Scottish Hospitals Inquiry
Witness Statement of
Dr Andrew Murray

Witness Details

1. My name is Andrew Murray and I am the executive medical director in NHS Forth Valley. I am also the co-chair of an entity called Managed Service Network for Children and Young People with Cancer (MSN).

Professional Background and Qualifications

2. I have a Batchelor of Medicine and Batchelor of Surgery degree (MBChB) and I am also a Fellow member of the Royal College of Surgeons. I qualified in 1988 and have been a doctor for the last 35 years. I was a Thyroid surgeon in Ayrshire and then moved to take up the post of Medical Director in NHS Borders in 2016 and then in 2017 I moved to take up the same post in to NHS Forth Valley.

3. I have never worked for NHS Greater Glasgow and Clyde (NHS GGC), as a consultant. Around 1990, as part of my training, I did a brief stint of working within the Southern General Hospital in Glasgow), which was the precursor to the QEUH

4. In 2019 I was appointed to the Oversight Board for Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), and NHS Greater Glasgow and Clyde to assist carry out a review to achieve clarification over the prophylactic prescribing decision making in both bacterial and fungal organisms within the QEUH and the RHC in Glasgow.

Oversight Board Appointment

5. In my role in the MSN we get information from across the country on occasional operational issues, but it's more to do with standards of care strategy and other sort of governance information. As part of my MSN role, it was brought to our

attention by some of the clinicians in Edinburgh that there was an issue with the wards 2A and 2B RHC in Glasgow. The Edinburgh hospital was having to accept patients in the very early stages because it was deemed unsafe for them to be treated in Glasgow.

6. This was before patients were decanted from Wards 2A and 2B in the RHC into Ward 6A of the QEUH. When we were made aware that the Edinburgh hospital was treating some patients, we become aware that there was an issue in the Glasgow hospital and we kept a watching brief. the MSN is not responsible for operational delivery, so it was very much for us to be aware and ensure there were safe pathways for the patients and that we could be assured, in a safety oversight role, that the pathway was working.

7. As the months went by NHS GGC explained to the MSN that they were dealing with a bit of an evolving situation; a deteriorating situation in some ways. They were becoming more aware of the scale of the problem, and then the issues were in the media and it became of much more public interest. Again, the MSN role was to be aware of it but we did not have any instrumental role in any decision making. NHS GGC had responsibility to manage the issues from a legislative and statutory perspective.

8. Then the Oversight Board was established by the Scottish Ministers, but I can't remember the exact dates when.

9. My nurse director in Forth Valley, Angela Wallace, was being asked to support Glasgow as an external expert in infection control. Angela was telling me everything that was happening and I am sure she would have told me there was an Oversight Board.

10. At that time Fiona McQueen was the Chief Nursing Officer. I knew Fiona McQueen from Ayrshire, she'd been the Director of Nursing there when I was Associate Medical Director. I don't think they knew we existed as an MSN. I

knew I could approach Fiona without it being seen to be anything other than a genuine attempt to help. I felt I needed to make sure that people knew that the MSN was there, and that we were taking an interest as well.

11. I got in touch with Fiona McQueen to say, “Just so you are aware Fiona, we are here. You know we are here, we’ve got clinical experts that work to the MSN. We’ve got people who may be able to contribute to the Oversight Board because they’ve got that objective expertise.”

12. She took me up on the offer and then that really then became an invite for me, from the Oversight Board to say “Oh right okay, Actually, there’s something you could do”. I was commissioned to undertake some work for the Oversight Board.

Overview of Oversight Board tasks

13. Being a Medical Director means that you’ve got the ability to go into other Health Boards and, carry out diagnostic works, inspections and those kinds of things if called upon. I was asked to take on a similar piece of work for the Oversight Board.

14. I was asked, “Could I find out a bit more about prophylaxis: antibiotic and fungal prophylaxis”? I wondered what was going on. Given all the media attention, it was difficult for everybody involved when it becomes such a hot topic. We also understood that there were families impacted. NHS GGS had been escalated to Level 4 in the Board Performance Framework. The escalation wasn’t just for infection control. I think that it was also for person centred care.

15. Therefore given the Board had been escalated, and families going to the media and making complaints, it was becoming apparent that the doctors were not all doing the same thing in terms of prophylaxis.

16. This was despite all the work that had gone in at this point, to making sure the water in the hospital was all cleansed. Tom Steele used to tell me that the

water in the taps was cleaner than the bottled water you buy in the supermarket. The fact was the water that was coming through the taps was cleaned, and yet the doctors were prescribing antibiotics, and this appeared to be unsettling some patients. They were saying, "Oh no, we're not sure about the water. We need to give you some antibiotics as well".

Oversight Board: Role and the Terms of my Remit

17. The Oversight Board had already been set up by the time I joined and the terms of reference identified. To the best of my ability, I would have seen, and read, the terms of reference and gone "Oh, it's fine".

18. It was to provide structures to performance-manage the improvements that are expected in this. It was very much aligned to that, and as I said, the areas that NHS GGC were escalated on, was mainly person centredness and Infection Control, which is an unusual group. I think there was also maybe stuff about leadership, but I didn't feel I needed a lot of detail around those more organisational issues, given that I was tasked with a very specific commission.

19. The official discussion was around the looking into the issue about the prescription of prophylaxis and was it being done consistently. I was trying to unpick that. My parameters were narrow. I was to achieve clarification over the prophylactic prescribing decision making in both bacterial and fungal organisms within the hospital. I was to look at this information and then it was come up with a view; it was really about clinical decision making rather than any other implication. The inference – and I brought that out in the SBAR with the recommendations – was that there was more and more unhappy patients and families because of the clinician concern being communicated to them. So, "You need more antibiotics. Oh, you need some of these." I think that was then appearing through whatever routes, and that was causing concern to the Oversight Board, and could I redress that to be able to help reassure those families. Could I reassure the clinicians, and that reassures the families.

20. I did not speak to patients and/or carers, and their families during my time with the board and any reassurance to them would be in my final recommendations.

21. Any clinical reassurance would not be directly down to me and would have been done within any recommendations and then it would have been for others and the operational leads to deliver.

22. I didn't specifically question the remit of the Oversight Board into the use of prophylaxis within the QEUH . As far as I could see, they had a remit to go wherever they wanted. That wouldn't have been encapsulated in the terms of reference, but it's difficult in that situation as the health board to reject specific questions. I mean, they did, they were escalated on Infection Control, so it's aligned to that. I don't think there's any doubt that the Oversight Board had a remit to ask me to do the thing they asked.

23. I was verbally asked to go and gather information around its current use and assess and make recommendations about its future use. I didn't look at individual prescribing records, I didn't look at individual patient records and I didn't go down to the individual clinician level. This was at the senior clinician level, and at the governance processes, so I was given probably limited information in that regard but, yes, that's fundamentally what it came down to. It came down to not building an evidence base for why things needed to be different, but simply going back to what had been agreed before and reminding people that that's what we were expecting to happen. They could have come back and asked me to do a bit more work on that but they seemed to be happy enough with the high level assessment I provided in the SBAR.

24. It was a given that the prescription of prophylaxis was above the norm, and it was freely expressed by the senior clinicians that it was above the norm, and it was above the norm because of the concerns about the water in the hospital. The time I came in was when the water had been improved, and environmental screening had been shown that it was a safe area, and it was at that point that

they were still seeing the discrepancies with prophylactic prescribing. It wasn't to do with anything up to that point, with the rate of it or whether it was justified or not. Things had changed and we wanted to stop, essentially, inappropriate prophylactic prescribing.

Approach to the Review

25. Following my appointment I spoke to Jennifer Armstrong, the Medical Director in Glasgow to say "Jennifer, bear with me. I didn't expect this but I am going to be coming into your area. There have been questions posed so I'm going to be having a look at the issue." She replied that was fine. We set up a time, and she put me in touch with her Deputy Medical Director, Scott Davidson. This was the first time I had met Scott. He and I had a conversation, so that I could understand what the issues within the hospital were from the clinical perspective.

26. We then set up a time for me to attend at the hospital to meet staff. I'm sure I was provided with some information. It might have been governance group minutes. Certainly I was provided with statements to what their journey had been like up to that point, and how the ward changes had taken place. Then I was given information about what was happening with the water and the safety of the water. This included information about all the devices that they had installed into their system, and therefore why they were confident in the safety of the water.

27. Scott also helped me understand the clinical context. By that I mean medicine can be very tribal; different specialties, different views on things, the same thing. He explained the infection control position. He explained the microbiology position: microbiology and infection control are different specialties. There was also infectious disease. There were the different players within those clinicians involved, and I was informed that there had been some tensions within those different clinical perspectives. I was also made aware

there was whistleblowing going on from within that group. That meant there might be different agendas ,and a group of people expressing different views.

28. However, despite that Scott was able to tell me that there had been consensus. I don't know if it was unanimity, but there was certainly consensus in the October 2019 prior to that December 2019 amongst these key players that the water purity within the hospital was absolutely what it needed to be; and it was safe.

29. It was important for me to know that that was something that had been established, but maybe hadn't been totally understood by everybody. Maybe I was becoming involved at a time when some communication was required.

30. I was dealing with, information from the senior team about concerns about practices. They said that may have been the follow-up work, to look at actual numbers and activity there. Actually, it was more about reminding everybody that we'd all agreed we weren't going to do this, and that was the message. The purpose of the SBAR, was to help move things on.

31. I think that what was driving the concerns that practice was inappropriate; there was widespread prophylaxis prescribing and we didn't need to do that anymore. This was the agreement: the reminder was that the environment was safe, but that was exactly what was driving it, was the comments from the clinical teams I spoke to. It was their concern about the safety of the environment.

32. My tasks wasn't so much about trying to identify individuals in the practice. It was about reminding everybody about practices: it's the first step really in addressing the issue. There might have been a need to identify individuals if there had continued to be concerns around prescribing practice.

Antibiotics, Antifungals and Antiseptics

33. Antibiotics short-term are great, but long- term will start to produce some potential issues. The usual problems with long-term use of antibiotics is that

bugs will grow which then are immune to that antibiotic and they'll start to cause disease which then don't respond to antibiotics. That's one of our concerns around those sorts of antibiotics, and also that can lead to fungal infections if you're using broad spectrum antibiotics on a long-term basis. There are definitely potential downsides. In my specialty, the ENT surgery, we use long-term ciprofloxacin for chronic sinusitis. I do have some experience of the pros and cons of it. I think in a group of patients there is a need for it to be individually risk assessed. There will be times when actually long-term antibiotic use is the best option for that individual, especially when they're going through a prolonged course of treatment, such as somebody that's getting chemotherapy.

34. Regarding the advantages, when you get in infection you're vulnerable to sepsis in that setting. The haemato-oncologist wouldn't do it just because of the media coverage, making patients anxious for their own personal reputations. They see how quickly some of these kids can deteriorate and die with sepsis, so they were absolutely well-intentioned with it: all we were really doing was asking them to make the decision on an individual basis to be able to justify it – but, yes, there are potentially side effects, long-term side effects. I've got a bit of knowledge of that from my own clinical background and in broad terms that's what happens when you use antibiotics long-term. All we wanted to do was make sure the clinicians were applying that thinking on an individual risk -based assessment. I think I've got enough clinical knowledge that I would have known what that was, and that we couldn't universally give prophylactic antibiotics. We would then tip the risk-benefit balance there. Where we ended up with those discussions it felt like it was a reasonable place.

35. I had enough clinical knowledge to know what that was likely to be, and that if we used them in every patient every time, we would start to run out of those. I knew that as a principle of good infection control was not something that we could support. We needed to move to the individual risk assessment.

36. I was provided with the prescription policy for antifungal prescribing, it may have been bundled up in an overarching policy about antisepsis measures – I cannot recall. I definitely saw something that was about how they would usually use antifungals, therefore I was able to then make that assessment that what was going on from the way people describing things was compatible with that. But I don't remember, and it was in discussions as well with some of the senior clinicians getting an understanding about their policies. So, yes, definitely that was a reference point.

37. It wasn't about identifying maverick prescribers. It wasn't about that. It was about trying to see it as an improvement opportunity and remind everybody to take them, hopefully refine their practice and be consistent. Although there was different people doing different things likely, I don't believe there was anybody that was doing anything that was way out of acceptable clinical practice, but it just needed to be modified for the benefits of a specific patient group.

38. I was going to look at prophylactic antibiotics and antifungals and use of antibiotics. Prior to visiting the hospital I was given some information around TauroLock, the antiseptic, just so that I could be assured that it was an appropriate area for them to be looking at, so I did that. The prophylactic antibiotics was a very common antibiotics that was used so there is not really any doubt about its application as a prophylactic antibiotic in a specific sense. The antifungals are very much matched to the organism, so, again, there wasn't any concerns around that. There wasn't any need for me, with this sort of review, for me to start to look at specifics of the antibiotics; it wouldn't have been appropriate. But I was provided with some details about TauroLock so that I could make sure that that was felt to be a reasonable step for them to be taking.

Build Quality at the QEUH

39. I had no inside track on that. I was as much a spectator as anyone. I heard the rumours that went around, and it started off a way back at the MSN, when the

Edinburgh clinicians were saying, “We're having to take patients from Glasgow” and you ask, “Well, why's that?” They say, “Oh, well” and then they're talking to their colleagues in Glasgow and they're getting their version of it. There had been the pigeon thing as well already, so it felt like everybody was in a heightened state of looking for a problem. Then, through that clinical network these guys were saying that they believe there is something wrong in the building; they're getting some funny swabs back, and they feel there might be some issues for the patients. And then people comment that it's built next to a sewage works, which is the conspiracy theories amongst them. When the whistleblowing started I understand that it was very much focused around the build.

40. I think it goes back to the conversations with Scott Davidson, where he was helping me understand the governance processes, the information that was available. I'm sure we exchanged some documents in the run-up to my attendance at the hospital so that I could build up a picture in my own mind of that,. The information I've quoted in the SBAR: -- they had met, there was a consensus about it, so yes. It was important. I just couldn't have made an assessment without getting some of that context.

Conducting the Review

41. We agreed that I was going to do it: I was on site for a day, met with various people and then I produced a report for the Oversight Board. Returning to the commission: I understood that the consultants were unsettling the patients and their families with the prescription of prophylaxis medication. These particular group of patients had cancer and they often have got pieces of plastic placed in them in order to receive medicine. The presence of the pieces of plastic in their bodies which means that they are vulnerable to infection, both because they've got cancer in the first place, but then also because they're getting these really toxic drugs which wipe out the immune system - they are prone to infection. In addition to that they've got a bit of plastic in their bodies that breaches all their natural defences. For all these reasons they are extremely vulnerable, and the

clinicians are used to risk-assessing that and making decisions around prophylaxis.: for example, “Does this person need to be on antibiotics to help support their immune system and reduce their vulnerability?”

42. Concerns were being raised because these central lines are flushed, and they also come into contact with the environment. Staff were cleaning the central lines with sterile water, but there was still enough concern from the clinicians, that simply being close to the taps, and being in the vicinity was potentially enough for these vulnerable people to develop infections.

43. I understood that view had been challenged and the consensus had been that that wasn't the case a couple of months earlier; but what tends to happen is doctors do not make good employees. They don’t understand they’re employees. They think, “Oh, that’s fine for you over there, and the rules and policy, and all that, but I’m still not happy, so-- and I’m going to look after my patients. I want to do the right thing by them.”

Visit to the Hospital

44. When I visited the hospital, I spoke with Scott Davidson, deputy medical director, Alan Mathers, chief of medicine on the Royal Hospital for Children site. Dermot Murphy, haemato-oncologist. Then there was about three other people. I spoke to somebody from infection control, and I spoke to another haemato-oncologist, I’m pretty sure one of them is a microbiologist, but I haven't retained their names, I'm afraid. They were chosen because they could confirm the status of the water, status of the environment; they could confirm that everybody had agreed and explain to me what the circumstances of that agreement were. They could also explain to me what the governance setup was. So, “This is how we’re monitoring this on an ongoing basis, and this is how we could monitor it if we are asking people to prescribe differently, this is the process that we could put in place,” and they would be able to deliver that. I was going through all that with them so that I could build up a view of -- because it's easy to be told, “It'll all be fine” or, “We'll make this change and it'll

all be good." I needed to hear how that's going to be sustained so that I can give some assurance to the Oversight Board. I was meeting key individuals at a senior enough level who could look me in the eye and guarantee, that whatever came out of this would be implemented and it would achieve that sustainability in a change of practice.

45. During conversations with professionals, who are being open and transparent with me, they are showing me information to confirm what it is they're saying. I've got no reason to doubt the veracity of our conversation, so I assess it because that's the professional world that we inhabit and when we're doing this kind of review, obviously we've got a sense of whether there's any gaps in the information that I'm being told. I explored that at the time and make sure that I've got those gaps filled with explanations as to so, for instance, "What would be the process hereafter? Did you guys actually come in contact? Did you just tell me something that's theoretical?" "Oh no, right." "Okay. So that is a potential way that we're going to be able to do that." So I assess it through just, you know, your professionalism and ability to test out what you've been told at the time and do it collaboratively. I don't do any of these things thinking I need to find a way to catch people out or double check what they're saying necessarily.

46. During my visit I got a sense that that was probably something that was playing out there. The doctors were well-intentioned, but were prepared to give prophylaxis antibiotics over and above what they've agreed initially, which is, "We all agree it's safe. The environment is safe. Yes, we're all agreed, but I'll just go and give antibiotics anyway."

47. In relation to prophylactic antibiotics, I mentioned that I know a bit about it because from a surgical background. Before you carry out a procedure you weigh up the evidence for prophylactic antibiotics. Our guidance for most conditions will have a section which sets out surgical conditions. For example if you're getting this type of operation, is there a role for prophylactic antibiotics? Yes/no? Therefore use and application of prophylaxis is something that I'm

familiar with. I also know that it needs to be evidence-based. It can't just be a comfort blanket. You can't hand them out like sweets. It’s got to be evidence-based and it was being used in a non-evidence-based way because of anxiety about the environment; but they'd all agreed the environment was safe.

48. Therefore, nobody should have been getting prophylactic antibiotics, but they were, and the patients were getting unsettled. That is not just a statement, that was my conclusion: we needed to reaffirm that everybody agreed the environment was safe, and therefore proper antibiotics should only be used in a very individualised, risk-based way. Sometimes there will still be times when there's enough clinical concern that prescription is justified, and there's an evidence-base to support that, but it shouldn't be used on a population basis where everybody was getting prophylaxis..

49. I also looked a fungal prophylaxis. There was also the other matter of real interest in respect of fungal infections. There had been the matter of an infection being possible related to pigeons. Everybody was on high alert, and a few of these unusual organisms were fungus. Speaking to within the hospital people though, it was clear that prophylactic fungicides were not being used to the same extent. They were being used based on the evidence base, or there was a swab, or there was something really to trigger that intervention. Therefore I couldn't see any evidence that that prophylactic fungicides was being used inappropriately, and so that was just a case of re-stating: stick to the evidence base: the practice of appropriate prophylactic for fungus seems appropriate in the circumstances.

50. I also looked a third thing: antiseptic. There's antibiotics and antifungals which work to target very specific species, and there's antiseptics like Dettol. If you splash it everywhere, it'll kill everything. In some ways it's safer because it doesn't lead to selective strains emerging. The hospital staff were looking at antiseptic use. Related to that they were looking at use of plastic device, there an antiseptic-covered central line called TauroLock, They were looking at that

as another way to try and minimise any infections. I would describe this third aspect as a compromise – what do I mean by that? We're saying, “The environment's safe, so why do you need to do anything else?” The way they explained it to me by the hospital staff was, “Absolutely, it is safe, but what we would normally do is, we would look at anything that's emergent best practice that might actually help, not prophylactic antibiotics, but something in the processes that might help eliminate more of these infections.”

51. I thought they made a reasonable case. They were doing it under a quality improvement approach, which means that you don't assume it's going to work. You try it, you see that it might be 10 times more expensive. If it doesn't seem to do anything. You bin it. Therefore here was a kind of agreement that that was how they were looking at that. That step for the clinicians was felt to be helpful because it gave them something else that they might give them that extra effectiveness with their clinical treatments. After I spoke with everybody and checked out a few of these theories, it was dead straightforward to produce what we call the SBAR. The SBAR is the communication tool that a record what was found

52. Information was gathered via the conversations with Scott Davidson, conversations with Fiona McQueen, the support for the Oversight Board and, I believe that there were documents that Scott provided for me. When I turned up on the day at the hospital, I was able to meet with the senior teams who were able to share some further information with me, again in their sort of preparatory meetings before I then went on to speak to other people.

53. I think understanding and defining the terms of reference and the scope of it, making sure that that was manageable and then being linked into a range of clinical experts who could provide me with answers to the questions that for me came out of the question that I was being posed. “This is what I need to know to be able to form a view on it,” and just building up that picture. This was at a reasonably high level and to be provided with what I felt was enough certainty and clarity that I could then reach that assessment.

54. I visited some parts of the hospital but I understood that the concern probably wasn't a physical location. This group of patients were in ward 6A QEUH as that's where all the patients were that had been decanted. I think at times they might have had to use other spaces as well – during my visit I was following the patients in the practice rather than the physical location. Obviously, the physical location was important because it was getting environmentally tested, but I wasn't told, “6A, stick to 6A.” It was more about the issue rather than the location.

55. I've got a vague notion that there was some comment that, people were starting to talk a lot about 2A and 2B which has been refit, or refitted or refurbed, and the standards that were going to be adhered to in there, and there was just discussions around how that would be ensured and how they would know that's going to happen, but there was no other hotspots, for want of a better expression, that were being signalled to me for any other concerns.

56. It was from that initial information that Scott and I had shared, and then on the day, that was confirmed by, either an Infection Control person or an infectious diseases person. Again, we got their professional opinion that that was the situation, and I also had heard informally in conversations the director of Estates that the water coming out of the taps was proving to be cleaner than the bottled water in the supermarket. Again, that's the professional opinion that I was getting. I wasn't asking to see, or for any evidence. I wouldn't be the right person to interpret detailed sampling information. I went with the professional opinion of those who had reviewed it. There had been a consensus conclusion regarding the cleanliness of the environment.

57. Given it was such a high-level piece of, and discreet, bit of work, I didn't feel it needed that level of, “integrity” around it. This was such a short, high level, “Can you go and answer this question?” piece of work, and then we'll see where we go after that. It didn't need the level of preparation or rigour that a more detailed or a more concerning picture might have merited.

SBAR: Findings and Oversight Board report – December 2019

58. I recorded my findings in an SBAR SBAR **(A42208416 – SBAR Review of prescribing in Haemato-oncology patients – Royal Hospital for Children (RHC) Glasgow – 12 December 2019, Bundle 6, page 10).**

59. After sense-checking it with a few people, submitted the SBAR to the Oversight Board who considered the contents at a meeting on 16 December 2019. At that point I had been co-opted onto a little bit more fully. The issue with the he discussion of the SBAR at the Oversight Board was that the timing of it was a direct clash with one of my NHS Forth Valley Board commitments. Therefore when the Oversight Board discussed the SBAR I wasn't in the meeting and I kept saying, “Do you want me there, because I can’t be there at this time? Please could you change the time?” The time was not changed and I did not attend the meeting where the SBAR was discussed.

60. Any views would have been collated verbally and any personal reports would have been compiled and submitted by me.

61. My findings from the review were that there was agreement that the environment in the water was of very high standards – was very clean, was very safe, and that that had been signed off by all relevant clinicians in the October of 2019. That was confirmed by the senior clinicians who said, “Yes, that’s exactly what’s happening.” It was confirmed that there was anecdotal reports of people not adhering to what had been agreed in that meeting, which was the restriction of prophylactic prescribing, and that it was, that would be agreed by the clinicians, including myself, that that was not a situation that we would want to continue because it was creating concern amongst the patients and the families: “Why am I getting antibiotics if it's all safe?” It was accepted there was a need for us to go back to the clinical community and restate that the environment was safe and that therefore prophylactic prescribing should only be done in the context of an individual risk assessment.

62. The work on antifungals appeared to be justified, and by that I mean the prescribing patterns that people were able to tell me there was nothing there that there was a concern, and that it was important to me that we built in a mechanism that if we make recommendations that those would be enacted and implemented. I got assurance by talking through the meetings and the governance processes that if we make that change that it's not just going to be an email goes out that says, “Don't do this,” but actually there's a way that we can have that very continuous attention on it until we're sure that they did the right thing. So that was how I went about it and that's the findings that were reported back to the Oversight Board on the 11 December 2019.

63. There was a small change made, by the Oversight Board, to one of the recommendations which I did not see as anything material. At their meeting on the 13 December 2019 my finding were considered

i. “The chairs introduced Dr Andrew Murray's SBAR on prescribing to haemato-oncology patients in the Royal Hospital for Children and asked for comment. CW Craig White suggested it’d be useful to get a steer on whether in light of environmental concerns recommendations around what to provide to patient families were implemented.”

64. I made some recommendations around what I think should be said to patient families.

ii. “AT felt it would be helpful to consider governance in more detail around decision-making in the audit trail with a more overt consideration of role of pharmacists prescribing. AM suggested that further assurance is required as to whether good practice is being implemented and evidence through patient records. [That's, I guess what, I was getting at through the governance processes.] The SBAR was accepted by the Oversight Board as agreed actions be remitted to

the communication and engagement subgroup and infection prevention control and governance subgroups."

The document I am referring to is (**A34120071 - QUEH Oversight Board - meeting 3 - 16 December 2019 – minute, Bundle 6, page 13**)

65. The recommendations were sent on to those subgroups, and at that point that was the action and at that point that was the bit of work concluded, really. I got nothing else. No other asks coming back.

66. Although I was not involved in any other communications or reporting with the Oversight Board regarding my findings I did join subsequent meetings and participated in the discussions around the sort of wider escalation issues. Professor Craig White wanted to take those recommendations for patient and families into the sub group for patients and families.

SBAR Findings: further comments

67. I have been provided with a copy of the SBAR **(A42208416 – SBAR Review of prescribing in Haemato-oncology patients – Royal Hospital for Children (RHC) Glasgow – 12 December 2019, Bundle 6, page 10)**. The lack of clarity for patients and families was coming because the clinicians. Families talk all the time, understandably, especially when their children get the same conditions. They come quite bound together in those journeys and I guess they'll be comparing what treatments they're getting and having those kinds of conversations; I think information sharing was through that. Whether that was getting out into the media, I don't remember, whether it was complaints or challenges from patients saying, "Why are they getting antibiotics? Why am I not getting antibiotics?" That was starting to happen and that was where the uncertainty was because of the inconsistent prescribing by the consultants.

68. I was being told by senior clinicians, I'd been told by Fiona McQueen at the Oversight Board that these were the concerns. I didn't look for complaints, I didn't necessarily look for it in the media and I wasn't going to go around to patients in a unit and asking, "Are you getting antibiotics or anything like that?" I was more focussed on the reports. The uncertainty for patients is really important, but it's almost secondary to the fact that consultants are doing things differently. It was the clinical practice that I was being asked to look at. The uncertainty I could fully understand; I think it's very plausible. I didn't feel the need to double-check it, and that's what happens when patients have a different experience under different consultants and compare notes: it creates that uncertainty, that's human nature. I was really being asked to look at the inconsistency of the prescribing that was driving the concern.

69. There were views regarding uncertainty. I think that we explored the fact that it was felt that clinicians were probably not doing what they'd all agreed to do. I'm sure that was touched on in the Oversight Board, but that goes back to the fact that most of this was conversations with people out with that room asking me if I would do that.

70. I think there was concerns that there was inconsistent practice. If I've said, you know, "There are clear concerns," I can't find it, but what I'm happy to stand by is that concerns were expressed that there was inconsistency about prescribing.

71. In this SBAR, I don't state, "There are clear concerns." As I said, what I can stand by is that concerns were raised, which initiated the commission, around the inconsistency of prescribing, and then from a clinical perspective, there are concerns if you do that what that might mean for long-term complications, etc. I think the use of the word "concerns" there is maybe being slightly overemphasised.

72. In the SBAR I talk about infection control experts and infectious diseases experts, but I don't mention pharmacists. Although I am aware of them possibly being there I am unaware of any concerns raised by them.

73. Alan Mathers is an obstetrician/gynaecologist who manages paediatricians. He gave a clear view from senior management and also the paediatrician perspective on this, and it was just restating, what I said. These are a very specific group of patients who are managed by super specialists, so paediatricians in general, their view would probably not be as relevant as the super specialists and the infectious control specialists. But Alan's view was, he was in the mix and he was explaining what he saw, - I don't remember him having any kind of different views to what we should be doing.

74. The confirmation was consensus from the people I spoke to and had actually arisen in a clinical meeting. My recollection was it was explained to me that infection control and infectious disease experts had looked at the environmental screening and had been able to explain everything to the haemato-oncologists, and everybody had agreed that the environment was safe and that they could stop using the prophylactic antibiotics. I took that at face value. If you want to design an in-depth investigation to test every word that's on the page, then you would go round all the clinicians afterwards and give them an anonymous survey or something to say, "Are you actually reassured?" The reality of clinical practice is if people are in a room and are saying, "Yes, no, we're fine with that," and they go out with the room, we're always aware that, maybe not everybody's completely on the page.

75. There was also comments made about, because childhood cancer is actually not one cancer. It's a hundred different cancers, so there's actually different levels of clinical decision-making that had to be worked through. The phrase that we used in the SBAR is "heterogeneity," so there's so much difference in there that it can take a wee bit of time before everybody applies the standards the same way, which gives people a bit of an allowance for that. From what I was being told, as I said, going back to that professional approach, high-level

approach to this question, there was consensus declared. Whether or not it was then everybody immediately doing what we thought they were going to do or that was thought by the management team, clearly that wasn't the case and this was the way to try and address that as a kind of intervention rather than necessarily investigation: but it was maybe more of an intervention than an investigation.

76. As part of verbal discussions with senior clinicians and senior managers, I was told they're reassured. I did nothing to then go and check that they were all reassured because my role was to ask everybody to remember what they'd agreed to, come back into line because it was unsettling the patients and their families.

77. At these meetings it was also agreed that antisepsis TauroLock commercial flush solution against Gram-negative infection in central venous catheter patients should be looked at and instituted, as it was felt to be best practice as an adjunct to current practice. I was reminded of and made aware again of the susceptibility of this group of patients to rapid sepsis. Because of these discussions and the initiatives that we were looking at, the teams felt they were aware that they shouldn't initiate any new changes in practice until that had been more widely discussed because of these sensitivities around prophylaxis, etc. They took the opportunity of explaining that there was a development that they had become aware of, I think that was being used in other centres in the UK, possibly Great Ormond Street, but they indicated that they wished to look at that as another way to minimise sepsis in this group of patients, and they have a good track record of quality improvement work as part of clinical practice, but they talked a lot about their experience in that. It seemed an obvious thing to encourage them to do that, but not in an ad hoc way, not in a way that would cause any difficulties or raise concerns in the way that the prophylactic antibiotic prescribing had, therefore they had to adopt a proper quality improvement approach to it, which means you test it, you see if it works:, you bin it if it doesn't work. It seemed like a legitimate area of inquiry

for them and something that could improve clinical practice. It was part of the discussions that this might be something that they could also look at and I was keen to support that and encourage that as best I could.

78. I noted that antifungal treatment is given according to prescribing protocols and which has a clear clinical criteria and evidence base for their use. This would have likely been after a positive swab result for that organism or a clear evidence base that this fungal organism is always associated with this condition. It would most likely have been that there is a confirmatory swab which says “This is what’s grown”

79. Through discussions with Alan Mathers, who was the chief of medicine in the paediatric hospital within that wider group, they were able to demonstrate the culture of engagement. They were able to explain to me how they had previously gone about improvements in clinical practice. The hospital are a kind of academic tertiary centre, and they pride themselves on those. They are a high-performing group who have produced an incredible amount of publications and research that produces improvements and standards. I can't remember the specifics that we spoke about, but Scott Davidson was able to articulate some of those improvements and the operational managers definitely impressed on me that. I don't think it would be too difficult for anybody now retrospectively to go back and actually look at the sorts of outputs from that/those departments.

80. Prior to me asking questions, there wasn't a policy which said because this is going on in an environment that we should be prescribing. It had been done in an ad hoc way. It had been done in a kind of belt and braces, safety net approach by the clinicians. There hadn't been a policy to say, “We now need to do this.”

81. In fact, I was met with, I would say consensus again from the people I was speaking with. I would often expect to find this in an area like which is under a

lot of scrutiny that there would have been differences of opinion, strong differences of opinion, and actually people representing that. I think that's why I was asked to go in, because I can usually bring that out of people in conversations. Senior clinicians caught in the eye of the storm were also agreeing as much regarding small things that there was any disparity on. It was like the TauroLock thing, “Should we, shouldn't we?” I said, “Well, you know, you could try it. You can see how you get on.” So it was those kind of things rather than it being any of the fundamental principles.

82. As far as I can tell, it achieved what it was asked to achieve, which was not to be too ambitious with this. It was just to walk the walk as a senior doctor and say, “Guys, remember that thing we all agreed to do? Can we just do that, please?” As we're talking about it, I'm seeing it now almost more as an intervention than an investigation *per se*, and it was to try and bring people back on board, and as far as I know, it had that desired effect and it had the actions which were then taken into the subgroups, which is what I was hoping for.

Oversight Board Meetings

83. In the end I probably only attended maybe three Oversight Board meetings, and it was just around that time because it seemed to go in a very different way. I think the work carried out was a discrete bit of work at the front end of all of this, and it was probably the Oversight Board testing out, and it was a bit of engagement. It was a question the Oversight Board wanted answered, but it rapidly seemed to become a lot more about the person-centredness and infection control stuff. It was cases, not reviews. Eventually, the person who provide administrative support to the Oversight Board and I between us we agreed that when the meeting would on if I can go, that's fine. I was there at the beginning but not for the majority of meetings.

84. My involvement with the Oversight Board tapered off when I was only able to make some of the meetings and not them all, because of scheduling on a

Friday afternoon. I thought it was important to keep on top of the conversations, they developed each time, and coming into it fresh meant you were at a real disadvantage. My involvement petered out and then I had to call it and say “Look, I don’t think I’m going to be able to make it anymore”.

Recommendations

85. I was asked for my professional opinion as co-chair of the MSN and as a medical director. Apart from drafting and checking out with the person who was going to do all the implementing, which would have been Scott Davidson, there was no other process there. It was very much a sort of privileged position, you can say, my personal opinion on this.

86. I wrote the recommendations, but I could never have come up with anything that looked reasonable without having discussed that with the relevant people; so everybody in some way contributed to it. I made the final decision what I thought was important from that and distilled it down in the recommendations.

87. It has been actioned in that, the Oversight Board put the SBAR recommendations to the correct subgroups. After that, there's no line of sight. I don't know what happened after that.

88. I am unaware of whether the Haemato-oncology clinicians have met regularly with Infectious diseases and Infection control colleagues to review any recommendations relating to the prescribing of antibiotics and antifungals, nor any review regarding any adverse events through the prescribing either in their regular weekly departmental meetings or any separate governance groups? . I am not there to assure, I’m not there to see that all the way through. That’s the local governance processes. I would be, I know NHS GGC has got a robust adverse events reporting process. I am very confident those sorts of incidents are getting picked up through that, but I don’t review that information.

89. As for the development of a protocol for the use of TauroLock that again would be down to the local governance process.

90. My recommendation ultimately was that they just needed to tighten up some of their governance processes around decision-making with antibiotics, but I restated really clearly that everybody was in agreement. I think that was important. I think that's what they wanted, the Oversight Board wanted everybody to be reminded and reaffirm their agreement that that was where we were. Then a few things, I thought it was important that we had some recommendations for the families, just so that they got that level of reassurance as well.

91. I didn't know the clinical staffs views on prophylaxis, I didn't know a lot of what their experience had been like and what their views were of some of the big issues, but I was aware. Through the MSN, we had a national clinical director, Professor Wallace in Edinburgh, who had been liaising with the clinicians in Glasgow and was able to keep us abreast of how things were in an informal way, but through the MSN. We were aware about their concerns, for instance, I talked to them about the sewage works and some of the things that they were seeing, and the fact that they had had to move locations and that they had their own concerns about the environmental safety. That sort of information was coming to the MSN, so I knew about that, but not the detail about what they believed about prophylaxis and those kind of more nuanced ones.

92. I did not test this agreement during this. Apart from speaking to senior clinicians, speaking to people who are not shy at saying, “No, actually, I would have done this instead” and that's a pile of rubbish.” I was confident in my reading of people and just the fact that I've been doing this for a long time, and my experience was telling me that I was in a group of people who had reached a consensus on that, and at that point I didn't see any need to question that. That might have arisen, if there had been any further issues that had fallen out of the fact-finding process or subsequently from the Oversight Board. There

might have been other areas that needed to be looked at and more rigorous questioning, really, of what I was being presented with but, at this stage, I didn't need to do that.

93. There wasn't really any dissent on that, the people I was speaking to about what the proposal was. The reality was, of course, that people were prescribing things a bit differently, so there clearly was still undercurrents of uncertainty, which is the word that I used, and that was explained to me. It is not necessarily that people have got different thresholds, risk thresholds. There'll be a bit of that, but also the heterogeneity of the patients meant that there was enough: you could give latitude to people that were doing things slightly different for a period of time.

94. I think what was described to me was more what I've explained to you, which is how it came to light. It wasn't that people were being informed or there was a consultant saying things like, “Well, I morally object to, I don't believe you're safe in this environment and I'm going to prescribe this prophylactically to you,” and there was no policy there. There was individual practice, which was at variance and, you know, patients and families do talk to each other. I think that's what was causing the slight unhappiness amongst those service users, that they could see the doctors doing things a bit differently, and that's an unsettling place to be. It wasn't that there was a policy and that they were informed to say, “We’re doing this.” That's not what I was led to believe.

95. Whilst there wasn't a policy, it wasn’t being the families weren't being informed through that. That wasn't how they were getting their information. I think there was a whole other arm of this with a patient and person-centred approach to it that was all about communication with families. I think whatever issues were arising that maybe were playing out a wee bit in this example actually were picked up as part of that much wider group. There will be a lot more informed opinion about the whole interactions with patients through that Oversight Board workstream.

96. I always go in with a view that I know exactly what it is that needs to happen here and it's just going to happen, and then you spend half an hour with people and you go, "All right, okay, it's a bit more complicated," and, "Right, this is actually very different," and you build up that much bigger picture of it all. There were things that as a medical doctor, you start to think, "Okay, is there a conduct issue here?". For example, somebody actually veering way off -piste, but when you feel that, when you hear the consensus and everybody's saying, you know, "We're working this through. Yes, we accept we're not in the right place yet. We have all agreed it, absolutely, and there's an opportunity for us to restate that to everybody and we want to take the opportunity," When you hear that consistency and you also hear some of the caveats around the different patient groups, etc. then it starts to become apparent that there's a reasonable way through all of this which will take everybody with us. It wasn't factual as in, "Oh, you've been lying to me." It was nothing with that. It was just me going in with my preconceptions.

Case Note Review Action Plan

97. In terms of the Case Note Review Action Plan, I definitely remember one which came to the MSN and Scott Davidson, and I connected my national clinical director with Scott Davidson and they were going to do the review. The unfortunate thing was the national clinical director, that was just coming out of the pandemic as well, resigned and took a grievance against everybody, so I don't know that that work was ever concluded.

98. In the situation of executive lead, I wasn't even asked. They just put your name against an action "You can do this." That's how that came about. It's possible that maybe somebody said to me, "Would the MSN have a view on this?", and I thought, "Sure," but it wasn't. Scott maybe emailed to say, "Would it be okay if we did this bit of work together?", but it really just comes back to the fact I'm in a pre-existing role as chair of the MSN, I think. And the fact that I

had been around and about the Oversight Board a wee bit and they were thinking, “How can we align this action?”.

99. I connected the teams who were looking for the support and the national clinical director, who works to me in the MSN. I can comment that the recommendations / actions remain incomplete.

100. The subgroup papers started to get tabled at the Oversight Board, if I remember rightly and, we were all asked for comments on them, so I would try and give a comment. I do not have these sub-group papers. I had a folder in my inbox for Glasgow’s Oversight Board, but I deleted it. I do an occasional clear-out. I hadn't anticipated that I would need it. I knew there was still a lot of controversy round about it, but I thought I was such a bit player in this, there was nothing really that I was going to need to retain. I'm afraid in terms of records retention, I wasn't given any instruction.

Duty of Candour

101. In the context of what I was investigating, to get it to an organisational level, you would need to do case note by case note review and you would need to then identify harm from a case note which is not always as easy as you might think it is. You've then got to apply a test to it to whether it meets the threshold of organisational duty of candour, and then you need to meet the family and write out to the family. That would have been a significant bit of work, which would have been part and parcel of their usual governance processes; so, in other words, when an adverse event was happening, as part of the internal processes for GGC, they should have been and would have been looking at that to see if their governance, “Is this organisational duty of candour?” and they would have been making that decision.

102. It would be really difficult to do as an external person, to make a call on the organisational duty of candour from that patient group. Again, that's all about individualised case note review before you could get at it the right information

to be able to take a view on that. That wasn't the gist and the drive of this particular review.

103. The SBAR report I produced was based on assumptions and some information, but it didn't require a huge amount of information gathering to then inform the next steps. It was quite a straightforward piece of work to be able to do.

104. If we were going to get anything out of this short piece of work, it was to try and bring that back into alignment with protocols as the clinicians were overprescribing prophylaxis because of their concern about the environment despite the reassurance. I wasn't totally surprised to find that people had been anxious about that and concerned given the tension that everybody was under.

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