hypothesis, but we didn't ever know how the infections actually got to the patient.

Q Okay. Do you think it would be helpful for staff and for patients and families to have clarity about these matters?

A Yes, I think it would be helpful.

Q Why do you think it would be helpful in terms of moving forward?

A Because then we could just close that chapter.

Q Now, Ms Somerville, just reflecting on everything that you've said today, are there any other lessons that you think can be learned from all of this?

A I don't know. I think the team went over and above to ensure that patient safety was delivered. I think we'd done everything that we could. I would just hope that nobody else would have to be in this situation that we were in. It was a really difficult time, but we're now coming out the other end and we've got an amazing team who all work well together.

Q Okay, thank you. Now, before we conclude, Ms Somerville, is there anything else that you have not had the opportunity to say that you would like to say today?

A No, I don't think so.

Q Okay. Thank you very much. My Lord, I do not have any further questions for Ms Somerville.

THE CHAIR: Thank you, Ms Arnott. Ms Somerville, what I propose to do is take about 10 or maximum 15

minutes, just to check with the legal representatives that there is nothing that has arisen that they think requires a further question. So, I will ask Ms Browne to take you back to the witness room. I would hope that we can convene again in no more than 15 minutes and either to confirm that your evidence is finished or possibly ask more questions, but we will find out what the situation is in about 15 minutes.

THE WITNESS: Okay. Thank you.

THE CHAIR: Now, maybe you would wish to involve Mr Duncan in any discussion, Ms Arnott. Again, ladies and gentlemen, if there's anything that has arisen which you had not anticipated, if you could first of all draw it to Ms Arnott's or Mr Duncan's attention. As I say, we will rise for, I would hope, no more than 15 minutes.

(Short break)

THE CHAIR: Ms Arnott.

MS ARNOTT: My Lord, there are no further questions for Ms Somerville.

THE CHAIR: No further questions. Could I ask for Ms Somerville to come back? Thank you for waiting, Ms Somerville. There are

no further questions, and you are therefore free to go, but before you do go, can I express my considerable thanks to you, not only for the attendance today, but for all the work that has gone into preparing for your evidence and in particular, preparing your witness statement.

As we are very appreciative, you are a busy person with other things to do, and I appreciate that helping the Inquiry has meant that you have been unable to do things that you would, no doubt, have thought of high priority. So can I thank you, as I say, not only for your attendance today but for all the work that is involved in preparing the statement, but you are now free to go. Thank you very much.

THE WITNESS: Thank you.

(The witness withdrew)

THE CHAIR: We will sit again at two o'clock with----

MS ARNOTT: With Anegla Howat this afternoon, my Lord.

THE CHAIR: -- with Angela Howat.

(Session ends)

12:45