Scottish Hospitals Inquiry

Witness Statement of

Melanie Hutton

PERSONAL DETAILS

1. My name is Melanie Hutton. I am currently the General Manager for Paediatrics and Neonates at the Royal Hospital for Children (RHC) in Glasgow. I am employed by the National Health Service Board for Greater Glasgow and Clyde (NHSGGC).

2. I took up the seconded post to Lead Nurse in October 2014 across in-patient areas at the Royal Hospital for Children Glasgow (Yorkhill) until July 2018. This was originally a secondment which later became a permanent position. In this role as Lead Nurse I had responsibility for Wards 2A and 2B RHC, which are for paediatric haematology and oncology in-patients and day-care, (from October 2015 until July 2018) as well as the other in-patient areas. My Line Manager at this time was Mrs Heather Dawes, who was the Clinical Services Manager.

3. From July 2018 until November 2021, I was the Clinical Services Manager for Paediatrics and Neonates at RHC.

4. My line manager from 2018 to 2021 as Clinical Services Manager was the General Manager for the (RHC) Jamie Redfern. Jamie is now the Director for Women's and Children's service and I took over from him as General Manager for Paediatrics and Neonates. I continue to report to him in this role.

PROFESSIONAL HISTORY

5. I began my nursing career at the Law Hospital in Lanarkshire, where I registered as a General Nurse in 1991. I originally worked with adults but,

having completed a conversion course in 1994, became a registered Sick Children's Nurse and began working at the RHC at Yorkhill in Glasgow, within the Accident and Emergency Department.

6. In 1995 I became a Senior Staff Nurse within the Accident and Emergency (A&E) Department at Yorkhill Hospital. In 1998 I qualified with a BSc Honours in Advanced Nursing Practice and became an Advanced Nurse Practitioner, still working within A&E at Yorkhill.

7. In 2006 I took over the role of Designated Senior Charge Nurse within A&E at Yorkhill, which involved management responsibility.

8. I remained in that position at Yorkhill until 2014 when I became Lead Nurse. During this time the role and responsibilities changed on several occasions so I was responsible for several different areas throughout that period.

9. In June 2015, we moved to the new Royal Hospital for Children, on the QEUH campus. I continued in my role as Lead Nurse there, from October, with responsibility for Wards 2A and 2B, which were haematology and oncology in-patients and day-care. Prior to that, the Lead Nurse for the Schiehallion unit in Wards 2A and 2B was Mary McAuley. She was with the Schiehallion patients during the move from Yorkhill to the QEUH campus, but retired in October 2015 when the wards then fell under my remit.

10. I also covered the third floor, which comprised three 24 bedded Wards: 3A (neurosurgery, neurology, complex airway); Ward 3B (general surgery, cleft and gastroenterology; and Ward 3C (renal, renal day dialysis, orthopaedics and respiratory).

11. I also had responsibility for Ward 1E, which was a 14 bedded ward for cardiac patients. At that point I managed the Clinical Nurse Specialists, whose specialities linked into those wards. They provide outreach and out-patient support by working with patients at home, providing them with the necessary

care and support to allow them to be treated at home rather than having to be admitted to the hospital as inpatients.

12. As Lead Nurse I did not undertake direct clinical care within my areas, however I did have leadership responsibilities for all of the areas which I covered. Each ward has a Senior Charge Nurse (SCN) and, as a Lead Nurse, I had a remit of multiple areas, so it was my role to provide leadership and support to the SCN's and their teams.

13. Prior to moving to the RHC, I did not have responsibility for haematology-oncology. At that time, that unit was under the remit of another Lead Nurse colleague, Mary McAuley, who subsequently retired in October 2015. After her retirement, responsibilities for the ward areas were changed and it was in October 2015 that Wards 2A and 2B and the Clinical Nurse Specialists all fell under my remit.

14. As Lead Nurse, I routinely chaired the daily safety huddle, at which I was responsible for ensuring safe staffing as well as escalating any concerns to the Clinical Services Manager and Chief Nurse. Each Lead Nurse has different areas of responsibility.

15. In terms of the supervision structure in the Wards, each ward under my remit had a Senior Charge Nurse and they all directly reported to me. There were nine teams of Clinical Nurse Specialists, whose team leads reported to me. One of the teams was the Paediatric oncology outreach nurses (POONS), whose main role was to aim to provide care in the home rather than in hospital. Anne Clarkin was the lead for this team. At that time Angela Howat was the Senior Charge Nurse for Ward 2B and Emma Somerville for Ward 2A.

16. In my role as Lead Nurse, Heather Dawes, who was the Clinical Services Manager, was my line manager. Heather retired in June 2018 and I was then appointed as the Clinical Services Manager for Paediatrics and Neonates at RHC until November 2021.

17. I succeeded Jamie Redfern as General Manager in November 2021.

CURRENT ROLE

18. Within my current role as General Manager, I have operational responsibility for the day-to-day running of the Children's Hospital as well as for developing and implementing services within RHC and Neonates, ensuring that there is a clear focus on the delivery of a range of high quality, safe and efficient patient-centred services to meet local and national targets. I work in close partnership with the Chief Nurse. She is responsible professionally for nursing staff. I currently line-manage the Clinical Services Managers, of which there are two. I am responsible for all national services. I also have budgetary responsibility the RHC.

19. Since being in my role, I have not made any changes with regard to the monitoring of environmental safety in Ward 2A and 2B. The actual audit of the environment status sits under the remit of the Infection Control team and I have adhered to the processes that were put in place by that team. The Chief Nurse takes overall responsibility for infection control within the hospital, with support from the General Manager.

THE NEW HOSPITAL: PLANNING STAGE – PRE 2015

20. I was not part of the Design Team for the new hospital. At the design stage for the new hospital, I was in fact Senior Charge Nurse of the Emergency Department (ED), so I was involved in some pre-hospital meetings in relation to some broad aspects of the configuration of the ED.

RHC: DESCRIPTION OF THE PHYSICAL ENVIRONMENT

21. The Nurse Specialists were all based in the office block which was co-located separately from the hospital. They were not always in the hospital because they worked a lot remotely and they did a lot of clinics. Because of the size of the Children's Hospital and the fact we have a lot of national services, they also

provide a lot of remote care to clinics and other neighbouring health boards, so we did not always physically see them inside the hospital on a day-to-day basis.

22. The third floor included Wards 3A, 3B, 3C and the dialysis unit, which is part of Ward 3C. Directly below that floor were Wards 2A and 2B which were the haematology-oncology wards. Also on that floor was acute receiving, which was managed by another Lead Nurse.

UNIQUE FEATURES OF WARDS 2A AND 2B RHC

23. At that point, Wards 2A and 2B were physically very similar to those wards on the third floor, although there were some differences. Wards 2A and 2B did not have a four bed bay. All the wards on the third floor had four bed bays. Ward 2A had all single cubicles and the staffing levels were determined on single cubicle allocation

24. Ward 2A also had the Teenage Cancer Trust (TCT) corridor which had the four TCT rooms; these were different to the other wards. By that, I mean when you come in the corridor, you go through another room and there is a sub-corridor, so it feels like their own suite of rooms rather than them being in the main ward area. Then there are four cubicles with a different interior design to the others. Clinically, they all look the same, but the designs of them were very much geared towards teenagers and teenager friendly so that meant they were different from the other ward. The lighting was nicer and the area looks more grown up; the soft furnishings have been chosen to reflect the age group.

25. TCT has its own zone sitting area, which has a jukebox, a pool table, gaming chairs and outlets and a nice large television for them. They have their own kitchen area. That is not offered anywhere else in the other in-patient ward areas, so I think that is why it is different.

26. The Schiehallion unit also had the bone marrow transplant rooms which had anterooms going in to the room. When you enter the room, you step into

another area called an anteroom, before you close that door and open the door of the cubicle into the bedspace. The other rooms, you would open the door and be straight in the cubicle. The anterooms were specially designed at the build stage of the hospital.

27. Wards 2A and 2B had a playroom, which is the same as the other wards. Wards 2A and 2B also had a parent room, a classroom area and an interview room which the other wards did not have a parent room or classroom.

28. Ward 2B was a day care unit so it was designed completely differently. It was not seen as an in-patient area, but it was designed very similarly to Ward 1C, which is another ambulatory care area.

29. Ward 2B was designed more like an out-patient facility so there are not in-patient beds; they have examination couches instead. There are single cubicles for the couches and there are also bed bay areas with beds to allow treatment to be carried out.

30. There are also waiting areas for patients and office areas located next to the waiting areas, which the in-patient areas do not have.

31. I was not responsible for the Paediatric Intensive Care Unit (PICU), however I am happy to describe the layout. The PICU is completely different to an in-patient ward: it has six cubicles in it and it has a negative pressure room which is where any patients with infectious diseases would go.

32. It has bed bays which are to facilitate one-to-one nursing and also to accommodate the amount of medical equipment required, so the bedspace configuration is larger than it would be in a normal bed bay.

Protocols For Specific Patient Groups

33. We have many protocols relating to care and treatment within the hospital called Standard Operating Procedures (SOPs), however as I am in a managerial role, the responsibility for these sits predominantly with the clinicians and the clinical teams, rather than with me.

34. We do have clinical guidelines for patient care or pathways. These would be signed off by the clinical team - the nursing team and ultimately by the Senior Charge Nurse - rather than myself

35. The clinicians are predominantly responsible for the clinical guidelines, so the consultants and usually the clinical leads for the areas would sign off any guidelines of that nature.

36. SOPs such as handwashing and the various other processes and protocols sit under the Infection Control nursing team rather than the ward nurses. I would have sight of these documents and would also give comment, however I would not be the author or the final sign off authority for them; that would remain under the team who had ownership for that particular SOP.

37. Most SOPs are general for the hospital, however the handwashing SOP would be a generic infection control SOP which would be used across GGC.

38. There are some SOPs which would only be specific to one area, however, because they would be more patient focussed or specific rather than general and standardised.

INITIAL IMPRESSIONS OF THE NEW HOSPITAL: 2015

39. When we arrived at the hospital there was nothing I could see that gave me any cause for concern. We did some pre-visits prior to the children coming over, and I do remember at times there were small amounts of materials still visible and areas still under construction, but that was all rectified prior to us moving in.

40. I remember taking staff around and having to make them mindful that certain aspects would still require to be completed prior to the hospital opening, as they thought they were going to see the finished result. Wires were still visible on the ground and, in the out-patient area, in the main atrium of the hospital, there were broken tiles and there were some roof tiles also missing in some of the areas. We were mindful, however, that the hospital had not been handed over at this stage. There were still workmen working on site when we attended site visits. Any unfinished areas were cordoned off and they were working on them prior to us moving in. We had to wear working boots, a hi-vis vest and a hard hat during the site visits and we first had to sign ourselves into the project building site. We were given different badges to get into the hospital and we all got a health and safety check about entering the building. We had to go through all of that before we went on to the site.

41. But that was prior to us moving in to the building; once we arrived on site on the day of the move, I had no cause for concern at all.

42. When we did move in, it was completely different to Yorkhill. The new hospital looked very child friendly and young person friendly. It was very colourful. It had been designed very much with colour themes in mind and it all felt new; it felt modern.

43. The atrium was impressive: when you arrived in the hospital it was like no other hospital I had been in. It looked completely different. There was the out-patient area which looked more like a science centre, so that visually was completely different, when we arrived the hospital looked modern and new, large and colourful.

44. Comparing the areas I worked in at Yorkhill Hospital to the new RHC, we went from an open ward to single cubicles, which were very well received by the parents because they all had their own areas as well as an en-suite facilities.

45. Previously in Yorkhill, parents may have complained about not being able to sleep because they were in open bed bays and could hear babies crying and did not have individual washing facilities, so those issues had been resolved.

46. Each ward had a treatment room, which they also had at Yorkhill, but the treatment rooms at the new hospital were more modern and there was also a lot more storage space.

47. Medical equipment was the same in the wards, but the single spaces had their own bed heads, so each bed had its own gases, suction and oxygen. This was an improvement to the facilities in Yorkhill.

48. The emergency department was also far bigger than we were used to previously. It was a designed with a standalone four bedded resuscitation area which they did not have at Yorkhill, which by comparison was all very crammed.

49. At Yorkhill the resuscitation area had been a redesign of an old part of the back of paediatric ITU and it had been made to fit, whereas in the new hospital it was designed for purpose, it had a much better entrance. The ambulances could come straight in, whereas previously they had to go through the clinical area, so everybody would see a sick child arriving in the hospital because they would have to go through the waiting area. When we moved to the RHC, we did not have that issue anymore.

50. We also had a separate area for triaging patients, so they had their own rooms. At Yorkhill this sometimes had to happen in corridors, so it was not private there at all. That issue had been resolved in the new hospital.

51. In the new hospital, within the Emergency Department, within the waiting area there was now an entrance and exit door for triage, so we were not having to take patients in and then having them feeling as if they had to go back out in to the main waiting area.

52. There was also a separate minors' area and majors' area too, so the emergency department was about three or four times larger than the ED we had in Yorkhill.

53. Also it was all very much better designed. At Yorkhill Emergency Department we were all in cubicles. With some of the doors you could walk along a corridor and often could not see all of the patients. Patients could be sitting deteriorating and the nursing staff would not be able to see them, but that is not the case in the new hospital.

54. The new emergency department is very much designed on what we call a 'ballroom facility': it is a round, curtained area and allows a member of staff to eyeball all of the patients in the unit at the one time. It all felt much safer than it did at Yorkhill.

55. I suppose now with the media coverage the general public may have now formed a different perception of the hospital. I do think that will change.

56. We have modernised the way that we work and we will continue to modernise, but that is probably more through IT and other innovations that we adopt rather than a focus on the fabric outlay of the building.

Room Temperatures

57. I was aware of issues with temperature in the rooms. There were times when people would report to the nursing staff in the ward that some of the rooms were too warm or too cold, but we had ways of escalating that through our Estates colleagues who would then rectify the problem. Issues like that would tend to be raised by the staff to the nurses in the wards. They would then log a call through our Estates facility which is done on our Facilities Management (FM) reporting system. The procedure is: the nurses would log the issue online; and Estates would then reply, and as the heating is controlled centrally, they would then adjust the temperature either up or down accordingly. There is also

a phone number that the nurse can phone straight through to the FM desk and Estates will respond directly to them through that if they do not immediately pick it up through the FM.

58. The temperature fluctuates quite a bit depending on the Scottish weather. For example, yesterday the building felt warmer because we had our heating on, but then it became warmer than expected outside and therefore Estates had to adjust the temperature down accordingly.

59. The Senior Charge Nurse would make me aware that they had contacted the Estates Department because the temperatures were either too warm or too cold, but I would not be the one to whom people reported the issue.

Functionality of Blinds

60. The blinds in the wards are all inside the glass units of the windows; they were designed that way for infection control reasons. Previously, when we were in Yorkhill, we had roller blinds, but these fell off all the time. They were always breaking and were challenging to clean, so part of the new build was to include what we call integral blinds. Now the blind units are all sealed inside the window. There are buttons on the inside of the window units that turn which can either open or close the blinds inside.

61. I am aware of times where blinds have broken and people have been unable to adjust them. Again, issues like that would be logged on our FM system and our Estates colleagues would come out and fix them. These issues would not be reported directly to me.

Television and Wi-Fi Issues

62. I am much more familiar with issues we had with the televisions than I am with the Wi-Fi. The televisions we had were patients' standalone televisions. This was something we were all excited about as we had not had anything like it

previously. Initially they worked very well, but then just with all the constant usage we had issues. I cannot recall when the issues with the televisions happened.

63. Remote controls began to go missing; people were accidentally taking them home or mistakenly putting them in the bin, so we went through an immense amount of remote controls at the very beginning.

64. Then the televisions themselves became problematic. There were issues with them not switching on and off, not functioning properly and not being accessible for everything they were designed to do. We routinely had Estates out checking them.

65. We couldn't really move the televisions ourselves because they were all wall-mounted, so we would try and accommodate patients as much as we could. If there were empty rooms, we would move the patients about so that they could get a room with a working television.

66. If we were aware of a television not working, we would offer DVD players.

67. Recently, however, just since the end of last year, we have rolled out a very successful redesign programme where we have removed all the previous televisions and replaced with iPads.

68. These have recently been installed throughout the second and third floors and are in the process of being installed across all of RHC. We have access to Netflix and Disney Plus on them and the children love them.

69. I was not as aware of Wi-Fi issues. There were spots when we moved in where we felt sometimes the Wi-Fi signal was not as great as other areas in the hospital, but these were resolved by the Estates and Facilities team who arranged for additional routers to be installed.

Plug Points And Battery Packs

70. I was not aware of any issues with plug points or battery packs, however, I am aware that, following the decant from Wards 2A and 2B, and we were doing the work for moving back from 6A to 2A and 2B, the nursing staff asked if we could put additional sockets in.

71. Our young people also asked for additional sockets in the TCT rooms, although that was more for having data points for charging their phones.

72. We did not have these originally, so we have put data points in the TCT room on the move back. We have also put additional sockets in, but that was the first time I was aware that anyone did not think there were enough power points.

Ward Entry Systems

73. I am not aware of any specific issues with the entry systems for Wards 2A and 2B. There was an issue with one of the other wards – Ward 3A that routinely had problems with their door when we moved in, however, that was resolved.

74. More recently, we have adapted our entry systems. We have moved on technology wise so we now have fingerprint readers for parents. I am aware that ward access was a problem felt by parents, not just in 2A/2B but throughout the wards.

75. We are obviously a children's hospital so we obviously have children and young people and babies in our wards. We only have swipe access for staff, so any visitor or parent had to press a buzzer to allow access and then they had to wait for a staff member to come and help. The buzzer would ring on the nurses' station, which is manned by the ward clerk.

76. Most areas, apart from Wards 2A and 2B, would only have a ward clerk on duty until 4 p.m. If nurses were busy in the evening, there may have been delays in

answering requests for entry where parents may have felt as if they were not being allowed access quickly enough. Ward 2A had cover in to the evening and over weekend.

77. We listened to feedback from parents, acknowledging that these delays were not acceptable, and therefore we looked for newer technology and we now have fingerprint entry installed in all of the wards. Now, when a parent is resident, we can take a fingerprint from them and it is recorded electronically, which gives them access if they use one of the readers outside the wards.

78. If you were to attempt to gain access to the ward and you did not have your fingerprint recorded, you would not gain access. When the child is discharged from the ward, the fingerprints of the parents are then deleted. This system is working exceptionally well.

Issues Relating to Sewage Leaks

79. There were more issues in external areas than in ward areas. I am aware that there was on one occasion a sewage problem in areas in the corridor behind the Aroma Coffee Bar; that was only initially when we moved in, and again that was escalated to Estates who rectified the problem. The Aroma Bar is not close to Wards 2A and 2B. The area with the leakage was in the corridor behind the Aroma Coffee Bar which is an office area.

80. I cannot remember the exact details, but I think that there was an issue in Ward 2C at one point, which is the acute receiving ward with a toilet which leaked. There was also an issue I think in the adjacent toilets to Ward 2C. I cannot remember the date this occurred

81. Our process in situations like these is for the nurse in charge to record the incident on our FM system. However, we also have our huddles that happen at 8am and 3pm every day, which is also an opportunity to raise any estates issues.

82. At the 8 am huddle, we would pick up anything that had occurred overnight and anything that needed action taken immediately. Our Estates colleagues would be at the huddle and we would escalate that straight away to them and they would send a team out, therefore, we do not always rely on the FM system.

83. If there was an issue with sewage, we would not just record that on the FM system and wait for Estates to pick up the call; we have a system where we can contact them either out-of-hours or during the day. Where we required an urgent response, we would phone the Estates Duty Manager, and they would respond immediately.

84. That would be over and above the online reporting, but we would also always log the call, so that this was recorded. It is the same if we are asking for a terminal clean of a cubicle. We have a system where everything is logged, for example, if you wish to request a porter, then you log it. But if you want something urgent or as a priority, there is another way that we could just pick up the phone and phone through to the on-call DECT (Digital Enhanced Cordless Telecommunications) phone and we would get an immediate response.

85. The term terminal clean is an enhanced clean. If we have had anybody that requires to be isolated due to infection, then we would request a "terminal clean".

Issues Relating To External Cladding

86. I am aware that the adults' hospital had some external cladding replaced and some panels in the children's hospital have also been replaced. I cannot recall when the cladding issue was, but I think it was around 2018.

87. The majority of the works in relation to cladding has been carried out in the adults' rather than the children's hospital. External panels were replaced in the children's hospital, although I am not sure exactly of how many or where.

88. **(A38845769 – Cladding briefing for inpatients dated 7 September 2018, Bundle 5, page 101)** I am referred to this document, which is a briefing for patients. This shows a picture of the Children's' Hospital. I do remember this briefing being issued to the parents when we had to make arrangements for a different side entrance to the QEUH and provision of a designated car park area. It was not me personally who issued this communication; it was the nursing staff. The leaflets were also posted out to families who were not in-patients at the time. I think we also provided the families with a site map showing the location of the car park and the side entrance in order to access Ward 6A. With regard to the fourth paragraph of this leaflet **(A38845769 – Cladding briefing for inpatients dated 7 September 2018, Bundle 5, page 101)** I would not have been involved in any discussions about the use of anti-fungal drugs.

89. I remember that there was an occasion on which an external window fell out of the Adult Hospital and, as a result, an area had to be cordoned off outside the hospital. If you can visualise the two hospitals sitting side by side, you have the main entrance to the Queen Elizabeth and on one side of that is what is termed the side entrance. This used to be the discharge area for the QEUH; it is currently the SATA (Specialist Assessment and Treatment Area)

90. It was one window that had come out as a panel on the right hand side of the Adults hospital, which was a completely different side of the building from Wards 2A and 2B.

91. I did not have any personal involvement in this at the time; we would only be notified of an occurrence like that if there were a piece of work being commissioned which would result in areas of the campus needing to be closed off. That information would be disseminated via core brief or direct to me from the Estates and Facilities team to notify the wider team.

Issues Relating to Smells Inside and Around The Hospital

92. I am aware that we received comments about the smell of smoke coming into the in-patient areas in the hospital from members of the public smoking outside the adult hospital. Smokers tend to congregate there and then the smell rises up. The smell of smoke from below was experienced more on the theatre floor. We have cordoned off the area where the problem was so that the public can no longer get into that area. This was initially done with a temporary barrier, but it is now a permanent, fixed barrier. We have also implemented a No-Smoking Policy and it is now easier to enforce that because of the implementation of the smoking legislation which prohibits smoking within 15 metres of the hospital site. Members of the public will still try to smoke, but they are always asked to move on and to stop smoking. These changes were actioned as soon as the issue arose.

93. During summer months the smell from the adjacent sewage plant on the QEUH site can be noticeable.

94. We were all aware of the sewage smell when we moved over to that site. I think that had been an ongoing issue for people who had worked in the old Southern General Hospital site which was there before. It only tends to be more problematic on certain days, depending on the temperature. You tend to smell it more in the summer on the hot days but you are not aware of it all of the time. The sewage plant is not part of the QEUH campus site. I have never smelt it in the hospital; only in the outside areas of the hospital campus.

INFECTIONS

Hospital Acquired Infections

95. My understanding of a Hospital Acquired Infection (HAI) is that this is an infection which is a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HAI covers a wide range of infections.

96. A non-HAI is an infection which would occur outwith a hospital setting.

97. I am aware there is a related term, HCAI – Healthcare Associated Infection - but I would know this acronym as being an HAI, a Hospital Acquired Infection. That would be the terminology I am more familiar with.

Protocols Around Suspected Line Infections

98. I do not have the expertise to be able to comment.

Monitoring and Investigation Of Infection In The Hospital

99. My understanding of the investigation and monitoring of infections within the Children's hospital is as follows. If a child or a young person is reviewed by the clinical team and there is a concern that the child may have an infection, then a blood sample would be taken and sent to the laboratories. They would then analyse it and send the results back. The clinician receives an automatic notification that the result is back and the results would then be passed to the person who submitted the sample.

100. If the Microbiologist in the labs feel there is an abnormal result, then that information is triggered directly to the Lead Nurse for infection control. If there is anything the lab is concerned about, they do not wait for it to come back through the normal process of it being updated on the Portal; instead there is an immediate phone call to the ward to say that the Microbiologists have a concern with a result and request for this to be passed immediately to the clinical team.

101. That information would then be cascaded to the appropriate people in the patient area, and that would be to the Clinical Lead, the Clinical Director, the Lead Nurse for that area and the Senior Charge Nurse for the area.

102. If the lab results show an unusual infection from the blood samples or if there is a concern that there is more than one patient with the infection, that would be a trigger for a Problem Assessment Group (PAG) to be held, which is a group which assesses an infection situation.

103. That is an initial stage which is led by the clinical team for the patient and infection control. If they then feel that the next level has to be triggered, then an Incident Management Team group which would be established, which is the IMT.

104. The IMT would be where the peripheral people to the patient would be involved, such as me in my role as Lead Nurse and then Services Manager, so I would not predominantly be involved at a PAG stage but I would at an IMT.

Involvement with Infection Control Procedures On The Wards

105. As a Lead Nurse I would be involved in attending the monthly Infection Control meetings that were chaired by the Chief Nurse. I would also be involved in cascading any information or policy changes.

106. I would also perform enhanced supervision, along with the Lead Nurse of Infection Control across all my areas. That would consist of ad hoc visits to the wards where we would go through a process looking at the cleanliness of the ward, inspecting the equipment, making sure we were happy with the standards within the ward, checking nursing documentation, checking our care assurance bundles and making sure that our CVC (Central Venous Catheter) lines are all marked that they have been checked.

107. It would be the same with the IV (Intra Venous) sites: we would check that all their paperwork was up to date, that we had assurance that this was all being carried out as per procedures, and this process would be across all my ward areas.

108. We would also seek guidance from Infection Control if we wanted to change anything in the ward or if we were looking for advice on visitors coming to the ward, or if there was concern that we had, for example, a patient with diarrhoea or vomiting.

109. We would also seek guidance if someone came in with chicken pox or anything else which is infectious. So in all these cases we would have direct communication with Infection Control.

110. Infection Control are always available for advice and support. They also have an on-call system; they have a Microbiologist out-of-hours. During hours you would predominantly go to your nursing colleague and ask them to seek advice from the Microbiologists. However, out-of-hours the nursing teams are aware of the on-call system through the switchboard which would access a Microbiologist if they were looking for any advice.

General Actions Taken In Respect Of Infection Control

111. I would walk around my areas every day when I was a Lead Nurse. I would not perhaps do an enhanced check daily, however we carried out monthly audits at that time and then, depending on what may have been found in some areas, I would go back more frequently until I was happy that any issues I had asked to be addressed had been resolved.

112. However, in general when I walked through my wards, I was very much aware of aspects which could potentially be issues, such as storage. For example, were there items stored on floors that should not be there? Was there equipment in corridors that could be moved? You get a feel for the general tidiness of the ward and you work proactively to keep it as clear and as safe as possible.

113. Equally, if I found that if, for whatever reason, there was a cubicle closed, I would take action to inquire why and, if issues were still waiting to be addressed, I would escalate it to Facilities

114. We would also be assisting the staff if occupancy was high in the hospital and we were looking to move patients, I would go and make sure that we had beds to ensure that the patient flow continued in the hospital. All that would be done as a Lead Nurse; it would not have been done as a Service Manager.

115. When I became a Service Manager, I began to have very limited access or presence on the wards. I would still have involvement but not as directly as I would have as a Lead Nurse.

116. The Clinical Service Manager is the line manager for the Lead Nurses. I am still very much aware of the Lead Nurse structure and, having being a Lead Nurse, I would like to think I am able to support them a bit more than if I had not been through that journey myself.

117. Once I was appointed as Clinical Services Manager, I did not attend the monthly infection control meetings. My colleague, attended on behalf of the Service Managers.

Cleanliness And Hygiene Within The Hospital

118. I have never had cause for concern about the cleanliness of the building. If we required an area to be cleaned, we relayed this to our Domestic Team/Facilities Team and it would be escalated to the supervisor via a telephone conversation. There would either be an immediate response or this would be actioned within a reasonable time frame.

119. There have been times when I might go in to an area and visually see something and want it cleaned. We all carry DECT phones and, if that were the case, then an automatic phone call would be placed to the duty manager for

Facilities. If they ever got a phone call from a Lead Nurse to say we had concerns about an area or room we wanted cleaned, then it would actioned on as soon as possible.

120. I would say that was part of everyone's role in the hospital: if we see something we are not happy with then we have a responsibility to escalate that and to ensure that it is done. Perhaps as nurses we are more visually aware than other specialities and, because of my role, I always wanted to ensure that my area was clean and tidy.

CHRONOLOGY OF EVENTS: WARD 2A/2B RHC
ISSUES RELATING TO THE WATER SUPPLIES: 2017 to 2018

CLABSI Group: 2017

121. In May 2017 a Quality Improvement project was formed following an upsurge in positive central line cultures in haematology and oncology patents since July 2016. The primary aim of the project was to reduce Central line associated blood stream infection (CLABSI) rate.
122. As part of this quality improvement group the use of Curos port protectors was introduced – I assume this is what is referred to as the green caps. Representation of membership of this group would have included the Lead Nurse for Infection Control.

123. The CLABSI improvement group demonstrated a reduction in line rate infections.

INCIDENT MANAGEMENT MEETINGS (IMT)

ROLE AT THE IMT MEETINGS

124. When I changed roles from Lead Nurse to Clinical Services Manager, my role within the IMT meetings also changed. Initially my role was more about

gathering information, so my presence more often or not was in listening. It was about being given information and then being asked to act on the information we were given, and to implement the recommendations from the group into practice.

125. Then when I changed roles to become Clinical Service Manager, I stepped back slightly from these meetings. To give you an understanding of the structure, at that point our General Manager, Jamie Redfern, was very involved in the IMTs and therefore he was my direct line manager so there was operational representation at that forum. It was felt that it was probably unnecessary that both of us were in the meeting because I also had responsibility for the rest of the hospital.

126. Because of this it was decided at that stage that he would attend the IMT and that I would take the lead for the move back. I then became part of the Project Board for the refurbishment in ward 2A/B Initially this was to be the redesign but, as matters evolved, it went on to become a complete rebuild of Ward 2A and partially 2B. This was managed by the Project Board, which was governed by the Capital Planning Team.

127. Initially my involvement in the IMTs was as Lead Nurse. It would be normal practice that the Lead Nurse would attend any IMT for any of their areas, so if that had been any ward under my remit I would have been invited as part of the membership to the group.

MEMBERSHIP OF THE IMT GROUP

128. Membership of the IMT group is based around the roles of the people involved. There are key people who are always invited; the clinical lead for the speciality is always involved. If there are single patients directly involved, then the lead consultant for those patients would attend.

129. The Senior Charge Nurse and the Lead Nurse would be invited as well as the Infection Control Lead Nurse, the Clinical Director, the Clinical Lead for the speciality, the Microbiologist and the Clinical Services Manager for the area. That would be the standard membership.

130. Infection Control send out the invites for the IMTs, so they have the protocols for inviting people. They have an organisational chart for the areas of responsibility and they know who the members should be for any specific incident.

131. Through time, the membership did grow as we discovered more along the process and more senior management became involved who would maybe not have usually become involved at IMT level previously; people who would usually have an awareness but would not necessarily have full membership.

CULTURE WITHIN THE IMTS

132. At the IMT meetings I attended, everybody was given an opportunity to speak. I always felt I was able to speak freely, voice my opinion and be heard. I never saw anything at any of the meetings that gave me cause for concern.

133. I am also unaware of anyone ever raising a concern that they were not able to speak out. At times we asked some external experts to come in, for example I remember a meeting where we had a drain and all of the plumbing components on the table. I can remember asking what parts were for, what the different sections did and why we were concerned about certain aspects of the drainage.

134. For me there was never a time where I felt any question I asked would not have been answered or that I would feel stupid in the way that I asked a question, so we were all given an opportunity to speak. In fact, at the end of the meeting we were all asked if there was anything else that anybody wished to raise or have clarified, so I felt that everybody in the group had an equal voice.

135. I can remember some IMT meetings more than others. I do remember a HIIAT (Healthcare Infection Incident Assessment Tool) scoring system, where there were laminated cards on the table and we were all given a HIIAT card with a red/amber/green component and there were four topics that we were asked to risk assess. All of the members of the group, whoever was present at the IMT, were asked to comment on each component of the HIIAT score. I did feel that it helped very much because it guided you to what level was the outcome. Each area was discussed and then it was a consensus agreement amongst the membership of that forum of the score for each section. The four sections then tallied up to produce the end result. The Chairperson of the IMT then talked us through the four components of the score but everybody present in the meeting had the ability to comment and give their opinion.

136. There were times when some people in the group maybe did not agree and that sometimes resulted in a bit of debate, but the consensus of the group was always that the whole group were asked to score, and then the final score would be the result.

137. We always scored the HIIAT at the end of the hypothesis and I do not remember any occasion where we ever disagreed on what the outcome of the final HIIAT score. There might have been some discrepancies as the meetings and the membership became very large, so it would trigger a lot of discussion at times. But I would always say that the feeling was at the end that any agreement reached was agreed by the whole IMT.

138. The first IMT was chaired by a microbiologist, Dr Teresa Inkster. I cannot remember if I was fully aware of the reasons for the IMT being convened beforehand, but it became clear through the meetings that there may be some concerns on the part of Dr Inkster that water may be the source of infection.

139. There were many IMT meetings as the group tried to establish what was or was not the cause. That was not something I was closely involved in as it is not my specialist area to interpret the water sampling or to understand infections in this

patient group. I was a member of the IMT group as the Lead Nurse for Ward 2A and 2B. I did not have clinical knowledge of that field but I was aware there was a potential concern over the water.

Water IMTS: 2018

140. As Lead Nurse I would have been involved in IMT meetings if it had anything to do with my area of supervision. I was at several prior to the IMT meetings of 2018, but the only one I can really remember was when we had a norovirus breakout in 3A in either 2016 or 2017 over the Easter weekend and we had to close the ward for a number of weeks because of it. I would have been involved in others as well but I cannot remember exactly what the cause was or what they were

IMT Meeting – 9 March 2018
(A36690458 – Incident Management Meeting, dated 9 March 2018 relating to Water Contamination in Ward 2A, Bundle 1, page 60)

141. I attended an IMT meeting on 9 March 2018. There are various investigations listed in this set of IMT minutes. I do not remember much about this meeting. The water sampling was ongoing at that time, but I would not have been involved in that; it would have been Estates team that would have undertaken the water samples. I first became aware of concerns about the water through the IMT meetings. I believe this IMT was called in March 2018 due to a patient presenting with Cupriavidus bacteraemia.

142. The results of those samples then went to the labs. I would not have been involved in any discussions about the results until it came to the IMT.

143. I remember Teresa Inkster asking for a tap to be brought along to that meeting by Estates. The tap was dismantled and bags containing all the component parts of the tap were displayed on the table so that we could look at them as a group. A member of the Estates Team identified a flow straightener and explained that the purpose of bringing the tap was for us to be shown what it

actually looked like because there had been a bit of discussion about the tap and the flow straightener being potentially problematic.

IMT Meeting - 12 March 2018

(A36690457 – Incident Management Meeting - 12 March 2018 relating to water Contamination in ward 2A, Bundle 1, page 63)

144. I attended an IMT meeting on 12 March 2018. There are a number of control measures listed in the minutes, some of which I had a role in. I would have been responsible for implementing some of the actions at this meeting along with whoever the nurse in charge was. This was when we had the mobile hand basins coming on site.

145. If I remember correctly there was a decision made that they were going to be brought in at night. We spoke about options, such as staying on shift and rolling them out at night, but the children would be sleeping, so the group agreed we would wait until first thing in the morning. I was in the ward the next morning and that is when I spoke to Facilities about bringing them in.

146. They had to outsource different suppliers to get them, so they did not all look the same. They were all different shapes and sizes and I remember that we asked for a demonstration from the Facilities team. The clinical team had various questions around the temperature of the water and how it would be controlled. I assisted the Facilities team to take the mobile sink units in to the ward area and it was the Facilities team that gave a demonstration to the nursing team on how to use them so they in turn could demonstrate how to use them to the patients and family.

147. We introduced bottled water at this stage for washing and bathing and I ensured that staff knew how to decant the water and assist colleagues with hand washing. I am not sure if any of these control measures at all impacted on the patients' treatments. I would say it impacted on them from the

perspective that it was not common practice to have a mobile sink unit in your room and it was not common practice not to be allowed to shower.

148. At this time sterile water distributed from the pharmacy was initially used for drinking. I cannot remember at what time, but we did begin to change to using normal bottled water for drinking, not sterile. We did, however, continue to use sterile water for our Bone Marrow Transplant (BMT) patients, who are our most immunocompromised patients.

149. I was aware that this was not normal practice; I had never done anything like this or been asked to do anything like this before, so I did ask questions. Myself and colleagues were giving assurances to staff and families that we had been advised by Infection Control that these were proper measures to put in place, and were doing our best to make everyone aware of what we were trying to do and why we were doing it.

150. At this time, I was not dealing with the parents directly; it was the nurses in the ward who were speaking to them. I am aware of one incident where a parent asked the nurse in charge to speak to the more senior management team. I then accompanied Jamie Redfern to speak to that parent. They wanted us to explain why we were bringing the sinks in and why we were asking them to use bottled water.

IMT Meeting – 21 March 2018

(A36690549 – Incident Management Meeting, dated 21 March 2018 relating to Water Contamination in Ward 2A, Bundle 1, page 75)

151. I attended an IMT on 21 March 2018. In these IMT minutes, it is noted that I raised concerns that a four bedded bay in Ward 3A had not been fitted with filters and that there were immunocompromised patients there.

152. By this time, we were now looking at filters outside Wards 2A and 2B, across all of RHC. I walked all my areas every day and 3A was part of that, so one of the things I started to do was making sure all the taps had filters fitted.

153. I do remember raising the issue that there was a sink in a four bed bay within that ward that did not have a filter on. It just so happened that I was coming to the IMT and I raised this at the time so that it could be actioned straight away. I remember Colin Purdon actioned it and they were fitted that evening. Colin was a member of the Estates Team but I cannot remember his title at this time

154. **(A39123924 – Email from Angela Johnson to all senior staff nurses subject: Water Incident Update 28.03.18 dated 28 March 2018, Bundle 5, page 132).** This was an email communicating the direction and actions that came out of an IMT that had to be circulated to update staff. It was my understanding that this was more directed at the nursing staff than a communication that was to go out to families, but there was information that was potentially going to be communicated to families within Ward 2A in due course. The people copied into the email are the Senior Charge Nurses and Lead Nurses, which would be the normal process and the Infection Control Team would be copied in too. I was a Lead Nurse at this time which is why I have been copied into the email. It was copied to all the heads of service, ITU, NICU and Theatres. It was for nursing staff to implement the actions that are taken from it as the result of an IMT.

IMT Meeting – 29 May 2018

(A36706508 – Incident Management Meeting, dated 29 May 2018 relating to Enterobacter Cloacae in Ward 2A and 2B, Bundle 1, page 91)

155. I attended an IMT on 29 May 2018. In these IMT minutes I have reported that Ward 2A are carrying out SICP (Standard Infection Control Prevention) audits weekly and hand hygiene audits monthly.

156. At this time, we had increased our normal practice and were carrying out weekly SICP audits (Standard Infection Control Precaution Audit). These are

carried out by one of the nursing team, usually the Senior Charge Nurse or a Band 6. The audit is then uploaded on to an IT platform which Infection Control has sight of.

157. SICP Audits review the safe management of care, environment and equipment.

158. There is also mention in these IMT minutes that I would arrange a peer review of line care on Wards 2A and 2B. Our peer review was an observational study carried out by our Clinical Educators. They are the nurses who train our ward nurses on line care and management. We have Clinical Educators across multiple specialities, as well as a generic team, to cover in-patient areas. A number of speciality areas have their own educator or Educating Team who follow a competence pack and complete a training structure in order that all the ward nurses are trained and competent in line care.

159. At the time, the Haematology-oncology department had its own Clinical Educator, who was responsible for delivering education and training to the ward staff. However, a peer review, is undertaken by another Clinical Educator from a different area.

160. So because of the high risk nature of Wards 2A and 2B, the Neonatal Intensive Care Educator and our Paediatric Intensive Care Educator were probably the best comparison areas where we had a lot of patients with lines in, therefore they would come and carry out the peer review.

161. Likewise, our haematology-oncology nurse would also do peer reviews in either NICU or PICU.

162. At this point, I had been asked to arrange a further peer review to make sure the same standards had been reached as the previous peer review. If I remember correctly, it was the educator from NICU or PICU who came over to do that and that report would have gone to the Chief Nurse.

IMT Meeting – 4 June 2018

(A16690448 – Incident Management Meeting, dated 4 June 2018 relating to Water System Incident in Ward 2A and 2B, Bundle 1, page 94)

163. I attended an IMT on 4 June 2018. At this IMT there was a discussion of cleaning with Actichlor. I do have an awareness of this process: Actichlor is a chlorine-based cleaning agent. The Estates and Facilities team undertook chemical dosing but I cannot remember the exact timeline.

164. This was arranged by the Estates team. From what I have read in the IMT minutes, we were suggesting that we could use chlorine dioxide for the initial drain cleaning and that would be followed by an aseptic acid as part of an ongoing programme.

165. In the same paragraph, the IMT minutes mention the decanting of patients to Ward 2C in order to enable the cleaning. I cannot remember if we decanted patients to 2C.

166. I was there at the HPV clean and I remember from reading this that there was a debate about whether the drain should be cleaned before or after the HPV. From reading the minutes, I think Teresa Inkster said they should be cleaned before it and then the HPV clean would happen afterwards and this was agreed.

167. I cannot remember if we had closed Ward 2A to admissions at this point or not. I cannot remember the number of in-patients at this time, but I do remember that, on the day of the clean, we had empty rooms to allow us to start the cleaning in the morning.

168. I emailed the Estates and Facilities team the details of what the empty room numbers were and we arranged for the HPV cleaning company to gain access to allow the cleaning process to start with an existing empty room first. Once that room was cleaned, we moved a patient out of a room that had not been

HPV cleaned into the clean room, which allowed HPV cleaning to be undertaken in the vacated room and we worked along that process, until all rooms were complete.

169. At this point, the HPV cleaning company only had a couple of cleaning units. The cubicle had to be emptied, the vents had to be insulated and at that point it was like a mist that came off the machines which could set the fire alarms off, so we had measures in place to prevent thisThe contractors came in and sealed up each cubicle. We did have patients in the ward when these were done, but we tended to try and move them so the patients were co-located in an area to allow three or four rooms to be cleaned at a time. Because Ward 2B is a day care Monday to Friday ward, it was felt that it would be better to clean it over the weekend when there were no patients, so that area was done on a Saturday and Sunday which was much easier to do.

170. The HPV was done over a set period of time, but I cannot remember how many days it took. The process has evolved and it is now completely different. The process took a lot longer than it does now.

171. After we arranged for Wards 2A and 2B to be cleaned, we decided we would do the PICU and then we also thought we would do the NICU (Neonatal Intensive Care Units), because they are our other high risk area. After advice from Alistair Leanord, who was the Microbiologist at the time replacing Teresa Inkster and also chairing the IMTs at this point, this became standard practice.

172. It has evolved into a much better process now. The cleaning is conducted with an electric wand rather than the big machine, which I think was carried out for the first time in NICU. The process is therefore much quicker and not as cumbersome. This method was in place and it was being used when the patients came back from Ward 6A to the new Ward 2A. However, while the patients were in 2A prior to the decant to 6A, we did not have the new cleaning system. It was rolled out when the patients were in 6A. Facilities co-ordinate the cleaning companies and it is a different company which undertakes the HPV

cleaning now. It is like anything else, it has improved over the years and now it is standard practice.

173. **(A39123885 – Update for parents on ward dated 7 June 18, Bundle 5, page 142).** This is an update on Wards 2A and 2B from 7 June 2018 when it was decided to undergo the HPV clean. We would have had approval for communication by Jamie Redfern, Jen Rodgers and Kevin Hill and the update would be cascaded down to the Lead Nurse, which would have been me at this time. We would then pass it on to the Nurse in Charge and the Senior Nurses for printing at ward level. Parents would then be given a paper copy.

174. Staff would not just walk into the room and hand families a piece of paper; there was an opportunity to have a verbal discussion and then they were given the paper as an aide memoire to ensure that they also had it written. Whenever communications went out, more often than not, the Chief Nurse would go with the Nurse in Charge or the Senior Charge Nurse and hand out the information to the parents so that there was an opportunity for the parents to ask any questions as well and they would give the verbal update.

175. **(A39123918 – CWH8 Poster, Bundle 5, page 143).** This is a poster/sign that was placed in Wards 2A and 2B in June 2018. From memory, I think there was a feeling at the IMTs that because the patients in the wards were long-term perhaps families were sometimes using the hand wash basins for disposing of other substances, such as the bathwater from the baby bath, or milk, coffee or juices. Although the staff were verbally explaining the position to them, we felt that an aide memoire at the sink might be a better prompt or trigger to try and prevent them putting liquids down the sink that should not be going down the hand wash basin. These signs were put above every hand wash basin in the ward.

<u>IMT Meeting – 8 June 2018</u>

(A36690464 – Incident Management Meeting, dated 8 June 2018 relating to Water System Incident in Ward 2A and 2B, Bundle 1, page 109)

176. I attended an IMT on 8 June 2018. In these IMT minutes reference is made to me speaking about a contingency plan which could be used if the cleaning did not go to schedule. The contingency plan related to how we could accommodate the patients who turned up on Monday morning if the cleaning in Ward 2B was not finished by the Sunday night.

177. The agreement was that they would be admitted directly into Ward 2A and we would run day care patients out of that ward, because by that time it had been fully cleaned.

178. I do not remember ever creating a formal contingency plan in relation to this; it was just an option that was available at the time. There would have been enough capacity in the ward for the day patients rather than them going in to day care.

179. I do not have any memory of us having to do that so I would expect that Ward 2B opened as planned on the Monday morning.

180. **(A38662234 – Updated for parents on cleaning dated 13 June 2018, Bundle 5, page 144)** This was an update about the HPV cleaning in the ward. Again, the communication would have come from Jen Rodgers and Jamie Redfern for cascading and that would have been given to the Nurse in Charge and the Senior Charge Nurses for communicating to the patients.

181. It would follow the same process I have just described. I think I have previously commented that the patients did not move back to into their room after the HPV cleaning was carried out. From reading this update, which notes that, "Your child can go back into the room once it's finished." I think there were some patients who wanted to go back to their original room and we accommodated that as well. But it would only have been if, for example, parents liked to be at a certain area in the ward, with window facing the outside. Some parents chose not to return and others did.

CLOSURE OF WARDS 2A AND 2B/MOVE TO WARDS 6A AND 4B: 26 September 2018

182. I did not have any part in the decision-making for the moving process when Wards 2A and 2B were closed and the patients within those wards were decanted to Wards 6A and 4B.

183. As noted above, in July 2018, I left my Lead Nurse position and became the Clinical Services Manager for Hospital Paediatrics and Neonates (HPN), that was across all of the Children's Hospital and the three neonatal sites and is very much a different role. This role does not require a clinical background, so I actually moved away from nursing at that stage.

184. I was involved in the IMTs because Wards 2A and 2B were under my remit the other Service Manager, had a different role; she led for the directorate on our business continuity plans and major incident planning.

185. I led on more operational day-to-day matters relating to patient flow, such as the front door, the waiting list management and the theatre management.

186. While I was on the IMTs as a result of my responsibility for Wards 2A and 2B, in the September I went on annual leave and when I returned from holiday the ward had moved to ward 6A.

187. I was away for just over two and a half weeks. When I left there was no indication that we were moving, then when I returned to the ward on my first day back, the ward had moved to 6A. It was my colleague who led on that in my absence.

188. I was told at that point that it was felt that there had to be more intensive inspections of the ward and that it would not be safe for the patients to be there when some of the works were undertaken. Therefore, it was felt it would be better for the patients to be re-located out to another area.

189. We did not have a spare ward on the children's site and I am aware from discussions which took place after the event that the likelihood of them going to a similar facility had already been scoped out.That would have been the Beatson Clinic in the Glasgow Area, but the Beatson is at Gartnavel Hospital and, from what I am aware, the management team did a risk analysis on this with the clinical team and it was felt it would be more of a risk to have the children off the campus site rather than to remain on the QEUH campus.

190. By remaining on this site, they would still be co-located near our intensive care unit and the Children's Emergency Department, bearing in mind that Gartnavel did not have an Emergency Department either.

191. Therefore, if we get children presenting through the emergency department who have a haematology-oncology condition, it was deemed to be safer if they remained on the campus site and hence why the Ward 6A in the Queen Elizabeth campus had been chosen.

192. The bone marrow transplant unit had its own specifications which would require the ante-lobby room and the only environment in the Queen Elizabeth campus which simulated that was on Ward 4B, hence why they had chosen the cubicles in 4B to be allocated to paediatrics.

COMMUNICATION RELATING TO THE CLOSURE OF WARDS 2A AND 2B

193. I cannot comment on what communication took place prior to the move as I was not part of that process.

194. I have been shown a number of documents which show communications from the Board on 17 and 18 September 2018.

- **(A38662124 – Press statement from NHS GGC on decision to move patients dated 17 September 2018, Bundle 5, page 148)**

- **(A38662122 – Briefing for parents for ward 2A and 2B patients dated 18 September 2018, Bundle 5, page 149)**
- **(A38662166 – Briefing for parents for other parents and patients dated 18 September 2018, Bundle 5, page 150)**
- **(A38662180 – Core Brief dated 18 September 2018, Bundle 5, page 151)**
- **(A38662164 – IPN updated from NHS GGC dated 18 September 2018, Bundle 5, page 152)**

195. The way we communicate with parents is discussed as part of the HIIAT. One of the scoring elements is how we will communicate with parents. There are various different methods of communication and the communication process would always be agreed in that particular format.

196. We would discuss parental anxieties and public anxiety. There would be a discussion about what do we thought needed to be communicated and at what level. Once we had reached a decision, information statements would be shared between the Infection Control team and predominantly the Senior Management Team and the Communications Team. A statement would then be agreed and, once we received the final document, we would be asked to circulate that.

197. I was on leave when the IMT took place on 17 September 2018.

IMT Meeting – 1 August 2019
(A37991876 – Incident Management Meeting, dates 1 August 2019 relating to Gram Negative Bacteraemia in Paediatric Heam Oncology, Bundle 1, page 334)

ISSUES ON THE WARD: AWARENESS OF REMEDIAL MEASURES USED

198. As mentioned above, I was aware that filters were used as a remedial measure for the water supply. Together with the chloride dioxide dosing and HPV cleaning, these were measures led by Estates and facilities. From a nursing

point of view, our involvement was mostly to make sure that we were facilitating access to the rooms to allow Estates and Facilities access to carry out the procedures.

199. I helped the nurses put them in to the rooms, so I assisted with that. When the bottled water arrived, we explained to the nurses how to do hand washing with them. We also supervised to make sure they were doing it in a way that was not going to give us cross-contamination with them holding the bottles.

200. I was also responsible for ensuring that the staffing levels were appropriate for the situation and that we could bring in additional non-registered nurses for cleaning. We increased our housekeepers at that time in the wards and we increased our staffing numbers to help assist with additional cleaning.

201. My understanding of the situation now is that we have a good maintenance programme in place. We have our filters on and we obviously have a sampling process. We have our sampling checks and assurances The sampling is undertaken by an external company, instructed by the Estates Team, but I do not know the process or the company name. The results are then fed back through Estates to Microbiology and the Infection Control Team and the Infection Control Team then cascades the results down to the Clinical Team.

202. I am confident that the control measures put in place have ensured the water we have in the hospital is within an acceptable level.

Use Of Source Isolation

203. I was not aware that we increased our use of source isolation. Source isolation is one of the processes we use for infection control, but it can be done for a number of reasons. Use of this is predominantly to protect the child, family and the staff members and also to prevent cross-contamination.

204. This is done throughout the hospital and for various different reasons. For example, if someone has vomiting and diarrhoea, we would put them in to source isolation.

COMMUNICATION RELATING TO WATER CONCERNS

205. At the very beginning stage, because the IMT was not aware of whether there was or was not an issue with the water, it was not sure what the communication to families should be.

206. However, as the IMTs evolved, communications were routinely issued to families either verbally or in a written format and holding statements were regularly created for the press.

207. The aspects of communication with which I was directly involved were my attendance at the IMT meetings and thereafter cascading information to staff. If there was an immediate action required after the meeting, it would be communicated verbally at the meeting and you would take that away as an action and then it would be followed up. These actions would be logged in the minutes of the meetings and a copy of the minutes of the meetings tracking these actions would be circulated to attendees after the meetings. I felt this was an efficient way of communicating. I did not ever leave a meeting not having a clear indication of what was expected of me as an outcome of that meeting.

208. There was information that external expertise was sought from out with the NHS with regard to water, and the Board set up its own water group that I was not part of, but information from that group would be relayed to us. I was not involved in this group at all; I am just aware that the group was set up.

209. If there was a wider cascading of information required other than me passing information from the IMTs via the huddles and staff meetings, that would be done through email, or it would be myself going round areas and making staff aware of changing circumstances and issues which were ongoing.

210. We also had a Senior Charge Nurse meeting happening monthly, so all the Senior Charge Nurses would also be updated by the Lead Nurse and Chief Nurses through that forum.

211. Even if we sent things verbally we would still follow it up by writing to the parents or by issues emails to staff. I would also send information to the Senior Charge Nurses and expect the Senior Charge Nurses to cascade that out to the teams directly below them. I would also be given information either from the Chief Nurse, or the Clinical Services Manager to cascade downward.

EVENTS IN WARD 2A/2B - COMMUNICATION WITH PARENTS AND FAMILIES

212. I was aware that meetings with parents occurred, but, as referred to above at paragraph [140], there was only one occasion where I was asked to accompany the General Manager, Jamie Redfern, at the time to meet with a family, and that was at the family's request. That was my only direct communication with a family.

213. I thought the communication was managed very well. I felt that we took decisions from these meetings and cascaded them immediately. There was both written communication and verbal communication. I am aware that the General Manager and Chief Nurse were in the wards more than once a week to pass communications on to parents.

214. Equally, I am aware that at Board level, Jennifer Armstrong, our Director of Medicine, Jane Grant, our Chief Executive, and Professor Margaret McGuire, our Nurse Director, had an open question session with families and parents, and that they were available to speak to them if they required.

215. There was a closed Facebook Group set up in 2019 but I had no input into this and was not a member of the group.

216. When I was a Lead Nurse, I did not have any role in the creation of content regarding the communication to patients and families in wards 2A and 2B at that time. Within my role now, I am more involved in this side of the communications.

217. I personally felt we communicated the information we were aware of at that time and we communicated it as quickly as we could.

EVENTS IN WARD 2A/2B - COMMUNICATION FOR STAFF

218. I felt I received all information that I required at that time and I felt that there was an open communication channel. If I ever felt that I needed further information I knew where to seek it and who to speak to.

219. I can only comment within my current role, but I feel I have good processes in place to communicate with staff. Visibly, myself and the Chief Nurse do walk-arounds and we conduct Question and Answer sessions with staff. These are not just for 2A staff but for the whole of the hospital's paediatrics and neonates. I feel we have a very good open door policy and that we are visible in the organisation.

RISK OF INFECTION FROM THE WATER SUPPLY AND IMPACTS

220. The control measures taken in respect of the water supply did have an impact. On a daily basis we were getting new information and we were cascading that information down, and that was changing some of our practices in the wards.

221. The installation of the portable hand basins at short notice caused some anxiety for the staff because each one of the basins worked differently and some of them were producing hotter water than others. There was also a question of who was going to top them up and where we were going to get the water from, so this did have an impact on the way the nurses worked.

222. The control measures had an impact for the patients also. The families and children were seeing this and it was abnormal practice; it was not what we were used to doing or wanted to be doing. I am not aware of any family member raising this as a concern and nobody raised it as a concern with me directly. I think that was the perception of the staff. There was a communication issued whereby the families were advised about what we were doing but the installation of portable sinks had not been done before so was abnormal practice.

NATURE AND IMPORTANCE OF THE VENTILATION SYSTEM

223. I am aware that outwith Wards 2A and 2B there are negative pressure rooms throughout the hospital. I am aware of what they are and that there is a Standing Operating Procedure on what the correct pressure levels are also that there are pressure gauges outside the rooms to check the pressure.

224. I am also aware that within 2A there are cubicles used for the bone marrow transplant patients or any patient that the clinical team feels should be in a positive pressure room. These rooms are used as infection control measures. There are also pressure gauges outside these rooms which are monitored and an alarm which goes off if the room pressure exceeds or goes below the acceptable level.

225. I first became aware that the Estates team was looking at a programme relating to ventilation as part of the IMT process. There was a group set up to look at ventilation pressures at the time, but initially that was in Paediatric ICU, in relation to air exchanges, rather than in Wards 2A and 2B. My understanding is that they were looking at the differentiation in air changes between some areas in PICU and others. For infection control reasons, the patients required to be segregated. For example, air changes for cardiac patients had to be higher than patients with Respiratory Syncytial Virus. I do not know enough about what happens technically when the air passes through the chambers, but this group was set up by Estates with Infection Control input and I did attend a few of those meetings. This meeting was regarding the ventilation pressures in

relation to PICU, it was a very technical meeting and it was chaired by the Head of Estates. We were given directions by infection control colleagues on where we could locate different cohorts of patients with different conditions, because the air exchange has to be different for an infection versus an immunocompromised patient.

226. How to achieve the air changes and how the levels were adjusted to allow that to happen was led by our Estates colleagues. With regard to Wards 2A and 2B, I probably only became aware of concerns with the ventilation system after the patients had been decanted from the Schiehallion unit and the contractors had come on site.

227. At that point we thought it was just going to require a few adjustments to the existing ventilation system to allow them the contractors to achieve the pressures that the Estates team felt they should be achieving. However, we were subsequently informed, via the Capital Planning Team, that the whole ventilation system required to be replaced, which would delay the decant time.

228. The Board Capital Planning Team is governed by Greater Glasgow Health Board. They run programmes relating to refurbishment. The Assistant Head of Capital Planning was James Huddleston, who led the capital project for the refurbishment of 2A/B.

229. Any control measures taken in respect of ventilation would have been arranged by Estates. I am aware that they attended on site, made adjustments in the plant room and measured the pressures on the ward. Otherwise I have no memory of being involved in any ventilation mitigation measures.

230. We now have a very good maintenance programe arranged and also for ventilation cleaning on a six monthly basis, at the same time. We have ventilation cleans of all our ceiling vents and then get an HPV clean in all our high risk areas. And with Wards 2A and 2B, the HPV cleaning was the last thing that happened before everyone moved back at the end of May 2022.

231. On the day prior to the ward returning to Ward 2A (Schiehallion) the ward was completely closed; nobody was allowed in, neither internal staff nor external contractors. All the works had been finished the day before. We did a full HPV clean and then the patients came back across from 6A to 2A within RHC. We moved back to the ward the following day. Since then we have a six month HPV clean in both these areas as standard practice.

COMMUNICATION RELATING TO VENTILATION ISSUES

232. I cannot remember anything specific about communication in relation to the ventilation concerns but the processes would have been just the same as previous communication processes.

GENERAL: COMMUNICATION

Staff: Communication through Core Briefs

233. A core brief is an email which is sent to all members of staff within GGC. They are prepared and sent out by the Board corporate team and include details of anything that might be happening that day which could affect our business or service.

234. For example, if there were to be ongoing campus works, an upgrade of our IT system which would result in downtime, or train strikes, that would all come out as a core briefing. Every employee receives this by email.

235. Some of the issues may have been communicated to us in the core briefings but I cannot remember any details exactly. I do not remember ever receiving any communication about smells. I do remember that, when the window fell out, we were all alerted to the fact that there was an area which would be cordoned off outside.

236. No communications were issued in relation to the TVs; we were all just very much aware of that and aware of the work that was being done in the background to try and resolve the issues.

237. The TV issues would be reported through our daily huddles, where we would often report how many televisions were not working and ensure that we had alternative provisions.

238. Over the period when investigations were ongoing in ward 2A/2B there was press coverage. It was not a pleasant experience to see what was being said in the press, and I chose not to engage or read it, and felt that that was better for me personally. I chose not to listen to media coverage at the time.

239. I can only comment on the current position in respect of my communication processes in my current role. I have good processes in place to communicate with staff, including conducting, together with the Chief Nurse, Q&A sessions with the whole hospital paediatrics and neonates department. We have an open door policy in the organisation and staff know how to get a hold of us.

Staff: Patient Safety Huddles

240. Patient Safety Huddles take place at 8am and 3pm every day. They are chaired by the Lead Nurse, and the Lead Nurses are on a rota for chairing the huddle. The rotas are usually made up for every three months, so you know in advance what day you are taking the huddle.

241. Pre-COVID, these meetings happened face-to-face and they were held in a seminar room. The nurse in charge for every area would come in for the huddle. We would have the flow coordinator in attendance, who completed the huddle paperwork electronically.

242. We would also have our Hospital Coordinator for the day in attendance, who would be a Senior Nurse responsible for coordinating staffing. Facilities and Estates would be present as well as a Child Protection Advisor. GGC has its

own Public Protection Team with its own Chief Nurse and they are called Child Protection Advisors and are employed under the Public Protection Group, rather than by the Women and Children's Directorate. There is a number of nurses who hold those roles but they do not do any clinical work within RHC. They would attend huddles as being the person on duty. Any concerns could be raised at this forum with an appropriate attendee. The Child Protection Nurse Advisors only came to the morning huddles. Usually one of the advisors or the Lead Nurse for the Service would have attended the huddles.

243. The Child Protection Nurse Advisors used to just be called Child Protection, then it was Child and Adult and it is now Pubic Protection. There are adult advisors too, working under the same structure as the Child Protection Advisors.

244. At the start of the huddle, each ward records the number of patients they have and any free beds, any free cubicles and what their staffing levels are for that day.

245. Where there are concerns about patients, these will be discussed and there would be discussions about how many high dependent patients we have, how many patients require IV (intravenous) infusion, and also how many patients there are who we would call 'watchers'.

246. A 'watcher' is somebody who is clinically scored on a Paediatric Early Warning Score (PEWS) charter or somebody the clinical team are maybe concerned about, so that we are aware of them. The PEWS is a recognised tool that all children would be scored on to track the severity of the concern. A patient with a higher acuity than another patient will have a higher score scored high on the PEWS charter and would be classed in the huddle as being a "watcher".

247. This does not always necessarily mean that the patient is very sick, it can also mean there are a lot of complex things going on with them. They are basically patients who we need to have specific awareness around.

248. We will also report on things for specific areas. Some of the wards will report how many long term ventilated patients they have or how many patients are in dialysis.

249. The Nurse in charge of the ward will then score the staffing and afterwards they are asked to declare whether they feel they are safe to start or not. 'Safe to start' means that they feel at that moment they are what we call 'green' and in a good position to go through the day without any additional support.

250. We might report 'amber', which means we are fine at that moment but we anticipate that as the day goes on, the ward may require additional support. That may be due to something like someone from PICU stepping down in to the ward, or it may mean they have four admissions due in at lunchtime or that they have two members of staff finishing early.

251. Each ward is then given a RAG (Red/Amber/Green) score and, at that point, each ward will also raise any issues that they have. This could be a child protection concern or an issue with facilities. It could also be that they have an issue such as discharge cubicles which have not been cleaned and they want them escalated and prioritised for a clean.

252. It could also be as simple as wheelchairs which have gone missing somewhere and we need a request raised for Facilities to retrieve them. Issues such as a light being out in a cubicle or a toilet not flushing would be escalated to Estates. As noted above, Facilities and Estates are expected to prioritise anything that is escalated at the Huddle and they will respond immediately afterwards.

253. Following the huddle, there is a brief time where the Lead Nurse and the coordinator will then look at safe staffing in all areas. We aim not to leave an area red, so we will look at what we can do to support the ward, ideally to bring it from red to green. At times we may not be able to get an area to green but we can get it to amber.

254. If there are any concerns at that stage that they are unable to bring a ward out of a red area, the matter is escalated to the Chief Nurse, because it will predominantly be due to staffing issues. The Lead Nurse will then speak to the Chief Nurse and escalate the matter that way.

255. The huddle is all about patient safety. Since Covid it is now conducted virtually on Microsoft team, which is actually a really good example of something that has gone well as a result of the pandemic.

256. Previously, if you can imagine having a ward which was going to declare itself red and you were asking the nurse in charge to leave that ward and come up two flights of stairs to attend a huddle room, it could put even more pressure on that ward for that 15 or 20 minutes. So holding the huddles online has had a positive impact.

257. Now every ward has an iPad. We have Teams on an iPad and the nurse in charge can take the iPad with them while they are doing their Huddle and therefore they are interacting, but they are still very visible in their ward at the same time.

258. Therefore, we are getting far greater engagement, so it is one part of Teams that nobody in the Children's Hospital wants to give up. We will not be reverting back to face-to-face meetings.

DUTY OF CANDOUR AND COMMUNICATION WITH PATIENTS

259. Everyone has a duty of candour to make sure that patients are informed and briefed and that the knowledge that the clinician has should be shared directly with the patient. In our case that also meant sharing information with the parent or carer.

260. In terms of communication with patients in general, and paediatric oncology patients specifically, the way I would communicate with patients would depend on the age of the child or young person, rather than what their clinical condition was.

261. I have an awareness of the process we should follow when telling a patient about infections, but I have not had direct involvement of having to speak to a parent to let them know that there is an infection.

262. Every child has their own named consultant, so it is the responsibility of that named consultant to make that communication, usually supported by the Infection Control Microbiologist and normally with a Nurse. They have that conversation to inform the family of the infection the patient is presenting with.

263. The Microbiologist is also there to support the medical member of staff and to provide a bit more in-depth knowledge of what the pathogens of the infection are.

264. A Nurse is usually in attendance to make sure the medical staff do not go off into too much jargon and to answer any further questions in a more relatable manner which the family might have after they have been given all the information.

265. If there were any problems with the treatment, or if anything had gone wrong, again that would be exactly the same process. It would be the responsibility of the Consultant and any other specialties who might be involved in that incident, whether the event happened in ITU or in theatre. Again these specialists would be supported by the relevant nursing teams.

266. If there was any cause for concern at all, then that would be recorded on the Datix system and it would be reviewed by the clinical team.

267. The Datix system is a recording system which is reviewed and held by the Clinical Risk Team. Anybody can submit a Datix and you can submit it for any reason, such as a fall or a near miss. The Datix are submitted and they are then reviewed by the Datix holder, which predominantly is either a Senior Charge Nurse or Head of service for that area. They can then ask for other people to investigate the incident. For example, if there was an issue that involved the Laboratory Team or Estates, then they would ask to investigate their part of the Datix. They are then reviewed and signed off by a final approver.

268. If any Datix scores a four or five, that means that it is scored higher when you answer the tick-box questions as part of the process and a briefing note requires to be attached. The briefing notes are then sent to Clinical Risk and they go through a process where the General Manager receives and reviews the briefing note with the clinical team and a wider governance team. A decision is taken on whether that needs to be commissioned for a Significant Adverse Event Review (SAER). If so, an SAER Team would be commissioned with a remit and a purpose for investigating the incident. It was previously called an SCI, Significant Case Incident. For cases involving a duty of candour incident, this is an automatic trigger for review.

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