**Scottish Hospitals Inquiry**

**Witness Statement of**

**Kathleen Thomson**

## PERSONAL DETAILS

1. My name is Kathleen Thomson.

## EDUCATION

2. I studied to become a registered General Nurse and achieved this in 1986 when I became qualified from the Victoria Infirmary in Glasgow, the School of Nursing. In 1987 I then took further education to become a registered Sick Children's Nurse. In 2005 when I was 40 years old, I completed my degree, which was a Bachelor of Science in Health Studies at the Glasgow Caledonian University.

3. Throughout my career I have completed many courses in Leadership Management and Professional Development. Additionally, I have completed other in-house courses and online courses. In 2018/2019, I became a Scottish Improvement Leader.

## PROFESSIONAL BACKGROUND

4. I qualified as a registered General Nurse in 1986 from the Victoria Infirmary in Glasgow, the School of Nursing. I then progressed to working in theatre for about a year, before undertaking my Sick Children's training. I qualified as a registered Sick Children's Nurse in 1987. After finishing education, I predominantly worked in theatres. I became a Senior Charge Nurse, which back then were called "Sisters." I was a Theatre Sister from 1998 at the Glasgow Royal Infirmary, where I was a Charge Nurse in the cardiac theatres.

5. In 2004, I left the Glasgow Royal Infirmary and went to the Children's Hospital in Yorkhill. This was to take up a Senior Charge Nurse role (Theatre Sister), which was a G grade nurse. This is known as a band 7 now. I was in that role from 2004 until 2017 and I was the Theatre Sister for general theatres and endoscopy.

6. In 2017, I took on a seconded role as the Senior Quality Improvement Nurse at the Royal Hospital for Children (RHC) in Glasgow on the new campus.

7. At the end of July 2018, I took on the role as the Lead Nurse for in-patient Wards, which included Wards 2A and 2B in the RHC. I also was responsible for the Clinical Nurse Specialists and Community Ventilation team. I was in that role for the nine months of the secondment, and I left in April of 2019.

8. At that point I returned to theatres. Half of my work was in theatre as the Senior Charge Nurse for Anaesthetics and half of my role was as the Senior Nurse for Quality Improvement for the hospital. I then returned to working in the theatres full time as the role required me to be there full time rather than part time. Within this role, I worked four days a week from 8.30am until 6.00pm or from 8.00am until 5.30pm. I did not work weekend unless I was on call. I was in this role until I retired in December 2020.

9. In December of 2020, I left my post with the NHS and retired. Officially, I did not retire until March 2021 however, this was due to holidays. I moved to Australia in May 2021.

**AWARENESS OF PATIENTS/FAMILIES EVIDENCE**

10. I have seen some of the evidence that has been given to the Inquiry and I have read one of the statements that was on the Scottish Hospitals Inquiry

website. I am very interested in hearing the patients' and parents' views as I think they are very important.

## OVERVIEW

11. As an individual, my specialism is managerial nurse leadership skills, but also with a focus on being a quality improvement leader. I was able to look at all the Wards with that view to see what improvements we could make within the clinical areas, to ensure high standards of care for our patients and parents that were using our services. I will come on to talk about that in more detail.

12. In respect of my experience of working in the RHC and QEUH, there are some specific events I will mention. I worked in the RHC from 2017 to 2020 and I spent time across many wards including in Wards 2A and 2B, and also Ward 6A QEUH. I worked in many wards across the hospital. I was present in the decant from Ward 2A/2B RHC to ward 6A QEUH, and I was also involved in the move from Ward 6A to the Clinical Decision Unit (CDU). I attended a number of Incident Management Team (IMT) meetings related to infection outbreaks. I will come on to talk about these events on more detail.

## PREVIOUS ROLES AND SPECIALISMS

### Senior Nurse for Quality Improvement – April 2017 – September 2017

13. In my role as a Senior Nurse for Quality Improvement, I was given key priorities within the hospital. I had responsibility for the whole hospital as well as neonates and worked with different teams. I supported them to improve, to increase capacity and capability within the hospital for quality improvement, and to encourage the staff to use quality improvement methodology when they recognised areas required for improvement. In my first year within this role, my focus was to introduce the National Paediatric Early Warning Scoring System (PEWS). We had our own Paediatric Early Warning System in

Yorkhill, which went to the Royal Hospital for Children with us, but the National Paediatric Team wanted to introduce PEWS.

**PEWS project**

14. My responsibility was to manage the PEWS project, and to manage the introduction and rollout across Greater Glasgow and Clyde, which not only included Sick Children's but also leading up to Inverclyde Hospital, Glasgow Royal Infirmary. There were many hospitals: there was Stobhill, the Royal Alexander Hospital, places that had Accident and Emergency departments where children could attend. I went along and did education sessions, held presentations to introduce the medical and nursing teams to the changes that were going to come into play in the September and supported the hospital during this time. I commenced the role in April 2017, and I think the rollout was starting from, 9 September 2017. We took up that challenge and spread across 14 health boards within GGC and we adapted it to be specific for us. The project had nothing to do with my role as Lead Nurse in Ward 2A.

15. In my role as Quality Improvement Nurse, I worked as an individual supported by Jen Rodgers, Chief Nurse. Jen gave me key priorities and how I would work through that. I met with her regularly, as often as every two weeks sometimes, to discuss progress within certain projects or what we were doing. I also took part in the Scottish Improvement Leadership Programme.

16. In implementing PEWS in Ward 2A came the focus of trying to improve recognition and escalation of care of the deteriorating child. I worked closely with Ward 2A to put in interventions within their Ward to improve the recognition and management of children that could be deteriorating. We put in interventions such as highlighting the watchers: a watcher is a child who has risk of deterioration. We introduced twice-daily huddles with the medical team meeting in the morning with the Nurse in charge and the Ward round was

focused on the watcher patients always first. Children that were identified as watchers in the Ward were discussed first at any case review or meeting.

17. We referred to academic research as part of this project. There is a paper written about a hospital in Cincinnati, one of the authors was Pat Brady . The researchers looked at hospital huddles, and how they mitigate when a child or patient was raising concern. Further they looked at how the teams escalated their care for a deteriorating child, whether it required attention by a medic, or whether the patient required to receive a higher level of care like Intensive Care or High Dependency. They looked at several different aspects that allowed them to bring down or increase escalation, but also improving situation awareness and therefore reduce harm: harm being that the patients were not required to have an unplanned admission to PICU or Intensive Care. From that paper, we copied what they were trying to do. To improve situation awareness there were several factors that we already were carrying out in the RHC.

18. We wanted to create a structured response, which was what Pat Brady had written about, and a lot of the Scottish patient safety teams across Scotland and Intensive Care areas have all tried to emulate that sort of system where there is a structured response tool. Their tool looked quite complicated, but they had success and what we were trying to do, was to develop a structured response tool that would work for us. We tried to look at reducing unrecognised clinical events and serious safety events. That was our goal.

19. Jen Rodgers and I were looking at patient safety across the children's hospital. We were interested in testing this and began by introducing some small steps: the first was meeting with the medics as part of the ward huddle in the morning before the ward round. This allowed the teams to make a decision as to whether a deteriorating patient required unurgent attention, or whether we had to escalate care. We did get to 95% reliability and now it is embedded in every morning meeting where the medics meet with the nurse in

charge and go over any deteriorating event or issues or situation awareness, or even thinking about beds and discharges and all that sort of stuff.

20. Following the huddle, we then encouraged teams to go to the sickest patient first during the ward round, regardless of team. Eventually down the line, after doing different cycles within that process, and identifying watchers in the ward, it became a visual prompt when you would go into the ward.

21. Our idea was that patients' names would be on the Ward board, and next to them there would be a denotation such as a red dot or a "W." It would mean that anyone walking into the ward, or a team would straight away see that there is a watcher in our ward. A watcher is a child who is at risk of deterioration or is even on therapy that required extra care or situation awareness needs to be raised about it, awareness need to be increased with this patient. We also did ward-based simulation training so that teams could work effectively, and we could learn from those events so that we could work better as a team and analyse those situations. They were quite real. In fact, the Simulation Team from Intensive Care, the crash team, would come along, and they would simulate an event, and the emergency buzzer would be raised, and they would come along, and they would be told by the simulation team what was happening, and they became part of that situation. Afterwards, they were given a brief of what happened and how it went, and if there was any improvement that was required or further training.

22. When the patients were discussed at the afternoon huddle for the ward, the watcher patients that we felt required a structured response or review were discussed first at those meetings as well.

23. We then went on to develop a structured response tool, which we adapted from another hospital, and we were testing before I left my post. The structured response tool was called SBARD tool, which was Situation, Background, Assessment, Review and Decisions. A decision was made as to what was going to happen with that child.

24. SBAR is a tool that is used throughout healthcare, or any sort of communication events, not necessarily in healthcare but in lots of industries as well. We used that tool because it was recognised within our areas. I worked with the Schiehallion team: medics and nurses, and the educators. The team had some good data from the tool, and they were developing what we first started off with.

25. We looked at how we could implement something like that within the ward, which would raise awareness of anyone coming into the ward as to what event or what situation or what awareness we need to look at for this child. So, we looked at various forums on how we could improve it and, prior to me leaving the Sick Children's, they were finding that they were able to use this tool more regularly. Whether you got reliability yet, I am not sure. I left it with Jen Rogers, and she had put on the improvement team - the risk management team, and there was a project leader who would be working with them. I am not sure how they are doing, but when it was introduced, we were getting good feedback from the Hospital at Night team, and from the teams in the ward. We chose to use a different coloured piece of paper, which was orange. It was quite visible in the patient's notes, and in the front of their room .

26. This was particularly good for people coming onto the Ward, like the Hospital at Night team, as they were able to identify a child very quickly. The Hospital at Night is a team. Every ward has their own night shift teams working with them, but Hospital at Night are a team of medics and nurses who provide immediate assistance which could just be the inserting of an IV. They were often required to give immediate assistance to a ward or assess children that may be a risk of deteriorating. They cover the whole of the Children's hospital, unless they were a specific medic working in Intensive Care, Theatre or Accident and Emergency as they had their own teams. Staff were available within that campus rather than moving offsite.

27. Finally, we also introduced simulation training and we looked at our data for unplanned admissions to the Paediatric Intensive Care Unit (PICU). We looked at the number of huddles that were actually carried out, the percentage of PEWS compliance and the number of SBARD forms that were completed for those children. The deteriorating child encompassed the use of the PEWS system, which was the national PEWS and it encompassed benchmarking with the Children's Hospital in Cincinnati. It was a paper written by Pat Brady where they used the methodology for quality improvement, and some of the key aspects that we utilised within our project, they had also had benefits and were able to reduce rapid admissions to the PICU.

**Additional Tasks Within the Role as Senior Quality Improvement Nurse**

28. Within my role ln Quality Improvement, I also worked with the hospital trying to reduce medicine harm and I worked with Ward 3C, the Renal Ward on the third floor for this. It never really got on track though and there are several reasons for that. When you do a project, you would often like the team to lead that project and, due to sickness and maternity leave, that never came to fruition on this ward. By the time that I moved into another role, it was no longer my responsibility, but they did try to look at reducing the medicine round. There is an actual visual cue within every ward, where the nurses that are involved in medication administration wear a purple apron, which alerts people to what is happening. We felt it needed to be more visualised, and we were looking as a project to think, "How could we make this apron or situation so that not only nurses would understand that the purple apron was for medicine, but also let the parents and patients understand that they're involved in this medicine administration, which required their full attention?". As part of that project, we were thinking of changing the apron, and we got some aprons that were going to be red, that said, "Please do not interrupt. I am giving medication" or, "Medication administration in progress." We also looked at the number of interruptions, and how we would try and reduce those. That is where we got with that. There may have been more, but I cannot remember as it has been that long ago now.

29. I represented the RHC in Glasgow with Excellence in Care and we looked at producing a Care Assurance Improvement Response (CAIR) dashboard for Paediatrics, which is now in use within NHS GGC. We reviewed all the Care Assurance Standards (CAS) documents for Paediatrics and reviewed them for neonates.

30. These projects I worked on differed in length. For PEWS, it was a project which was time sensitive. We had targets to work with teams, to work with the experts in the fields from Neurology and PICU. There were lots of people that collaborated with that document and how we were going to roll it out. We then did a series of testing with certain Wards. For instance, we looked at Ward 2C, which is the Acute Receiving Ward, and they assessed that form to see how reliable it was in identifying a child that could deteriorate, although all the data had been collected by the national team and therefore sensitivity and specificity was approved by them. We just needed to test our staff and how they would respond to the escalation process that we had identified would be for our health board. Once that was done and we had reliable data to show that the staff were able to understand the process, we then did a gradual rollout with a rollout date to be 9 September 2017. I did a lot of education sessions prior to it being rolled out and set live because the whole of GGC had to be starting this on the same date. That was from when I first went into the post, which was in April 2017, and the rollout of national PEWS happened in September 2017.

31. Other projects were dependent on the team that you work with. During one of the education sessions about PEWS, when I spoke to Professor Gibson and her medical team at one of their meetings, they asked me to join them. They wanted to participate in this project, and I was looking for a team to join us to look at reducing harm in a child that was at risk of deteriorating and the management of their care. They asked if they could be part of that and it seemed that they were one of the Wards that could be represented and give

us good results because we were able to study what happened with their children. Their children are in a High-Dependency Unit and often require the care within the Intensive Care Unit also, dependent on their conditions. We worked with them and that went on until I left the post in 2019.

**The Rights of Child Group**

32. I was part of the Rights of Child Group. It is a group where they looked at different facilities and programmes throughout the hospital that could make improvements within those groups of children. I cannot tell you much about it because I cannot remember. We met bi-monthly and issues about the televisions and other issues surrounding the rights of the child were discussed at those meetings. I attended them as a Senior Quality Improvement Nurse along with Lynn Robertson and the Patient Engagement team. There was parent representation also at the meeting. I cannot remember all the team members that attended. There were also play leaders and lots of different disciplines that are involved in that group: chaplain, child rights group, external group members. It was just another meeting that I attended, and we would have some responsibility to put some actions in place if I had been given that responsibility.

33. The Rights of the Child Group is to do with the European Association for Children in Hospital (EACH) Rights of the Child. There is a charter that we have which is about ensuring that we set those standards and we agree to those standards and work towards, during that, at all options.

34. The Rights of the Child meetings are good meetings because it brings external people into the hospital, such as the teams that work for Children's Health Scotland. I cannot remember all the organisations that come along. However, they can then put some onus on the hospital to ensure that they are meeting those standards, or question what are we actually doing to improve, or what is the situation at the moment? They might ask if we can work on a

certain situation? Or something may have been raised as part of the meeting that everyone must concentrate on. Ensuring that we know about the Children's Charter and working towards that and ensuring that the child is foremost, and families are foremost in their vision, or going forward, is something that we all want to work towards. My attending that meeting was good because then I could look at my areas of work and ask, "Is there anything we can work on for improvement?" or as a Lead Nurse, "What is happening with the wards? Do we need to make changes or is there something we need to focus on?" Those were particularly good meetings I just cannot remember them all.

**Lead Nurse – September 2018 - April 2019**

35. In September 2018 I took on the Lead Nurse role. Given my previous experience of being a Nurse for 38 years, of which twenty-five of those years were spent in management leadership roles, I had built, within the hospital, strong relationships with the multidisciplinary teams including medical, nursing, Allied Health Professionals (AHPs), clinical and non-clinical staff.

36. Within Wards 2A and 2B they provide quite specific and specialised care in Oncology and Haematology. I did not have this specific experience at the time; however, I brought experience in management and leadership to the team. Oncology and Haematology was only two of the six Wards that I was responsible for managerially, so that did not exactly need to come into it. With this role being a new role for me, it was a learning curve to find out about the specialisms within each of those areas. A lot of that time was spent within Wards 2A and 2B finding out about what was required of me to support that team and what the needs of that department were at that time. Over time that progressed to attending some of the Incident Management Team (IMT) meetings and the decant from Ward 2A/2B to 6A, and then to the CDU.

37. In my role as Lead Nurse, I was leading for six Wards, all the Clinical Nurse Specialists at one time in that role and the Ventilator Support team. Wards 2A and 2B were just one of my roles I took on in the seconded post. Melanie Hutton was a Lead Nurse beforehand, and she took a seconded role as the Clinical Service Manager. She was my line manager and was the Lead Nurse for Ward 2A/2B and all the other Wards. She took a Clinical Service Manager's role for nine months, and her role was advertised as a seconded nine-month role. A decision was to be made whether she was going to stay in post and then for the post to be substantively advertised. She now is the General Manager for the hospital, and at the end of the nine months, I asked to be relieved from the post, and I went back to theatres and still kept on that role a half of the time as the Senior Nurse for Quality Improvement. Latterly I went full time into theatre as the Anaesthetic Senior Charge Nurse. I did not stay in the Lead Nurse after 1 April 2019.

38. Within the role as Lead Nurse, I worked five days a week starting at 7.30am and finishing at 4.30pm. That was officially my shift, but I worked longer hours when I was required. If the service required me then I would stay on. Sometimes over that period, I would also work at weekends, depending on what was happening with Ward 6A/Ward 4B, Ward 2A/Ward 2B, when they were housed over in other hospitals. It depended on what was happening.

**Royal Hospital for Children - Area/Unit worked in**

39. One of the Wards that I was responsible for was Ward 2A, which is a Haemato-Oncology Ward with 26 beds. They were all single rooms with an en-suite. There was a Bone Marrow Transplant (BMT) unit within the Ward, which had positive pressure rooms with an anteroom next to it so the staff, when entering the room, would wash their hands and then go into that room. It acted as a barrier for ventilation coming from the corridor into that particular room for that child.

40. The Ward has a long straight corridor, splitting the Ward in two sections. There are quite a few sections because the BMT unit was down one side, with the Ward going further past the nurse's station and up to the end where the Teenage Cancer Trust (TCT) rooms were for the adolescents. The Ward had a treatment room, a medicine storeroom, a store area, offices, and meeting areas where the Senior Charge Nurse could be. The Doctors and research staff had a Ward kitchen and there was also a parents' kitchen. There were two quiet rooms, one which was adjacent to or near to the parents' kitchen. There was a quiet room where staff could choose to talk to parents confidentially and give them space and time to reflect on any news they were given. There was a playroom and a Nurses' station with an integrated monitoring system. The Ward also had a Ward View board which gave you access to individual patient's details, where they were in their journey, access to track care, etc. The TCT rooms were up the other end of the Ward where the adolescents were and there was a TCT recreation area, which included their own kitchen, microwave, fridge, and there was also a bathroom with a bath.

41. Ward 2B in the RHC was an out-patient day care. They delivered chemotherapy and it was a pathway for admission to Ward 2A. If a child became sick out of hours, they would be directly admitted to Ward 2B to be seen by a Medic or Nursing staff to decide what their journey would be from there, whether it would be admission to Ward 2A or to another Ward within the hospital if required. There were several single rooms in that Ward. They were like treatment rooms, quite large that allowed parents, children, and staff to work easily around in those areas. There were four bedded areas, an interview area, medicine preparation area, a store, and a waiting area.

42. In September 2018 Wards 2A and 2B of the RHC moved to Ward 6A in the QEUH which was an adult Ward. I will come on to describe events on Ward 6A later in my statement. Ward 6A had to be commissioned to receive the children from Ward 2A. It was not what we had in comparison to Ward 2A, so

we had to look at the area closely. Ward 6A had 26 beds in total and 17 clinical beds were for Ward 2A. though the rest of those beds were used for the day care unit. They had a day reception area at the top of the Ward which was used predominantly for Ward 2B's out-patient area so that the children and their parents who came along to wait for a clinic appointment could have somewhere to sit. We had to close off that area completely to Ward 6A and it was then used for our patients.

43. In Ward 6A, there was a bathroom at the end which was redundant. We could not use it. We were not going to use that bathroom for the children. We were only going to be in Ward 6A temporarily, and therefore the bath area was deemed not to be used because we were not having a bath area. Every child would have their own shower, and therefore that whole room was not going to be used. I think it was also due to the situation that we were in that it was deemed the that showers were the best course of action for the children.

44. That bathroom had a toilet in it as well. It was a huge room because it would take the facility of a hoist and disabled access, possibly even taking a bed, because it was adult patients that were in those wards before, and so therefore that was a redundant room.

45. There was a Nurses' station, a couple of small offices where the Senior Charge Nurse had access to the Doctors, and there was another small room , which I do not think was used very often, but the play team could be there to have access to it, especially TCT. Every room was single, with en-suite facilities. There were small storage areas within the Ward and a kitchen, which was only accessed by staff. Outside the Ward, there was a large area which was used as a meeting space. Initially, there were two toilets on either side and the lifts adjacent to that. There was a call entry, which was a buzzer, for anyone that was coming to the Ward to gain access.

46. In regard to Theatre, in RHC it is on the first floor and the QEUH it is on the second floor, which also has a link to the second floor of the RHC. Although

co-located, the theatre suite is our theatre suite. When I talk about the theatre suite, I talk about not only our theatres, which there were 11 theatres, and I am talking about the joining corridors, the corridors that go up the stairs that our patients and parents are walking up to go to our theatre suite. When I talk about the theatre suite and environment, I am also talking about that as the area where our patients and parents would have contact with.

**Protocols In the Schiehallion Unit**

47. On the Wards, my role would be there to support the Senior Charge Nurse and the Nurses in the Ward. Their responsibility is for the protocols within the Ward. When we moved to Ward 6A in September 2018, we had enhanced supervision which continued throughout my time in post. We had weekly visits with Infection Control (IC) coming to the Ward to assess the environment and to ensure that standards of care were maintained from a nursing perspective, IC perspective and from Facilities. I was the Lead Nurse on Ward 6A at that time, so I was going to these meetings, doing the audits, and walking around the Ward. If there was any increase in infections or a new infection or something had happened within Infection Control's remit, they would put that in place to ensure we can make improvements.

48. We were doing weekly enhanced supervision where we would access five rooms, for instance, we would choose different rooms at different times. In the process of that, I would look at the environment. It is also the Senior Charge Nurse's responsibility to look at these rooms, and it was Angela Howat, the Senior Charge Nurse for Ward 2B, who had noticed in one of her rooms, which was not used for the shower, that there was a sealing problem.

49. Enhanced Supervision is an Infection Control term, meaning that it is an audit which involved various members of the team, the Nurse in Charge, the Lead Nurse, Facilities Manager, and the Senior Infection Control Nurse would be on this team. They would do a weekly or bi-weekly audit on the level of cleanliness, and facilities or defects to things that could be improved.

Information was then fed back to the Nurse in Charge as to how the audit went, whether it was a satisfactory visit or whether improvements had to be taken and turned into action; an improvement plan would be given, and she would make those changes until the next audit.

50. The rest of the Wards under my responsibility did not have enhanced supervision. The other Wards, including Wards 2A and 2B, participated in IC audits and Standard Infection Control Procedures (SICP's) audits, but in Ward 6A at the time, given the level of infections that we had prior to moving to Ward 6A, there was a requirement for us to ensure that standards of care were maintained. Therefore, we assessed the environment and the nursing practices weekly until IC looked at the data that we were receiving, if there was sustained improvement, then we would agree to reduce assessments and auditing to, for instance, twice every second week rather than weekly.

51. I was not the Lead Nurse until the Schiehallion Ward had moved over to Ward 6A so I cannot comment on whether enhanced supervision was done then it not.

## CHRONOLOGY OF EVENTS

### Involvement at Planning Stage of the new hospital: pre-2015

52. Before the move to the new hospital, I was consulted about the theatre suite, but not for the Wards. We would meet with the Project Managers, and the Architects, they would look at the drawings within the theatre suite and they would ask for our opinion and ask for some advice. We would give our opinion and, over the time before the hospital was built, we had several different plans presented to us. The final plan which was eventually signed off is what we have at present. A team of Senior Charge Nurses, Medics, Lead Nurses, Clinical Service Managers, and possibly the General Manager, attended the meetings. We discussed changing rooms and storage facilities within our area

and whether there was any way within the plans to make alternative arrangements.

53. However, I do not feel a lot of what we said was taken on board. When it came to the changing rooms, I had a particular issue with the size when I saw both changing rooms, given the number of staff that would access theatres at the time, and I made my comments that the system would not work. At the time, the Chief Executive felt that the way that we access theatres and changing facilities should change in recognition to what we were going to be receiving as that changing facility. For instance, I would never own a locker and therefore it would be a daily usage locker, which could work in effect. But, given the amount of space we did receive, that model did not work and could not work from day one of moving into the theatre suite. Therefore, those rooms were not suitable and alternative arrangements had to be sought once the hospital opened. I cannot remember who the Chief Executive was at the time, but I do remember they were a Cardiac Surgeon.

**GENERAL VIEWS ON THE OPENING OF THE NEW HOSPITALS: 2015**

54. When the hospital opened in 2015, I thought the newly built hospital looked fit for purpose and clean. Having a new hospital was good and the new equipment was also an added advantage. It was also good to have parking located near the children's entrance of the hospital. The ceilings looked nice, colourful, bright, and inviting for the children. It was a very vast and large open space which gave a sense of space and volume. At the time when the hospital was built, I was a Senior Charge Nurse in theatre.

55. Good things about the hospital were the newness and single rooms. We felt that the single rooms would pose an issue for staffing, although single rooms gave privacy to the patients and their parents and gave them facilities like en-suites. At Yorkhill, in the old hospital, there were very few single rooms and that always posed a problem when a child was either immunocompromised or

needed to be source isolated because they may pose an infection that could affect other children or patients within the Ward.

56. By the time I retired, I was still happy with the hospital. Looking at other hospitals I have worked in, I think the site and the facilities are very good. I have no problems with the hospital.

**Issues with the New RHC**

57. One thing I did not like was there was no dedicated restaurant for the children and their parents or staff within the RHC. The restaurant was co-located in the adult hospital. It did not cause any issues for me personally or our staff, because we worked in theatre and we had facilities within theatre, as every theatre suite, we have our own kitchen. I suppose when you look at a comparison form the other hospital we came from, which was very much its own hospital and had its own canteen, which was then perfect for parents and children to go down and enjoy a social event eating with each other, and staff also had an area that was cordoned-off for staff. That was the ideal situation that you would have, but when they make a campus, I can understand why they want to bring services in one place, which makes it easier to manage. There were advantages of having the Queen Elizabeth University Hospital (QEUH) co-located to RHC and the fact that there were resources, staff, and expertise on site.

58. However, when it is children's hospital, we are still wanting to have that social event, if we can, and somewhere that parents can easily go and grab some food. What would have been better still, would be if we had our own facility on-site that allowed parents and children to sit. There is a small coffee area at the front of the hospital next to the charity shop, where people can go and grab a coffee, but they cannot really have hot meals other than soup. There was just the canteen area and that was all. It was just a comparison to what there was in the old hospital to what they have now.

59. The other thing was it brought perceived problems, the fact that we now have adults from another hospital who may have other issues pertaining to their problems that might include drugs or alcohol, or patients' relatives smoking outside the hospital. Those sorts of things we did not necessarily see when we were at Yorkhill.

60. The theatre suite was based on the first floor, co-located adjacent to the Intensive Care Unit (ICU) and the cardiac Ward was adjacent to the day surgery unit. Day surgery, theatres, ICU, and the Cardiac Wards are on the same floor.

61. When we first moved into the theatre suite, it was quite evident that the changing facilities were not adequate and Surgeons, Medics, Clinical Nurse Specialists were no longer co-located in the Wards with their own office next to the Wards. They were now located in an office block, which was some distance from the main hospital.

**HPN Control of Infection Steering Group: 13th of June 2017**

**(A36412002 - HPN Control of Infection Steering Group, dated 13 June 2017 – Bundle 6 – Page 6)**

62. In June 2017 I attended an HPN Control of Infection Steering Group. In relation to the information contained in that minute, I am unsure as to the reason for the change in policy with Cleanliness Champions being replaced by Scottish Infection Prevention and Control Education Pathway. They looked at the Cleanliness Champions and decided that they would need to improve the access to the Cleanliness Champions, and I think they put access online so that nurses could access that course. There was a change that was accepted, and if you were a Cleanliness Champion and you were ensuring that your staff were going to go forward, they would go onto this other platform to ensure that they had the same knowledge that was required as a professional within whatever group or Ward they were in.

63. At the meeting, I made a point about proposing a tagging system for cleaning the orthopaedic beds. We had a situation where Facilities were feeling under pressure about the support they could give to the extra requirements. But through the environment of the hospital, we lost storage space of where we could keep our beds because with children, we need all different sizes of beds. This then means we need to have a storage area, which would be a repository sort of if you need a cot, a bed, or a chair, that we would have a storage facility, and that was no longer available in this new hospital. What we were finding was that beds were in corridors outside particular Wards. For instance, in an Orthopaedic Ward, they need to have a special bed which allows the patient to have traction for splinting a fracture or to support a hip or different joints. These beds do not always need to be used, so have to be stored somewhere and they were in the corridor. In the audit from HAI, they noted that there was dust. One of the things I thought about was, you could know how often these are cleaned if you had some sort of process in place to identify a cleaning date, and therefore if you walk by, you could see a tag easily. It was just a suggestion, one I would hope they would take up, and I am not sure if they ever did.

64. I advised I would like support from IC regarding information for staff wearing uniforms out-with the hospital. I do not think I received further guidance about this, but there were constant updates that were given to staff in the hospital. There was always communication regarding uniform wearing outside the hospital. Therefore, you would question if it was acceptable. That was the support I was really looking for, to find out if in fact there is an issue with them wearing their uniform out-with the hospital, with it being such a large campus and a lot of access to the Wards were outside.

**Quality Improvement Project: 2017 to 2018**

65. This period would have been late 2017 into 2018, when we were working on the Quality Improvement Project. The project was sets up because there was an increase in infections, and the management team had asked to speak to Tim Bradnock, Surgeon, to see if there was any change with insertions for example, the lines they were using, anything at all that could indicate a problem.

66. Mr Bradnock became involved when there was an increase in line infections, and he had been looking at what happened around that time in the timeline to see if there was anything that could be associated with the increase. From that point, we started looking at all of our own techniques, be it insertion, maintenance, education, how we access the lines, what we put on the lines, how we clean them, aseptic non-touch technique, and what the children were doing with their lines.

67. Mr Bradnock, gathered a multidisciplinary team together, consisting of key people within the wards including me as a quality improvement nurse, to look at several aspects within his project to try and reduce the amount of line infections. Everything within the group moved quickly once we had the team teams together. The aim was to reduce Central Line Associate Bloodstream Infections (CLABSI) to under one per thousand line days, put some interventions in place, and work through different teams. There was a Theatre team, a Ward maintenance team, Staff Education, Insertion Group, and they all worked together to reduce the central line infections, which was compounded at that time, when the water portable sinks were in place.

68. We saw a rise in our data, but we were seeing a shift in the data indicating there was an improvement in the line infections, and we were able to attribute those to the different improvements that we had put in place. We had put some interventions in place, such as review of practice.

69. We had looked at an alcohol-impregnated cap which had very good results in lots of literature and research that had been carried out. Some of it may have been done by companies but this Curos cap was showing good results, and

therefore, Vygon was invited to come along and talk to the improvement group with Tim Bradnock, and a decision was made to introduce what we call the green caps to the patients' lines. With using the green caps, it negated the need to scrub the hub: when you access a line the nurses should undertake decontamination of the hub of the line for 15 seconds and because we use chlorhexidine, the line should be left to dry for 30 seconds. Now that is 45 seconds, which is a long time before you can access a line, and therefore that was variable when looking at auditing the nurses and the time they took to access lines.

70. The standard was not always being met, because people felt that 15 seconds was shorter than it actually was, and that happen in a lot of things but with using the Curos cap that negated the need for that. As long as the Curos cap had been on for one minute the efficacy of decontamination and disinfection was far better than any scrub the hub wait time to access a line that you would ever have. I think it reduced the bacterial count or CSUs down to under six. Prior to doing it that way, we worked with Nurses to show them how techniques in accessing lines could be improved by using Curos caps.

71. We were benchmarked against a big children's hospital in Cincinnati, America. The reason for often picking Cincinnati: the first one was really because Jen Rodgers did her improvement fellowship there and worked with those teams and saw the kind of work they were doing, as did Tim Bradnock. I understand that Mr Bradnock benchmarked against the hospital as well. Often, in improvement methodology, you would do a lot of research and benchmark against different hospitals, or reading paper research that you would try to see the standards or interventions that they had put in place and whether that would work for improvement methodology. The CLABSI rate is based on how many infections you have per one thousand line days and the Quality Improvement group, looked at various aspects, to again, reduce the CLABSI per one thousand line days within that population of patients in that ward.

72. The company, Vygon, worked alongside us to see if we could achieve that level. Vygon were the company that made those Curos caps, but they also had their own hub or access port which our nurses and some of the medical team did not like because of their bulk, and it was difficult to see them. We were using Vadsites at the time, which is an access port to the central line, and this Curos cap would go on top of that, but that proved not to be suitable just using our data, and we switched to smart sites. The Curos team had looked at both hubs and were happy for us to use it. Later, once SmartSite – which the company is BD, they produced their own impregnated cap for lines, which we then swapped over to. Again, through data, able to demonstrate an improvement or if it needed to be changed. Quality Improvement in this sense is driven as a quick step of change, and if something does not work then you look to see why and if improvement needs a change to happen.

73. Throughout that whole project, there were lots of interventions made to improve and decrease the central infections. From what I have read recently, it has gone down to 0.77 infections per thousand line days, which is really a good standard to have. The team worked through different parts of the project to achieve that.

74. We would collate data and you can see there were situations where there had been improvements. There was a shift in the data which indicated improvement in line infections, and we were able to attribute those to different interventions that we had put in, for example, the Curos caps I have spoken about and education. We saw a shift and an improvement in line infections, and they were able to demonstrate improvement and sustained improvement, but I do not know what it is like now and I do not have any of the graphs or data now. The person you would be best speaking to about all of this is, Tim Bradnock.

75. At this stage, there were not any suggestions that causes of infections were from the water. At the beginning, yes, we were looking at ways to mitigate the infections. At the beginning of that project, we were concentrating on line

infections as in practice, by ensuring that practice was sound within the Ward, looking at practice across the hospital including going to other Wards and looking and reviewing their practice as well. The Nurses would also be peer reviewed by their own educators or educators from other areas who would come in to ensure that nursing practice was good, and having confidence that the practice was sound.

76. In communicating about the Quality Improvement Project, there were key people within the group that were responsible for going back to the Ward and letting the staff know what was happening. The Educator and the Senior Charge Nurse, the Advanced Nurse Practitioners and the Paediatric Oncology Outreach Nurses were all part of the group because they all had specific roles to play within that Project Management team, therefore their responsibility was communication. We also did newsletters, and we showed the data for what the changes were bringing about. We would leave the newsletters and data in their coffee room on the Wards. They still would have access to the data that would be updated.

77. I was not aware of communication with staff and patients about the water, however I would imagine that there was a lot of activity within Ward 2A. Before I took responsibility for those Wards, the point-of-use filters were put in place. The parents were asked not to drink the water or use the sink for disposing of their cups and washing their plates. It was important to point out to the parents and children of those areas that the handwashing sinks were for hand washing. Therefore, to mitigate the risk of any further infection happening within the sinks, for splashback, a staff member came to wash her hands and check that a cup had not been poured down the sink. I would imagine the staff in the Ward would have been informing the patients and parents that the point-of-use filters are coming in, that the sinks were being cleaned with Hycin, which I believe as a cleaning solution that hadn't been used before but was now part of the regular cleaning due to the situation within the water and the drains, and there it was said that it was necessary as

part of the IMT and the Infection Controls and their recommendations along with the facilities Management Team I think. The drains were being washed, when staff were going to do specific cleaning within the drains or the sink and when the parents and children had to be re-moved to another Ward. Therefore, there was a constant move of children to a different room to accommodate the cleaning that was required within the room.

78. I was not aware of communication with external bodies about issues with the water. I can only comment from the IMT meetings where there was a representative from Health Protection Scotland who directly reported to the government. I come on to talk about that in more detail later on in my statement.

79. By the time I retired in 2020, the issues were not resolved because the children were still in a Ward which was out-with the RHC and had not moved back. They were still using point-of-use filters and we were still giving bottled water to the children. Although, I think the water was deemed wholesome to drink, the children remained on bottled water and were still in Wards 6A and 4B. By the time I had left the hospital, they still had not moved back. From the time I left the post as lead nurse to leaving my post completely as a retiree, I cannot answer whether the issues with the water system have been resolved.

**Incident Management Team Meetings (IMTs): 2018**

80. I was invited along to IMT meetings as the Lead Nurse of the Nursing team, and I would attend with the Senior Charge Nurse. My role would be to inform of the events that were happening if required. I would be able to advise and allocate resources to them. For instance, if extra Wards or extra rooms were needed, I would take actions from the meeting as well.

81. The IMT is confidential, so I would only take back anything that I was asked to communicate. There's representation at the meeting which includes both

Senior Charge Nurses of the Ward and/or a Senior staff nurse who would be there to represent the Nursing team. There were Senior members of the team from the Wards who would go back and tell their teams anything they needed to know.

82. I was invited to IMTs because of my position, but ultimately the person who would decide suitability would be the IMT leader, who at that time was Teresa Inkster or the Chief Nurse. I would imagine because of the nature of this IMT that the Lead Nurse would be required to be there to be able to direct resources, to be able to give advice, to lead any changes or suggestions that were asked of them. If it were an all staff meeting however, I would attend those and be there to answer any questions that staff would have.

83. I think IMTs were very effective in giving information. For me, I learned a lot because I was not aware of the Health Protection Scotland involvement with the drain issues. All of those different issues came and gave me more understanding and knowledge of what was actually happening prior to me taking up this role. They were managed very well, sometimes because of the nature of what was happening it was a very stressful environment and they often helped people who came onto the meeting. From the first meeting that I was at, there was more and more attendance, and from that came frustration of having to repeat certain issues. The same sort of questions came back, but they were necessary questions. I could understand the role of the IMT Chair could be quite stressful for that individual and the decisions that were at hand of what was actually happening at that time with the increase in infections. It actually settled down, but a decision had to be made as to how we went forward investigating it. It was a very contentious situation, but other than that my experience of the IMT was informative. Decisions had to be made and it was a good forum to have everybody there from different specialties and bringing different skills to give advice with regards to the situation at hand.

**IMT - 5 September 2018**
**(A36629284 - Incident Management Meeting Minute, dated 5 September 2018, relating to Gram negative) bacteraemia at Ward 2A – Bundle 1 – Page 149)**

84. The first IMT I attended was on the 5th of September 2018 when the IMT was reconvened from prior to the date that I started in post.

85. The IMT minute notes that there were concerns of staff being pulled from other areas to cover and advised this action would be based on a risk assessment. As the Lead Nurse on duty that day, I was also responsible for the safety of the hospital, as in the safe staffing of all the Wards. Every day, the staff in the Wards have to identify if they are safe to start. That means I would identify that they are safe for staffing, they have enough staff to nurse the dependent children in their Ward and the level of dependency is identified as well. The Lead Nurse also identifies how many watchers they have. On that day that the staff were alluding to, there were shortages within the hospital. To allow the safe staffing of another Ward, I had to, when I was aware that Ward 2A were in the process of trying to move rooms, allow for the extra cleaning that was required, to move a patient from their room that they were currently in to move to another room to allow the cleaning of that room and for them to subsequently move again. It would require extra healthcare support workers to provide support within that Ward. They had extra healthcare support workers over and above the level of nursing that would provide them with a safe environment. The Healthcare Support Workers were there predominantly to help move the items. A very important job, but at the time the hospital required assistance to ensure safe staffing within another Ward. My decision that day was to take a Healthcare Support Worker from the Ward.

86. The Senior Charge Nurse, Emma, was concerned that this had happened and had asked for reassurance that it did not happen again. This was raised at the IMT meeting that day and, given the complexity of everything that was happening, I tried to explain the reasons to justify what happened. I was very

mindful going forward of how I would be able to support the Ward again. Risk assessment is based on what actually happens to allow other Wards to have a safe environment, and unfortunately, that day, which was the decision that had to be made.

87. When there's not enough people, other areas have to support the wards that need it, as long as what they were doing did not involve the safety of an individual child at that time. The process was an ongoing process and, although I was delaying that from that shift, the action that required was still going to get carried out. On that day I needed to think about safety of the other Wards I was responsible for as well as Wards 2B and 2A, not putting them in any risk that I perceived until I went to the meeting and the concern was raised by the Senior Charge Nurse. It was also the concern that was shared by Teresa Inkster, the Chair of the IMT. I cannot change what happened that day but, going forward, I was more aware of the support that was required for that team.

88. I queried the quick generation of dust within Wards 2A and 2B and also reported dust in the vents and chilled beams. From memory, dust would generate very quickly within the Ward which is why this was raised. Angela Howat, the Senior Charge Nurse for Ward 2B, would be more equipped to give the full explanation. There were so many things that we were noting that we wanted to make people aware of and to see that processes were going to be put in place to ensure that these areas were dusted. You would look at the vents above, it was constant scrutiny of every area and therefore you were very aware of the environment and changes in the environment.

**IMT - 13th of September 2018**
**(A36629307 - Incident Management Meeting Minute, dated 13 September 2018, relating to Gram negative bacteraemia at Ward 2A – Bundle 1 – Page 160**

89. I attended an IMT meeting on 13 September 2018 and I asked if families of patients present on the Ward should be informed that the incident had

reopened. However, I did not have direct conversations with the families. The background to this IMT is that by 5 September 2018, they had another three cases of infection in the ward. This is when I started to become more involved. As there were another three cases, the decision was made to re-open the IMT, The IMT had been closed down from prior to this happening again. Therefore, they were meeting with the three parents of the children who were now involved, and I asked if everybody should know that they have reopened this IMT and let everyone know and the IMT agreed, yes.

90. I was new in role and had never been to an IMT until this had happened and therefore my questions were of an inquisitive nature. The group agreed that Teresa would work on the information and after the IMT, Teresa and, Jen Rodgers, the Chief Nurse, and Jamie Redfern would communicate with the Health Board with regards to how the information from the IMT was to be communicated with parents and staff. I would imagine that it would be confirmed at the next meeting that parents had been spoken with. There were daily meetings at this point and so much was happening. They were going to meet with the consultants and nurse representatives from the ward so all of this would definitely have been communicated to the ward.

91. When a decision was made as to the communication, which often came late at night, we would go into it after 5PM and it would be often late, six/seven o'clock at night, before any information would come back. By then, it was the responsibility of the Senior Charge Nurse, Jamie Redfern, or Jen Rodgers to actually go round and speak to patients and parents individually. That role was never left to me. I had other areas of responsibility that took up some of my time, so I did not always have to concentrate all that effort on Ward 2A/2B. I had the Senior Charge Nurses on the wards to be the communicators.

**IMT - 17 September 2018**

**(A36629315 - Incident Management Meeting Minute, dated 17 September 2018, relating to Gram negative bacteraemia at Ward 2A – Bundle 1 – Page 169)**

92. I attended an IMT on 17 September 2018 and it is noted that I enquired whether the Clinical Decision Unit (CDU) would undergo a drain cleaning, however at that time it was classed as low risk. This was concerning as the patients that go there are from a high-risk group, which is our patients that are immunocompromised. What happened was an immunocompromised patient could be attending the hospital via A&E, Thereafter the children would be directed either straight to Wards 2A/2B or, out of hours, would go to CDU if there was a bed issue on Ward 2A. Therefore, I asked that question as I wanted to ascertain whether CDU should undergo the same drain cleaning and filters as was initiated in Ward 2A/2B and any other Wards where the patients might end up. The meetings were evolving very quickly.

93. As the IMT meeting progressed, you would see the questions were evolving and you would produce another idea, “Well, what about this Ward?” Often, I would come into the next meeting saying, “I hadn’t thought about Ward 3A, I hadn’t thought about Ward 3B, can we add this?” Andy Wilson was constantly getting updated from me with extra requirements, which put added pressure onto the Facilities, Maintenance, and Estates teams. In asking these questions I wanted to make sure that every option or area was covered and that I was not missing anything. I asked a question to make sure that someone asked the question. If not me, someone would ask the question because everybody was heavily involved in trying to do their best to make sure that we had covered every eventuality and mitigated any risk.

94. At this IMT I also raised the question of basins. Basins should be single patient use only, but what Annette from Health Protection Scotland requested was that these basins should be single use only. Once they have been used, they should be put in the bin, and that is what had to be put in place. My confirmation or response to her was, “At the present time, these basins should, in the Ward, be single patient use. From that meeting, the Senior Charge Nurse and the other Senior Nurse from that Ward put that measure in place. I spoke to them afterwards and they ensured that they bought more

because the resources that were required to ensure that every basin was going to be single use meant that they had to increase and buy so much more basins because single patient use is completely different from single use. Single use is use once and bin; single patient use is used for that patient's entire visit, which would be decontaminated in between times and cleaned and then dried and left for that patient to use, and then it should be binned once that has been used.

95. On every basin it would have a sign denoting whether it was a single use with the symbol "2" with a line through it which would indicate that it is single use.

**IMT – 18 September 2018**

**(A36629310 - Incident Management Meeting Minute, dated 18 September 2018, relating to Gram negative bacteraemia at Ward 2A – Bundle 1 – Page 175)**

96. I attended the IMT meeting on 18 September 2018. I had concerns about rooms 19, 20 and 21 in CDU and wanted those rooms specifically cleaned because they had positive pressure air ventilation. They were the pathway rooms on the ground floor where patients are admitted from Accident and Emergency prior to being admitted to a long-term ward, which could be Ward 2A or 2B. Those were probably identified rooms, room 18 and then they would also use 19, 20 and 21 for those patients because they had possibly positive pressure ventilation systems.

97. We were ensuring that all rooms where patients in this group of patient population were going to different areas of the hospitals through their journey. Therefore, we needed to ensure that those rooms were having the same standard of cleaning. The draining cleans for example, were also happening I those rooms as well.

**IMT – 19 September 2018**

**(A36629316 - Incident Management Meeting Minute, dated 19 September 2018, relating to Gram negative bacteraemia at Ward 2A – Bundle 1 – Page 180)**

98. I attended an IMT on 19 September 2018. There was a delay in terms of waiting for Ward 1B to be cleaned first. Ward 1B is quite an extensive out-patient area where our patients could have access, especially Haematology patients. I emailed Andy and I gave him the room numbers, and he just said, "Look, I will get to this job eventually." I remember I had put on extra pressure now onto the system by requesting extra rooms to be cleaned or to put to the point-of-use filters in, the drain cleaning, all of those things add extra pressure to the process he has already got in place. I have to agree that he should do 1B because already they have identified one room in CDU, which was room 18. I have now come back and said, "Well, actually, I would really like these other rooms to be available for the children if needed." It was always just a safeguard to ensure that we had a safety net in place.

99. We had to make sure that all opportunities were ensured that we were going to have these measures in place. If I was going to put the measure in place in one area, then I wanted to make sure that, if any child was going to go to any of the other Wards, we also had those measures put in place as well. This is what happened in other Wards as well, in Wards 3A and 3B. Then those rooms those children were going to be in, they had the extra interventions too that they had in their other Wards.

100. I never had concerns that the cleaning regimes would not be carried out, it would always be done as they had a template which they updated. IC were already involved in that, and they had a programme of vent cleaning, and when that was going to be done. There was a full programme in place. If there was any reason for it not happening, they would justify and they would arrange another day if it were like vent cleaning.

**IMT – 20 September 2018**

(**A36629320 - Incident Management Meeting Minute, dated 20 September 2018, relating to Gram negative bacteraemia at Ward 2A – Bundle 1 – Page 185)**

101. I attended an IMT on 20 September 2018. At this stage I was confident with the decant plans. I remember that decision, and the decant was when patients would move to certain areas. The proposal, at the end of the day, was agreed that the BMT patients would move to Ward 4B, and the other patients would all move to Ward 6A. This would allow Ward 2B to continue operating on that day of the move, they would continue with their out-patient Chemotherapy treatment and reviews. By the end of the day, we would move that Ward over, which would just only include staff and equipment that they would require when patients would require to be moved or to be in an environment, they were unfamiliar with at that time. It made sense to move the patients from Ward 2A to 6A first, and 2B latterly, and they would start operating the next day.

102. There was a mention about information provided to the media was wrong or had been published wrong. I do not understand how that happened, I cannot remember or recall, but I do know that families understandably were upset, not only with the move but also the timeframe of when they were given the information prior to notification on the television. You can understand that they should hear from us first. I do not even know how that information got out to the media and so I cannot comment.

103. I asked what would happen if a Middle East Respiratory Syndrome (MERS) patient arrives at CDU, would they use one of the four beds already assigned for the Haematology-Oncology patients? I was covering all aspects. At that time, MERS was quite prevalent in the UK and therefore we could get a child with that condition, and they would require a positive pressure room to ensure that it does not go out into the corridor, and they would use one of our rooms. I was just wanting to make sure that I had four rooms available to us. If they did use it, what would that mean to us, having it in that area, because we would have children possibly in that area where a MERS child was getting

cared for. It was an evolving situation that could or could not have happened, and I do not think we ever got a MERS patient, but it was just something I wanted to query.

**IMT – 25 September 2018**

**(A36629324- Incident Management Meeting Minute, dated 25 September 2018, relating to Gram negative bacteraemia at Ward 2A – Bundle 1 – Page 190)**

104. I attended an IMT on 25 September 2018. With regards to if a patient from Ward 2A/2B was going to need to have a bed on any other Ward, I wanted to assure that every Ward was capable of having the same standard that they would expect in Ward 2A/2B. I asked that I could identify rooms. I was adding to an ever-growing list, but I had to ensure that I had confidence that if a child were required to be on any of those Wards, I could say I put the same process in place, and that was it. All in attendance agreed, and although it was noted that the requests were sporadic, it would be difficult to do. They wanted me to identify and email all the tag numbers.

105. With the drain cleaning I wanted to make sure if you are doing something in one Ward, I would do the same on the other Ward. I think what happened from there, was that they would consult with Susan. I am absolutely positive they got the drain cleaning done as well down in 4B, but I just wanted to make sure.

106. I was quite confident in the plans for the proposed move at this stage because there were other teams working on this. The IMT would discuss the instances you can see in the minutes, but in the background there was a Clinical Service Manager, Lynn Robertson, who had a dataset of everything that was required to assist with the move, looking at the business contingency plans, looking at the risk register, what we could do, how we were going to ensure safety of the children's move and all of those things were getting looked at. There was also a huge datasheet that Jen Rogers and Jamie Redfern kept ensuring that we were on target for the move, that we were at green, red or

amber. It was all rated and we knew that we were on course. Nothing was going to happen unless every single eventuality was looked at. That went from getting more staff to help with the move on that day, whether it was ensuring that we had an intensivist moving with every patient, ensuring we had oxygen facilities, what we were going to do in the lift, how we would move a child's belongings, ensure it was in the right place and medication with pharmacy input. We had every input you could think about, including telephones, walkie talkies, absolutely every option, eventuality, situation was reviewed and played out to ensure that we were in the right place. By this stage we were definitely sure that we are going to manage this successfully, although it is something that nobody ever wants to have to do. We had done it five years ago prior to moving from the children's hospital in Yorkhill to the new hospital.

**Closure of Ward 2A and 2B and the move to Ward 6A and 4B: September 2018**

107. I was involved in the decision to move Wards initially. As part of the IMT, when it reconvened in the beginning of September, we had regular daily meetings, and it got to the stage where the control measures that were put in place, like the point-of-use filters on the taps, showerheads, the drain cleaning and the hydrogen peroxide vapour cleaning. At that stage we were no longer managing to keep to a timeframe between the cleans to mitigate those risks. When they were making monthly changes, it was gradually becoming unmanageable. They would look from the IMTs perspective as to, were there any more infections.

108. They were monitoring water and different things that needed further investigation and for us to do that they needed to move the patients to allow that process to happen effectively. Each time they were trying to investigate everything over that time as much as they could with a ward present in those areas, and therefore, a decision was made at the IMT that the children should

be moved from Wards 2A and 2B. This was to allow the Wards to be fully investigated because the investigations that were required would be quite substantial, including opening drains, and would not be conducive for care for the children in that Ward with that undergoing at the same time. There was a lot of anxiety with the staff about the safety of the Ward and how the infections were happening.

109. We moved on, 26 September 2018, and the decision to move was made around the middle of September. There was a lot of discussion around the water, the drains, access to drains, cleaning of drains, cleaning of drains within not only the Wards 2A and 2B, and any Ward where those children may have access to. They had to look at how to mitigate risk for the patients, and to ensure there was safe points-of-use filters, cleaning, drain cleaning was happening in those areas that they may be exposed to. The timeframe is in the IMT minutes; it involves various people within Health Protection Scotland (HPS), Directors of Facilities, Health Board Chairman and people that came out-with our own hospital that came along to the meetings such as Infection Control out-with our hospital, so they would be from the Health Board. I would imagine they were maybe invited to the meetings, but I do not know for certain. We reviewed several options for the move for the children and discounted locations not suitable. The Ward where the children were moving to was not decided until one was identified by the Health Board and from there, we reviewed that Ward to see its suitability.

110. Ward 6A and 4B were deemed suitable because that was a Ward which was used for winter planning for the GGC. It was on the same campus next to the RHC, so we had facilities such as paediatric intensive care (PICU) and access to medics, in particular Hospital at Night.

111. The reason for Wards 6A and 4B was 4B was an automatic choice because it was the Ward for the Haemato-Oncology adults, and bone marrow transplants took place in that Ward, so it made sense to accommodate some of our children there. We were lucky to gain four beds in that area. Initially they

offered us three, but because of the number of patients that were required, we were able to accommodate four children. Ward 6A was just two floors above Ward 4B, so out of the Wards that could be in Queen Elizabeth building, it most likely was a better choice than any other. I do not think any other Ward was offered. Those patients that were in that Ward were easily moved within the hospital.

112. The Nurses on the Wards and the patients had to go through a process of relocation. We reviewed that Ward to ascertain its suitability for our needs, and although it was never going to be the exact same as what we had in Wards 2A and 2B, given it was two separate units, we could see how it could work given that it was only going to be for a few weeks. The whole process initially, to gain access to the drains and the units of work that was going to be required in Wards 2A and 2B, was only going to be for a short period of time, but prior to that move, we had to ensure that the standards that we had left behind were going to be maintained. The Ward had to be ready for us to move in and the Facilities Management team assured us that that would be the case.

113. The Ward was, however, located in another hospital. Therefore we had to look and ensure that we had safety routes for medics out of hours to be able to access the Ward; that included things like thinking about the access to the Ward via the lifts, so they would have to have a special key to access the lift so they could get there if they are in need for an emergency. Having the Ward out-with posed a problem for hospital at night and therefore also part of our staff, which was the Advanced Nurse Practitioners, who then had to change their shifts to ensure there was a presence on the Ward overnight, to ensure there was a Nurse Medic there at all times to support the hospital at night team. The environment itself of Wards 2A and 2B, it was one Ward that was going to be split into accommodating an out-patient section of the Ward as well as an in-patient section.

114. There was no playroom for the children, so we had to consider this. Play is very important to children and socialisation, as the room is their home. When a child is in hospital, especially with conditions that are long term and they are requiring lots of treatment, the parents and the child are often there for a long time, so their room becomes their own personal space. Not all children can get to a playroom because often during their care they may have various types of infections that do not permit them from leaving their room. However, with the play service provided across the hospital, it gives that area for children to allow them to play, do different activities and meet other children. On the ward at that particular time, we didn't have the facility to have an actual dedicated playroom and we were trying to use the space in the Ward as effectively as we could to accommodate the requirement to have those two teams together, and also give the aspect that initially it was going to be a short-term solution.

115. We had to consider the layout of the Ward and the usage of what we were going to use the Ward for. At the top of the Ward, where the large dayroom was, this could have been used as a children's play area, but it was going to be used for the out-patient waiting area. Therefore, how could we guarantee that would be cleaned and given the attention it requires to use it later on in the evening. We thought about, out of hours, would the children play in that area? What should we do? Should we just separate that whole Ward? That is what we decided in the end, given the time frame that we were going to be in the Ward. That would be an inconvenience that the children could get over that period of time, that short period of time which we expected.

116. The Ward did not have any areas for the teenage children to meet. We had this small room, but again it was too small, and they probably would not want to go in. There was no kitchen area for the parents because the kitchen in the Ward was not open to the parents. The play area that they created for the children was in the corridor which was a small desk. It was not really a play area at all, the play was going to be limited to the children's rooms, the individual rooms themselves, so that was an issue. There was not enough

office space but given the timeframe that we were going to be there for, these workarounds could be effective.

117. Distance is always a problem when we are transferring a patient. We need extra resources, and therefore that would be not only for intensive care but taking patients to and from theatre. The theatre orderlies and staff who would transfer patients to and from theatre had access lift keys, and therefore, for them, the time waiting for lifts were greatly reduced. The journey from theatres or intensive care was increased because they had gone from access from Ward 2A by one floor to now going through hospital corridors to access a different set of lifts to go up to six floors. Distance, therefore, would be an issue, but one that the risk was mitigated with the access of the lift keys and the staff knowing the routes. There was signage throughout the hospital to raise awareness of how and which lift for staff to go for, for example, hospital at night, if they had to attend the Ward.

**IMT – 26 October 2018**

**(A36629329 - Incident Management Meeting Minute, dated 26 October 2018, relating to Water Contamination in Ward 2A – Bundle 1 – Page 212)**

118. I attended an IMT on 26 October 2018. There were mentions of a desk being unavailable and this was because there were quite specific in their requirements. There are a set of doctors within that Ward who everything that they record for the patients' clinical episodes are done electronically. They have specific requirements where for a desk that would walk with them and is able to store securely a laptop and secure the case notes if there was any written at all, and that as well. I just got online to medical equipment companies, and I took some time to source different options, and I gave it to the clinicians. They were quite happy with the choices, and they selected the one that they wanted and, and I ordered it.

**IMT – 2 November 2018**

**(A36629288 - Incident Management Meeting Minute, 2nd November 2018, Water Contamination in Ward 2A – Bundle 1 – Page 233)**

119. I attended an IMT meeting on 2 November 2018. There was a discussion about trough sinks and whether they were to be removed or not. This conversation meant a lot to Professor Gibson, and she relayed that her colleagues also felt the same. There were two camps there, and I can understand both, but I cannot give an opinion as to who is right and who is wrong. That responsibility is left to the decision of both individuals to go back to both of their colleagues or professional experts to understand the need for what they were wanting. What I got from that was a decision not necessarily needed to be made that day, but because the move was only going to be weeks, I suppose a decision like that may have needed to be answered. Professor Gibson was looking for support and I cannot give support in that, and I could not give that precise knowledge, I would have to do some research myself and look into the pros and cons. Knowing the way sinks work Professor Gibson's concern was about moving the trough. When a trough was actually required, which is a scrub sink, it could have been reduced to a hand-washing sink, that is something that they would have to decide. From that conversation, the next meeting I was not involved.

**IMT – 30 November 2018**

**(A36629326 - Incident Management Meeting Minute, 30th November 2018, Water Contamination in Ward 2A, RHC – Bundle 1 – Page 241)**

120. I attended an IMT Meeting on 30 November 2018. There was a discussion in regard to sinks and I made a request to receive additional sinks, but I probably just added to his list. I am only acting on my other Wards who have told me that their patient had gone to that ward, and so therefore I have added to the list. The list became quite extended, and therefore what she was meaning by that was we were then going to get a work plan in place so that the rooms were all identified and therefore you could have a process to ensure that the cleaning process was being done.

121. There was an error in the minutes where it says, “Kathleen Thomson stated original date” it was given the 14th of February, but it should have been the 14th of December.

122. The 14th of December was a move back date. If you did not have a date, then we had to look at other options for how we go forward with the Ward. What facilities were going to be acceptable for a longer stay? For example, the central monitoring. I wanted central monitoring to put in place then and got advice from medical physics department and got quotes to get a central monitoring system put in place that can allow the patients to be monitored from the Nurses station and alerted for alarms. I wanted to see a kitchen put in place for the parents. I wanted a playroom and all these things that were that were very important, but because of the length of stay that we initially were having, if this was going to change then the requirements for the Ward would also have to change.

**IMT - 18 January 2019**

**(A36690595 - Incident Management Meeting Minute, dated 18 January 2019, relating to Cryptococcus – Bundle 1 – Page 274)**

123. The first time we were aware of the Cryptococcus incident was at the IMT and thereafter, at the IC meeting. The incident was a terrible thing to hear that we had moved to another area that again was raising concerns, had an associated infection and ultimately a child had died.

124. We were informed at an IMT and also at an Infection Control meeting, that where were two patients with Cryptococcus. [redacted]. It was felt when they further investigated it, that the cryptococcus, came from the ventilation system. Other than [redacted], I was not aware of any other issues with the ventilation.

125. The sealing around about the shower area had given way, so the Senior Charge Nurse brought that to the attention to estates, and it was recognised that the sealants were required to be looked at in several of the rooms. That was brought to the attention at the IMT. The Lead Nurse for Infection Control, Susan Dodds, and one of her colleagues, Teresa Inkster, looked at the rooms and identified eight rooms that required some resealing done.

**Move from ward 6A QEUH: January 2019**

126. At that time, which was after January, when it was noted that parts of the shower were coming away from the wall or the fabric of the building of the shower area, we had to move some of the children and identify children that would move to Ward 4B. There was a requirement to refurbish these areas and when the work started, it was noted that every alternate room was going to be involved and therefore, for works to be carried out in these rooms, they had to be screened off and that would make it impossible for an individual room to be blocked and would make it an impossible area to work from in the safety of the children, the parents and the staff. This was because they could not gain access to certain rooms because they would be blocked off. A decision was made that we should look for alternative accommodation for the Ward over that period of time while that work was being carried out not only to ward 4B, but also over to the Children's hospital because that was the only other place we could go back to, and they would accommodate us in the Clinical Decision Unit (CDU). The Clinical Decision Unit then had to be accommodated throughout the hospital. The CDU area was then used for the then-Ward 6A, which was initially Ward 2A.

127. There were not many people in the Ward at that time. The same process happened as it did in Ward 2A and 2B regarding the information of patient and families. Jen Rogers and Jamie Redfern would, I imagine, have went round individual patients and parents to explain to them the situation that required us to move to CDU. I am sure we did get a script of what we should say and go

round, because it is hard to articulate the right information to ensure that we are getting the correct information to the parent and children if it is appropriate to talk to them (the child) about what is happening. It was a very emotional time.

128. Remedial work went on for just under a couple of weeks. We were concerned of links with the ventilation, with regard to the Cryptococcus infection. A room was closed off [redacted] and it was at the same time that the showers were noted for sealant. I am not sure if there was any mould in those rooms, but I know the sealants definitely raised the concern. Prior to this, I had no concerns about infection in Ward 6A.

129. In regard to communication, the IMT would give us direction as to what communication that we would give. At the time, we would meet with the staff, both medics and the nursing staff, and explain about what had happened [redacted] within the hospitals. They had contracted Cryptococcus infection, and it was presumed it came from the ventilation system so that room had been closed. Communication with the parents, again, would have been through a written form that had been given to the staff to give to the parents, and we would talk to the parents and let them know about the situation as well.

130. There were situations where parents and children who were out-patients did not get the opportunity to get first-hand confirmation of what issues there were within the hospital, whether that be in Wards 6A, 4B, 2A or 2B. They saw the information first hand on the news. They were particularly angry or concerned that they had not been informed directly by us, and we had several phone calls to the Ward resulting from that communication.

131. Communication came directly from the IMT, which would be approved by the Health Board, and they would give us information as to the means of communication to give to the parents. Staff would have been informed by the Senior Charge Nurse on the Ward as to direction and lines of communication.

## BUILDING ISSUES

### Interior Issues

132. I did not hear about issues with the temperatures of the rooms *per se*, but over the course of my time being a Senior Charge Nurse in theatres and Lead Nurse for the wards, I became aware that the rooms could become hot and therefore the patients and parents relied on fans. Mainly, this was due to the fact that a child could spike a temperature and one of the ways of trying to reduce their temperature, not only with drugs like paracetamol and fluids, is to cool the patient down by means of a fan. The fans were available to patients and parents up until a time when the board, IC and GGC had asked for the fans to be removed for infection control purposes.

133. With blinds, because the windows housed the blinds within the two sheets of glass, often if the blind was broken, there was no means of fixing that or bringing it down. That would pose a problem for patients and yes, anecdotally, I was informed about issues with the blinds.

134. TVs were a problem throughout the hospital. This was raised several times in many meetings, the rights of the child meeting and at health and safety meetings. It was raised continually not only for remotes, but also that the entertainment system would not work. There was going to be a process of when these were going to be fixed and a programme to do this, whether to replace all of the televisions. There were decisions that had to be made regarding this and that posed quite a lot of problems, especially in my quality improvement role. In a lot of the questionnaires, we asked parents and children, the television was a common theme. The TVs never seemed to be fixed.

135. I did not experience any issues with the Wi-Fi, power outages, plug points or battery packs.

136. The Ward entry system can be troublesome. Jen Rodgers was keen on having better access for parents and families to come into the wards and improving that service. We were looking at how we could upgrade what was at that moment just a bell system, which had a camera and relied on the patients' parents or carers or family members to buzz to get entry, then someone who was at the desk, which often was the Ward Clerk for the Ward, would allow the entry of that parent or carer. They would be able to see a video of that person and they would then get access. If there was no one on the desk, that would pose a problem for the parents or carers or family members to gain access to the Ward. Also, with Ward 6A, because we were directly next to another adult Ward, often people would be confused as to which Ward they were going to and the Wards on that block do not communicate on either side. Initially, when we first moved in, people thought it was a shortcut to another Ward and it was not, so we had to make sure that that did not happen. Therefore, we looked at how we could get a fingerprint system within all of the wards. This was prior to me going back to my role in theatre, and I would imagine other priorities took precedence however, I did pass the information over to the then Lead Nurse who was taking that on board.

137. In regard to sewage leaks and issues with the roof, I do recall them however I cannot remember specifically what happened in each case. I did not experience any leaks from the roof or anything like that in my time within the hospital.

138. I was aware of flooding in en-suite bathrooms. The flooding that I was experiencing was when we were moved to Wards 6A and 4B, and there was flooding in one of the bathrooms in Ward 4B. It was due to the fact the floor was bevelled and the water automatically drained towards the door of the

bedroom. Job requests were requested for those bathrooms. I am also aware of the flooding of the bathrooms from some of the parents' interviews from the Hospital Inquiry. The extent of my awareness of flooding in Wards 2A and 2B is through this inquiry because my experience with the Wards was limited in Wards 2A and 2B. Ward 4B is where I witnessed the water not flowing as well to the drain because of the direction of the floor. This issue was mainly in one room on Ward 4B. The majority of the water drained into the drain but, because of the bevel on the floor, the direction of the water took towards the door as well.

**Exterior Issues**

139. I was not aware of any issues with the play park. I am aware that the play park was closed off at the time when we were removing the cladding.

140. The cladding on the building of the RHC could have been related to the same cladding that was used in the Grenfell Tower tragedy. Therefore, the decision was made by the health board that this cladding would be removed at some stage, which it was during the course of my responsibility within Wards 2A and 2B.

141. Around about the time when the cladding was being removed and we had the contractors outside the building, a glass panel had fallen from some height in the adult hospital, which then fell below onto the area where everybody goes through the main entrance of the adult hospital. No one was injured in the process of this falling, but I am aware that a glass panel fell from the QEUH building.

142. Routinely, I would smell the sewage, and that was not only outside, but also inside. The smell was not constant. It was particularly noticeable at certain stages of the month. We had concerns that we could smell the odour through the ventilation system, in particular in theatres. Any smell that came through

theatre, we would raise the issue through a Datix, or we would put a risk report in. I got used to the smell within the hospital and out-with the hospital, so I took it that the smell was part of our environment, whether it be external or internal.

143. A Datix is a reporting system for incidents that happen within the hospital. It is the recording of any clinical or situation that you want to raise awareness of. The reports submitted to Datix are sent to key people within the organisation who are made aware of the situation. It is then the responsibility of, for instance, the Senior Charge Nurse of that area to ensure that the appropriate action is taken and decide on what individual teams need to be informed. It can then be closed off by the Lead Nurse if it has been resolved.

144. In terms of the issues, I have discussed above, it would not be my job to communicate to the patients or families. For example, talking about the televisions would be the responsibility of the staff on the Ward. They would explain that our report had gone in or that job request had gone into facilities. There was a system that the staff would use online for reporting a job that was required, whether it be TVs, whether it be a sink or any issues, or a light out or a bulb out, they would put that on FM facilities website. I would then ensure that those jobs were carried out. As a Senior Charge Nurse in theatre, I would be responsible to see when those jobs were carried out or still outstanding.

145. All of these issues impacted the patients with the main impact being frustration. Television is quite an important part of a child's entertainment, especially in a hospital, if a child is in a single room with their parent and they want to watch television. That was frustrating for parents and disappointing for children. We would try our best to provide game stations that would come in on the trolley, and they would have access to those. Often children had their own iPads and streaming systems. The heating was not an issue apart from the fact that the fans were no longer there, then that was a source of issues for parents.

146. These issues also affected staff as they compounded their workload. The issues ongoing with Wards 2A and 2B were compounded by the day-to-day issues such as TV, blinds, heating. I would imagine that the entire process of this was stressful. The staff worked extremely hard to protect their patients and the families, and anything else that compounded it would have made their job more difficult.

**SEWAGE WORKS AND ODOUR**

147. In relation to whether I thought the environment was fit for purpose including its design, accessibility, and practicality: one of my concerns, amongst others, was the hospital's close proximity to the sewage facility. We raised this concern at the first consultation meetings prior to the build. I brought it up and said, "What is happening about the sewage facility?" We were told that the environmental issues were raised within. I do not know if it was the council or someone else, they raised it with, but they gave a clarification as to the reason for building at that area and that it did not pose any problems that we were perceiving. I cannot remember who was at these meetings. It was 13 or 14 years ago. Any smells that we could smell that were out-with the theatre environment, we would make a Datix report and that would be logged in that system.

148. Regarding the smell coming into the theatre, we did not know whether it was a risk or not because the ventilation system should be in place and therefore ensure that we have air quality. The smell did come through and not just me or my team complained, medics complained about it and wanted it recorded. Whether it was recorded at every opportunity, I cannot tell you, because there were a lot of theatres. Depending on the situation or what somebody felt took priority to their activity that day, because you could be busy in theatre doing other things and that would be a low priority in some teams to fill in that sort of paperwork.

**WATER**

149. I did not have any concerns about the water supply until I was involved in Ward 2A with regard to the increase in infections. Other than that, I was not aware of any issues with the water supply. I became aware of concerns regarding the water system during the quality improvement process and then further on during my Lead Nurse role. With Ward 2A seeing an increase of infections there was a quality improvement project, which was set up to reduce the number of central line bacterial infections. I was part of that team and we looked at practice within the Ward. I reviewed and changed the central venous catheter maintenance bundle and tested it on Ward 2A.

150. The water problems were evident in that Ward because they used water filters: that was the point-of-use filters. The patients, at a certain time, were asked not to shower or drink the water. That was during the course of the quality improvement project. We brought in portable sinks and alcohol gels for staff to clean their hands with and cleaned the drains. Until that point, within the hospital, we were not aware of any issues with the water.

**VENTILATION**

151. Ventilation systems allow the passage of clean air and the prevention of what is deemed as a 'dirty' environment going into a 'clean' environment. When a child is immunocompromised, they should be shielded from the air or environment out-with their own particular room. To achieve that, the patient should be in a positive pressure room which stops the external ventilation from out-with that room from entering and allows the passage of air to move out at a positive pressure. That is a problem when a child has a communicable disease, such as chickenpox, and therefore they should then be in a negative pressure room which will ensure that their air does not go out into the general corridor.

152. Ventilation is important in the theatres. We have to have a set standard of flows per hour, and we would want at least 20 air changes in that environment, in particular theatre. There are different criteria for different types of rooms, and we would ensure that we would have those monitored. In a theatre suite, we would have validation checks of ventilation carried out at regular intervals within the calendar year. It is once a year, and therefore ventilation is important when a child requires protection or when you want to protect others - so it is source or protect the source. I do not know if there were any validations carried out on Wards 2A, 2B, 6A or 4B.

153. I was never aware of any issues with the ventilation until later in the IMT meetings when it was raised. It was the water investigation that triggered the decant from Wards 2A and 2B to Wards 6A and 4B, and in the course of the investigation and changes of the environment with regards to the water, the review of the ventilation took place. Through that, from what I have read too and listened to on the website from this investigation, and in the IMT that the ventilation was also investigated over that period of time, it made sense to do everything whilst patients were decanted. I was not aware of any issue with the ventilation until it was disclosed at the IMT. We were reassured that it was slightly negative neutral but that was no issue with regards to any of the infections that transpired prior to the children moving to Wards 6A and 4B.

154. HEPA filter units were put in place in Ward 6A to ensure that the air that was filtered in the corridor was as clean as possible. We needed to ensure that when the doors opened in those rooms, there was a degree of HEPA filtration within the unit and these were recommended units to use within a certain distance, spaced out within the Ward.

**INFECTION CONTROL**

155. In regard to HAIs, originally the term universally used was “hospital-acquired infections,” but latterly the term is “healthcare-associated infections” because healthcare infections can happen not only in hospital, but in day care units and in the community; therefore “healthcare-associated infection” is what it is deemed as now. It is important to know that the patient normally does not have an infection prior to admission or access to that healthcare. In determining if a patient has an HAI, we have to look at infection within 48 hours of admission to the ward. It can include infections such as catheter-related urinary tract infections, the central line-associated bloodline infections, wound infections, ventilator-associated Pneumonia, and also C. Difficile and MRSA. The term encompasses a broad spectrum.

156. Patients that are immunocompromised cannot fight infections as others who are not immunocompromised would normally do. Their immune system is extremely vulnerable and therefore they require added protection, and often the protection is prophylactic medication, be it antibiotics or antifungal medication. It is important that they are shielded from infection.

157. Different ways to mitigate risk of infection are using prophylaxis, ensuring that standards of care are high, using aseptic non-touch techniques when accessing lines, that we look at the processes that are in place and ensure that practice is of a high standard. We look at the general environment and look at the standards of precaution for infection control and do regular audits to ensure that we have confidence in our area.

158. The group of patients that are severely immunocompromised, going through chemotherapy, are subject to more infections or they are more prone to infections than others. Therefore, everything we can do to mitigate that risk is put in place. I am sure that there are infections that are exceedingly difficult to treat like MRSA or Vancomycin resistant infections that are proven now to be very difficult to treat, but we still progress and try to fight those infections.

159. One of the different lines to give drugs to patients are peripheral lines. The downside to peripheral lines is they do not last very long, so they are at risk of tissuing and no longer working.

160. Peripheral lines are a small catheter which goes into a vein, so it is a peripheral cannula. They are secured with a small dressing and, with the movement of a limb or children touching them, or with skin that becomes wet or sweaty, there is a risk of the dressing dislodging and the line dislodging. Also, with the amount of fluids that can go through and particular drugs, it may not be suitable to use that vein because certain drugs require a central venous access, which is a deeper vein that goes directly into the heart, and they can take the different drugs that are required for those lines and they are longer term. The peripheral lines have a risk of what I said was tissuing, which is extravasation, which is when the fluid leaks out of the vein and penetrates the tissues around the vein just below the skin. That can cause irritation, if it is certain drugs into the skin and can often even cause a burn around the area, depending on the fluids that have been used and it can cause pain. The nurses use an audit tool which allows them to assess the peripheral vascular catheter twice a day and they will look out for signs of redness, swelling or pain, and if any of those aspects happen, an assessment would be carried out and most likely the cannula would be removed.

161. For some really strong medication that we use, such as chemotherapy, they require access to a central vein and therefore we would use a Hickman line, or another line called a Port-a-cath. A Port-a-cath is buried under the skin and is accessed through what is called a ‘Gripper needle’ through the skin and medication is given that way so it is completely enclosed in the skin. The Hickman line is a line that goes into the main vessel, the main vein into the heart, into the right atrium, and is accessed via a subcutaneous area in your clavicle.

162. If we suspect a line infection, we will take blood cultures and we would stop using the line. We would put a peripheral venous cannula in position and

administer medication that way. Often, if a child is showing signs of infection, we should initiate antibiotics once the blood cultures have been taken. Often, we need to resuscitate the child with extra boluses of fluid, so we would give 20ml per kilogram of Intravenous Therapy fluid to ensure the child is not in septic shock or any sign of sepsis.

163. If a child is showing signs of infection, they can do several things: one is taking swabs from the wound site, the access site of the port or Hickman line, blood cultures, and, a line would be removed if it were deemed necessary through microbiological review. If the microbiological review could include antibiotics, that is what they would do. I think they would rest the line and they could challenge the line. I do not have full knowledge because I was not a Clinical Nurse within the area, but it is fairly recognised that investigations into any infection would take place, and microbiological review along with a pharmacist review of appropriate antibiotics would be deemed necessary for each child individually.

164. I did not have any concerns of amounts, locations, clusters, or types of infection within the hospital until I was aware of working with wards 2A and 2B in my role as Quality Improvement Nurse and then latterly, as the Lead Nurse. I was informed of those environmental infections that were out-with the normal expected infections that we would see in that population, especially having Hickman lines but not whilst I was working with the Ward itself. For me personally, as a professional, I did not have a good understanding of the different types of infections there are. A lot of the terms that are used for infections and the names or infections, the nurses who were the Senior Charge Nurses or nurses who worked in the Ward, were familiar with those terms. I did not come across those terms as most of my background was in theatre, but I was informed that some of those infections could be based as environmental. I was informed of this at the meetings.

165. In theatre, we often saw an increase in infections in cardiac surgery. Cardiac patients are a group of patients who, again, were at greater risk of infection

because of the type of surgery. They were a group of patients renowned, not only in paediatrics but in adults as well, of having a higher risk of infection and therefore work or quality improvement would be carried out by your tissue viability nurses. Therefore, there was always a group that worked alongside that team, looking at dressings, access to the patient's wounds, along with tissue viability and infection control. They would try to ensure that infections and improvement methodology was put in place to mitigate any risk to them, and that happened in our hospital as well.

166. I was not aware of more infections being found in QEUH compared to Yorkhill and due to my role, I was not exposed to any of that information.

167. I cannot comment on whether there was an increased risk of infection from exposure to the ventilation system because that was not raised until the incident on Ward 6A. In regard to the water supply, when I attended the IMT and we were aware that the mitigations to reduce the exposure to any environmental organisms within the water were not working, I felt that was a risk and therefore the most appropriate action was to move the children from that Ward to understand what was happening. From that time, I had confidence because of the interventions we put in place, such as Curos. The change in practice to Aseptic Non-Touch Technique, which is a recognised technique, all of these different things that were put in place, the dressing changes, then I was hoping that it should be getting resolved.

168. My impression of infection control procedures and governance was that the staff were very visible within the Wards, they were a very good resource, they were knowledgeable, they would answer questions, assist you, and support you when you had any concerns. I always had access to them at all times. They were incredibly supportive and visible on the Wards to answer any questions, queries and to give advice.

169. In regard to cleanliness and hygiene within the hospital, I had concerns regarding resources. I felt that facilities, the domestic service that clean the

Wards, did not have enough staff and so they had to concentrate their staff on many of the clinical areas. On opening the hospital, the changes for cleaning the Wards and the floors were to use water, and to use water and Actichlor during the winter months when we had high levels of infections within the hospital such as Human Respiratory Syncytial Virus, winter bugs, viruses and the flu. My concern was using water only on the floors. Was it appropriate when surfactants were needed to remove dirt from the floor? We possibly needed some sort of detergent, and I asked for advice from the facilities and infection control regarding that in my role on many occasions. Other than that, in Wards 2A and 2B, they had dedicated domestic staff and all-round people that were monitoring that area, so therefore that should have been quite sound within the remit of domestic support.

170. I cannot remember if I got a response because in the notes dated in 2017, I asked for that to be clarified. Regardless, that question was put to infection control to go back and find out whether that was appropriate. The floors were made of an antibacterial material, and I had questioned if that would negate the need to pour the detergent. They had not come back to me after that meeting and that had been discussed prior in the many years when we first opened that I had asked that question.

171. Apart from IMT meetings I had been involved in a Problem Assessment Group (PAG) meeting. That was probably for chickenpox in one of the children in one of the other Wards. They are the only meetings that I have been involved in.

172. I was aware of the views from people in infection control from the IMT meetings. When we discussed these infections that were not normally seen routinely in that patient group, that is when that was discussed and the link to the hypothesis was that these infections could be linked environmentally and could be linked to the drains or water from the samples that were taken.

173. I am aware that some children's treatment had to be stopped or paused because of an infection, and their treatment was reduced or prolonged. Obviously, having an infection could have a detrimental effect on their life and how they go forward with their treatment. It is always a possibility.

174. [redacted]

**PROPHYLACTIC MEDICATION**

175. I do not have in depth knowledge with regards to prophylactic medication and the treatment of Haemato-Oncology patients. I do know that because they are predominantly immunocompromised and as part of their treatment protocols, they would have been prescribed prophylactic antibiotics and antiviral and antifungal medications. All of these medications would be given as part of a course of treatment to protect them.

176. I do not know specifically if all patients were on prophylactic medication. I would imagine that the group of patients, in particular patients that are on strong chemotherapy and are immunocompromised, would require a certain amount of prophylactic medication for their protection. I am unsure as to the duration of time that patients were on this type of medication. Additionally, I could not go into the side effects or risks of prophylactic medication.

177. The patient's individual clinician would be responsible for prescribing the medication, including the team they work with. If it were the Haematologist team, it would be the patient's Consultant or the patients' Doctors that are working alongside the Consultant. If it were the Oncology team, it would be

the patient's Consultant or team that would prescribe the medication unless it was an Advanced Nurse Practitioner, if that were his/her role as well.

**COMMUNICATION**

**Communication with Staff**

178. For staff, we have core brief that come from our own board and there would be team briefs. There are quite a few avenues of communication with the staff but mainly electronic versions through emails; the core brief would come out and you would be given that by email. Everyone has access to email in GGC, so they would be expected to access their email and you would also put the core briefs up on the staff message boards. There were also notices: if I were in charge of an area, I would put a notice up on the Ward or on the wall of the department informing staff, at staff meetings, etc. Everyone has access to computers but there will be a pinboard in areas too.

179. The core briefs would tell you about what was happening and why it was happening. For example, with the cladding outside or things like that that had happened. We would be told things like that.

180. The core briefs are regular, I do not think there is a day goes by when there is not some sort of brief happening that you are told about. It is not always corporate things; it can be social things too that are in it. I think they come from a communications team however, there are some that are directly from the Chief Executive. The core brief can be downloaded as its online.

181. It was information to the vast majority of staff that it possible did not affect. I felt the information was appropriate that was given out.

182. In our team huddles in the morning, we would discuss team and core briefs. The wards have their own huddles, they would be told anything that came back from the big huddle. They would talk to their team about that, and same

in theatre as well anything that came up in the core brief that the Senior Charge Nurse felt was important to discuss directly, then it would be. If not, it would be up on a notice board that people would have access to and their emails. Staff do not have allocated time slots; they have to find the time to do it.

183. I would imagine we would be told about any infection outbreaks, for example. We would be told by Infection Control at their meetings. Infection Control meetings happen monthly so anything that happens, that are outbreaks they are discussed at Infection control meetings and the Senior Charge Nurse who are at those meetings, would then tell their teams about that. I would imagine the Board had to let us know so we would be told but as I have mentioned, there are core brief.

**Communication with staff - Team Huddles**

184. As a Lead Nurse, I would be responsible for possibly leading the huddle for the hospital huddle. That started at 8 a.m. every morning, and we met with all of the nurses who were in charge of either wards or areas, and we would discuss the challenges or situations within the hospital and staffing. We would look at situations that may arise throughout the day and put plans in place to mitigate any problems we were foreseeing. The same would happen in theatre. We would have a huddle every morning with all of the leaders from every theatre. We would discuss staffing, challenges we may face throughout the day, break times, how we would coordinate sickness, staff issues, equipment, that sort of thing.

185. We put plans in place and then after that, we had a team huddle with every individual team, where we met with the surgeons, anaesthetists, and nurses. Every theatre met at quarter to nine every morning before the list starts. They would discuss challenges they were foreseeing, and we would discuss every

patient before we came and any issues or concerns that we may have about going forward.

186. There would be a hospital meeting, which is the huddle for the hospital. Every team leader from every area attends that. That would include theatre, Intensive Care, all the ward areas, any area that would require any assistance, and including domestic service, such as Facilities. Anyone who had to forward information or receive information would be at that meeting. If you could not attend it, you would send someone else in your place so that your ward would be represented and if they could not attend, then we would link in with them via telephone. There were a few areas that would link in via telephone. The maternity units would link in via telephone and they would listen to the huddle. The huddle was also streamed up on a screen, where you would be able to visualise the areas that we were discussing and look at the staffing levels which was a concern, and whether any of them were safe or unsafe to start. They were categorised by a RAG system: red, amber, and green. Green meaning safe to go, amber meaning there is some concern that we could possibly help mitigate their problems and red meaning that they are unsafe. Therefore, action would have to take place to allow them to move into either an amber situation or a green situation with consultation with the Nurse in Charge and the Lead Nurse, the Hospital Coordinator, and the Bed Manager.

187. Huddles are an effective way of getting information passed out quickly. If I had to speak to everyone about a situation or inform them of anything, I would do it in the morning huddle.

**Communication from IMTs**

188. From IMT, communication would be verified or accepted by the Senior Management Team who would possibly take it to the Health Board or Senior Management there so that everyone would know exactly what to say, so the

conversation was guided. They would be given some information that would be written, so that it could be verbally given to the patient or parents and/or given as an information leaflet. I think for example, this may have happened regarding the cryptococcus case, but I cannot remember.

189. IMTs were an ever-evolving event. Every single day information was being updated or new information was coming to light. The communication had to be agreed by the team and also confirmed by the Board and you had to be able to facilitate meetings with the ward staff and the parents.

190. Communication can always be improved. You have to work with what you have at the time. My level of communication that I was given would be sufficient for me, but it did not necessarily mean it is going to be sufficient for someone else. It is also subjective and objective with the person that is giving it and therefore often being given a script or a paper to tell staff or parents is giving objectivity.

191. If there was anything in the media, that would be discussed at the IMTs too. Part of communication considerations looks at several aspects. They look at the level of concern as well and what needs to happen. There is a communication team there as well on the press and whether they decided what information has to be given over to the wider public, that is discussed at that meeting and decisions are made. Communication is always discussed at the meeting; it is part of the process. I do not know if the communications team was the same team who we sometimes referred to as the corporate press team. I imagine however, that the corporate team would always have a communications team.

192. Regarding the communications that went out round about the time of all the infections, I did not have anything to do with that.

**Communication with patients and families**

193. Communication to patients and families would be from the Senior Charge Nurse, General Manager, would communicate with parents and go around and give them information.

194. For the bigger things like the cladding, in Wards 2A and 2B, it required the Consultants or the Clinicians and Nurses within that Ward to talk to the parents to let them know that the cladding was being removed because it affected children with immunocompromised conditions. The cladding, once removed, could create spores in the external environment, where the patients would be walking through to come into out-patient clinics, and therefore they would require some Prophylactic Anti-Fungal medications. The Consultants would inform them of this Prophylactic and Antifungal that would be required. I think most of the patients were on the Antifungals and as part of their treatment plans, but anything extra they would be informed of that. I cannot recall whether there was an official notice that about the cladding.

195. Communication from Clinicians to patients and families was the first course of action because they have a close relationship, as do the Nurses in the Ward; anything that was official would come through in the form of a letter.

196. The ward also had patients coming from out-with the ward and it was difficult to get over the information as quickly as it was required. Therefore, there would be some patients that may have missed that, and the communication was not delivered as effectively as it could have been. Whether communication needs to be looked at as team communication within that group or population, it is difficult to know. How do you get information out? Is it through the media? That is not the way most people want to hear things. You want to be able to contact everyone but what resources do we have to contact everyone? People are going to be missed so it was as effective as it could be.

197. In particular with the Cryptococcus incident, we knew it was going to be on the news, we are going to move the patients again to another Ward and explain the situation. We were also talking to the staff and having meetings

with them. It was a challenging situation for all. I would have spoken to parents individually as well, explaining perhaps why we were moving or what the situation was.

198. There was talk of doing text messages at one point. That was an issue, because we had to get permission to use people text and quality improvement was looking to get feedback and also looking at ways to trying to get feedback and the big problem was, do we have permission to use people's texts or their emails? You would also have to make sure that their contact details were up to date and ensure that you did not make any mistakes. That suggestion was a particularly good one, to use text groups, WhatsApp groups or whatever to disseminate information quickly but there will always be someone who feels, "Actually, I would rather have that personal information given personally, rather than as a group text." It is a good idea, and it is something I think in healthcare that when you ask for someone's phone number, that you are basically giving your permission to say, "contact me."

199. I think in healthcare, where we over-analyse a lot of things and to the extreme where you may be missing out on vital feedback. For example, I was looking to try and get vital feedback from patients and parents and how we do, as I have found it quite easy here in Australia to just be sent a text and it is done, I never gave my permission for them to do it, but they do it.

**Communication: Cladding 2017**

200. I do remember seeing a Core brief sent out about the cladding **(A38845623 – Core Brief dated 12 July 2017 – Bundle 5 – Page 67)**. I remember the cladding was looked at because of what happened at Grenfell. I cannot remember if that was the exact briefing, but we were told that the cladding on the Children's Hospital was going to be removed.

201. A similar document was given to the patients and families regarding the cladding (**A38845769 - Cladding briefing for inpatients dated 7 September 2018 – Bundle 5 – Page 101**). As I mentioned earlier, their doctors would tell them what was happening but there were two areas in Ward 2A/2B. The in-patients who then are readily able to be given that information. Those that are outpatients or are not in the ward at the time are not there to receive the information. They would not have had a clue about what was happening and so they were going to be admitted from A & E or from home and they do not understand what is going on, and then there are the other set of patients who are out-patients and there are a vast number of them who access the hospital not only from Glasgow but also from other health boards. (**A38845789 - Cladding briefing for outpatients dated 7 September 2018 – Bundle 5 – Page 103**). It is about ensuring that everyone gets the information in a timeous fashion and often that did not happen.

202. I remember that the cladding was going to be removed and that it was similar to Grenfell, but it was not a concern because we had been given assurance that it would be removed as part of a programme for anywhere in the country that had similar cladding.

**Communication: BBC Disclosure Programme – 2020**

203. I am unable to fully comment on the communications about the BBC documentary because I was in another role at the time. From memory a core brief was issued but I did not have sight of this at the time.

**Duty of Candour**

204. When something goes wrong during care or treatment, you should be open and inform the patients and parents or carers as to that event. Sometimes a

doctor may have to give information that something may have happened, harm or an incident for example and this covered by the duty of candour.

205. The duty of candour is when a clinical event has not gone to plan, where there is often in extreme danger or an event that may have caused care not to be as planned, and therefore you have to explain to the parent, a child, or a patient as to what has happened, and be open and honest about it. Often there is a criterion for duty of candour, as in the event could be one that is detrimental to that person's health, treatment plan, or indeed has caused severe injury, which could also include death. It could be an act or omission.

206. When I was a Lead Nurse, I did not have any concerns about wrongdoing, failure, or inadequacy within the hospital. If there was any situation that was not in the course or the plan, you would report that. First, you could write a written report on Datix and report it to your manager and seek advice as to that situation. There is always a way of reporting an issue. I always felt encouraged to raise any concerns I had.

**OVERSIGHT BOARD / INDEPENDENT REVIEW / CNR / PUBLIC INQUIRY**

207. The impact of participating in the Public Inquiry, from my own perspective, it has made me quite anxious. It causes me anxiety, wondering if people think we did anything wrong and really the interest for everyone is to ensure that best care is given, and we were all working to ensure that that happened. I can imagine, for me, looking in and looking over as to that period of time and what other people must be going through now, then, yes, it must be causing them great anxiety too. That whole time was a tremendous strain on teams working out-with their normal environment, working with parents and children who were upset and not understanding what was going on.

208. Now, I have been four years down the line after events and I have been asked questions when I do not quite understand the whole thing. There have been so many reviews carried out.

209. I cannot understand what more there is to learn from it. I just felt that when the first review was carried out, the independent review, which was what was required and now there is this Inquiry. I have listened to lots of parents and through the YouTube videos, I have listened to some professionals from Edinburgh, and I understand the parents, how they feel about the situation. I do not know what to say. I am taking part in this; I just wish it were sooner that they had some more information. I wish that I were one of those people still working in the organisation where I would have access to everything rather than trying to remember a job that was extremely stressful at the time. It was a secondment to me that became very much the focus of my role predominantly was taken over by working with Ward 6A and 4B along with my other remits. I am sure lots of people had the same constraints, but I do not have anything (emails, notes etc). I do not have any information to refer to. For me, this has caused me a lot of stress, but that is nothing as my stress pales into insignificance compared to what our patients and families feel or may have gone through and so I am happy to participate. However, from a personal note I can state that it has caused me a lot of stress and anxiety.

## IMPACTS

### Impact on Staff

210. Regarding the staff, anecdotally they may have felt that it was so much more work than they were ever expected to have to do prior to those times. Pressure would be on them because ultimately when anything is being reviewed or audited a certain level of what they may feel is blame. They may feel that they are being subjected, or they are being blamed for things that are out-with their control, but they feel responsible. Therefore, the added pressure

of cleaning and moving patients to different rooms, preparing the rooms, or getting ready for HPS cleaning or any of those sorts of things, they ultimately took the blame. Any audit that was on the ward technique, for example, when we audited their line access and all that makes them think they are to blame when in fact, auditing demonstrated positive outcomes and their level of care that was given was exemplary. We had to assure the care that was being delivered and make sure that, if anything, we were going to improve.

211. There was an impact on the staff during the moves too. I was not there for the first move as I was on leave. It was all co-ordinated, but it was out-with the norm. People would be anxious, that is a given, because they are not sure why or how it is going to move to another area. But it is co-ordinated with the teams have a plan and so therefore they try and follow the plan as best they can. We transfer patients throughout the hospital all the time, for example, back and forward to theatre, to intensive care, these things happen. What was happening in the wards was we were moving belongings as well as patients. We can move patients anywhere. We are all very familiar with doing that in a safe environment and a safe method, safe transport. We can do that. We just need to make sure that there are plans for lifts, for freeing up corridors, all that stuff. The extra work that comes along with a move is the belongings and the furniture and ensuring that you have facilities available so when you arrive on another ward that you have things like resuscitation carts, medication, all of those sorts of things are duplicate. Before you make a move, you involve all the teams that are going to have the specialist knowledge in all those areas, for instance, resuscitation, pharmacy, intensive care, extra doctors, extra porters, facilities, we have all those teams working in the background. Therefore, it comes to on the day it is just the physical move, which is another added pressure, but it is basically straightforward. By the time the second move happened, we were used to it.

212. There was planning for all the moves from the day that the IMT started back again until the patients moved and even to the point, I left that job: itwas

constant. There was constant planning for teams to be available, doctors to be available, nurses to be available, it was always, always in the forefront of everyone's mind.

213. When I say everyone knows what they are doing, there is always going to be team members who are unfamiliar and have come from another area and when they may discuss or talk and give that impression that they do not know what they are doing and therefore just one person saying that, what everybody thinks, "Oh, you do not know what you are doing, actually." The amount of preparation and planning for all of those moves was documented. It was talked about with various teams, meetings were taking place ensuring that everybody knew what was going to happen on those days, ensuring we had the right amount of staff and the time of day that it should happen: the movement of patients, all of those things were discussed with lots of different teams.

214. Staff were all putting in extra hours at this point too. They were working in different environments. They were going to have two different wards they were going to be working in. We had to staff the teams and ensure we had enough staff. Sickness was an issue with some of the staff, maybe that be long-term or maternity leave. We had to cover two different areas so therefore we had to ensure we have more staff available and with the team limited numbers they have for that ward that has been agreed. We then have to find more staff and ensure that you have the right staffing levels to accommodate that. At the beginning, it is always going to be anxious for all teams, working out-with a norm for them.

215. The teams often had to change their roles, so the Advanced Nurse Practitioners, they went onto the medic team for covering at night, we had different levels of teams to cover Ward 6A and some to cover Ward 4B. There were times where, yes, their stress and anxiety came to the front, and we would be made aware of how they were feeling. I think that the movement of

the ward did have an impact on the staff, but they are a very resilient team, and they should be congratulated for everything that they did, and they continued working as they did, and they did so as a very professional group of staff.

**Impact on Patients and Families**

216. The inconvenience of moving a room on a regular basis over that period of time, which would have been out-with the normal. Patients do move rooms, especially if they are in long-term, because they have to do like a real deep clean because you cannot get into half the room because of the patient's belongings, for example. It must have been a real inconvenience to the parents. But that I was never really aware of anything like that because I did not work on the ward. I do know, by listening to the YouTube hearings, that that had an impact on several of the people interviewed.

217. When the cladding was removed, there was an impact on the patients and families. The patients in Ward 2A and 2B, because of their conditions had to be very careful. When the cladding would be removed, there was a perceived risk that it would increase spores. They would therefore have to look at reducing fungal spores and they would have to have antifungal drugs. Now, a lot of patients that are in that population in Ward 2A/2B are already on antifungal drugs and those antifungal drugs were already protecting them for that event. The other thing was to look at mitigating the risk to them by asking them to take a different route to the hospital. We closed off certain areas so that they would come through the other part of the building which was through the adult's hospital.

**CONCLUDING COMMENTS**

218. The last few years of my employment have been an extremely difficult, challenging, stressful time for not only myself but for all staff, patients, and parents, and carers, the families that were involved. Everything that we did was to ensure that the best option we had at hand was in place for those families. We were hoping that this time would have been short, and not the extended time for them to be back in Ward 2A/2B. and I only hope now that they have a Ward that has got everything they want and need. Prior to all this happening, there was a plan that I worked with for some of the Doctors that was a room for Radiotherapy which would allow the doctors to carry out treatment that would normally send a patient down south to receive. All those things went on hold when this decant ultimately had to happen. Everybody did everything they could, and more so the staff that were present on that Ward Day in, day out. They were coping with the things or issues that were in front of them on most days, proactively and actively dealt with the challenges in front of you. Everybody did their ultimate best in a professional manner.

219. 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.